2010

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 (EQR) is the analysis and evaluation by an approved EQRO of aggregate information on quality, timeliness, and access to health care services furnished by MO HealthNet Managed Care Health Plans (MCHPs) and their contractors to participants of MO HealthNet Managed Care services. The CMS (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 MCHPs represented in this report:

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

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 MCHP conducted performance improvement projects (PIPs) during the 12 months preceding the audit; six of these PIPs were validated through a combination of self-selection and EQRO review. The final

[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.

selection of PIPs to be audited was determined by the State Medicaid Agency (SMA; Missouri Department of Social Services, MO HealthNet Division (MHD).

2) Validating Performance Measures[2]

The three performance measures validated were HEDIS 2010 measures of Adolescent Well Care Visits (AWC), Follow Up After Hospitalization for Mental Illness (FUH), and Annual Dental Visit (ADV).

3) MO HealthNet MCHP Compliance with Managed Care Regulations.[3]

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): and

4) Special Project – Case Management Record Review

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

[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 (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 (one clinical and one non-clinical) for each MCHP that were underway during 2010. A total of 12 PIPs were validated. Eligible PIPs for validation were identified by the MCHPs, SMA, and the EQRO. The final selection of the PIPs for the 2010 validation process was made by the SMA in December 2010. The SMA directed the EQRO to validate the statewide PIP, Improving Oral Health. Below are the PIPs identified for validation at each MCHP:

Blue-Advantage Plus	Little Stars Program for Teenagers
	Improving Oral Health
Children' Mercy Family Health Partners	Improving Childhood Immunizations
	Improving Oral Health
Harmony Health Plan	Improving Asthma Management – Ages 5-50
	Improving Oral Health
HealthCare USA	Decreasing Non-Emergent/Avoidable Emergency Department Utilization
	Improving Oral Health
Missouri Care	Increased Use of Controller Medication for Members with Persistent Asthma
	Improving Oral Health
Molina HealthCare of Missouri	Members at High Risk of Cesarean Wound Infection
	Improving Oral Health

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, each MCHPs 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 MCHP 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.

- The non-clinical state-wide PIP (Improving Oral Health) attempted to impact the access to dental care.
- One PIP focused on providing in-home support to mothers at risk of Cesarean Section Wound Infections (CSWI) for women with risk factors (Molina of Missouri) and actively provided access to home health services.
- One PIP focused on improving access to immunizations through provider and member education on the importance on obtaining healthcare (CMFHP).
- One PIP focused on educating and assisting members in developing a medical home in an effort to reduce their need to use the emergency department as their primary healthcare resource (HCUSA).
- The on-site discussions with MCHP staff indicate they realize improving access to care is an essential aspect of all projects that are developed.

The PIPs based on the statewide topic of improving Oral Healthutilized MCHP individualized interventions that informed or educated members about the availability of these services and encouraged increased utilization of healthcare 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 MCHP, 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 MCHPs during the on-site review. These interventions addressed key aspects of member 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 the 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 (HCUSA, CMFHP, MO Care and Harmony).
- One project addressed Prenatal and Postnatal care for teenage pregnancy (BA+).

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

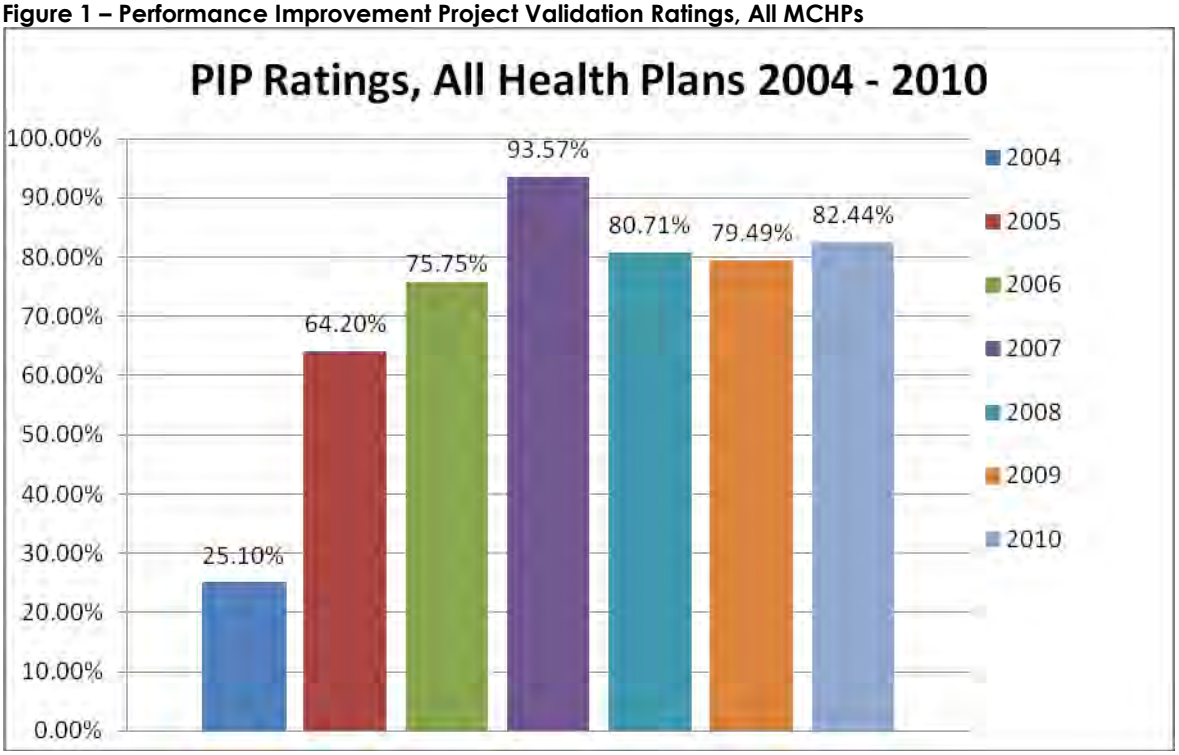
The PIPs related to Improving Oral Health included a focus on obtaining timely screenings for interventions and recognized that this is an essential component of effective preventive care.

Conclusions

The MCHPs have made significant improvements in utilizing the PIP process since the EQRO measurement process began in 2004.

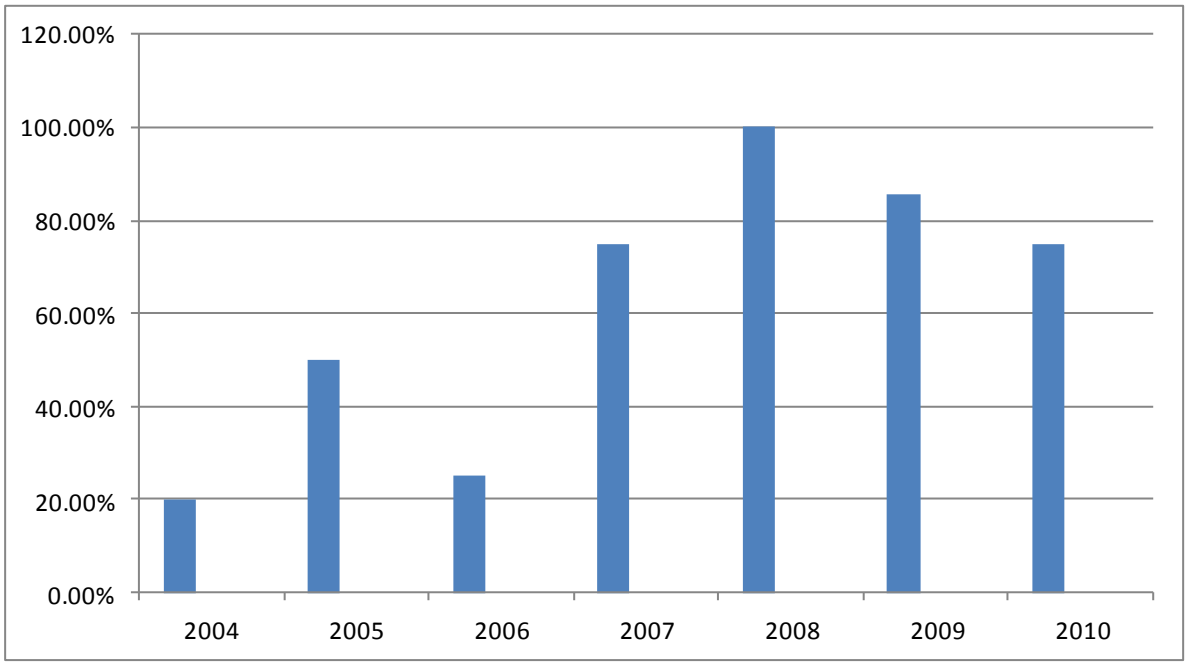
Figure 1 indicates the improvements the MCHPs have made in providing valid and reliable data for evaluation.

Figure 1 – Performance Improvement Project Validation Ratings, All MCHPs



In Figure 2, an essential element in validating these projects is represented, that 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. In 2010, only four PIPs were considered mature enough to evaluate their ability to produce sustained improvement. Of those four PIPs three were considered likely to sustain improvement, thereby the PIPs are only rated as 75% compliant for the 2010 review. The MCHPs 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



1.3 Validation of Performance Measures

The Validating Performance Measures Protocol requires the validation or calculation of three performance measures at each MCHP by the EQRO. The measures selected for validation by the SMA are required to be submitted by each MCHP 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 the HEDIS 2010 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, MCHP extract files, medical records, and data submissions provided to the SPHA to conduct the validation activities of this protocol. The data reported to DHSS was based on MCHP performance during 2009.

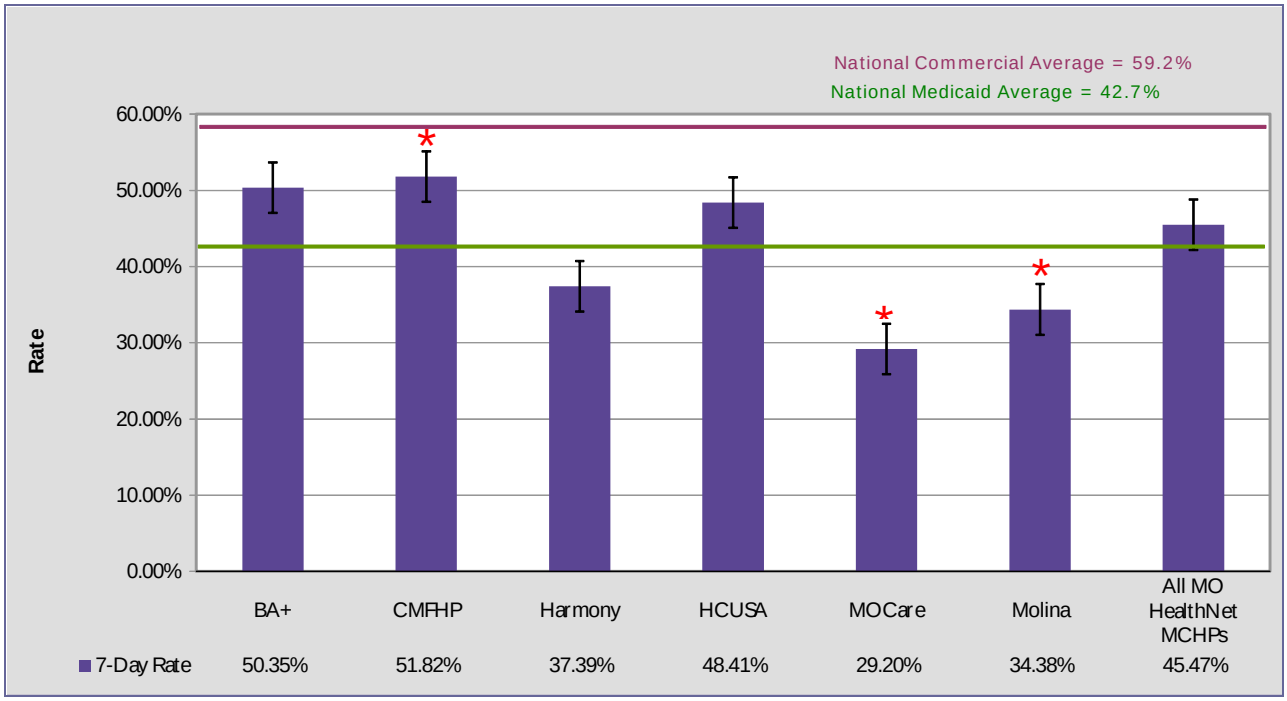
QUALITY OF CARE

The HEDIS 2010 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 MCHP members.

Two MCHPs were Fully Compliant with the specifications for calculation of this measure. The four remaining MCHPs were substantially complaint with the specifications for calculation of this measure.

Three MCHPs (BA+, CMFHP and HCUSA) reported rates (50.35%, 51.82% and 48.41%, respectively) that were higher than the National Medicaid Average (42.7%) for the 7-day follow up rate,.

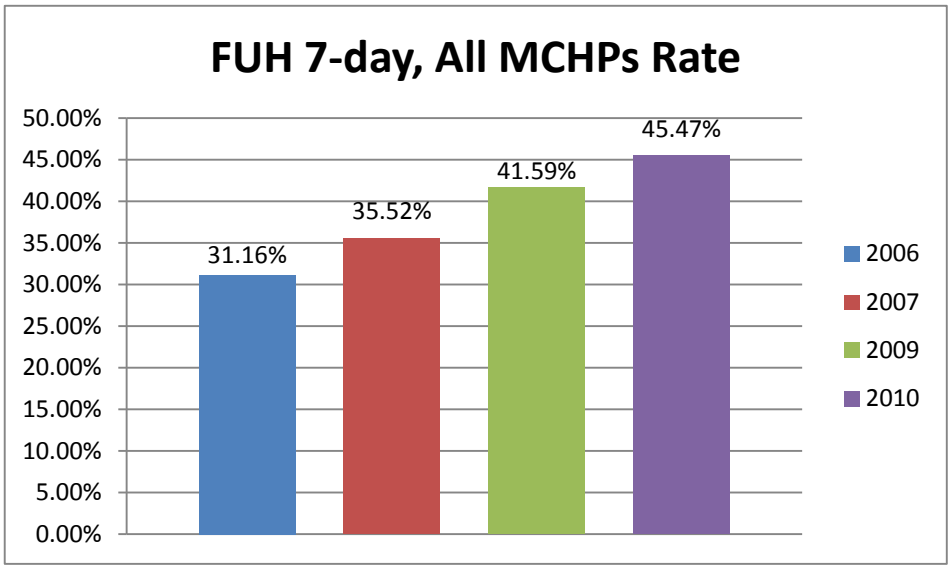
Figure 3 - Managed Care Program HEDIS 2010 Follow-Up After Hospitalization for Mental Illness, 7-Day Rates



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: MCHP HEDIS 2010 DST; National Committee for Quality Assurance (NCQA).

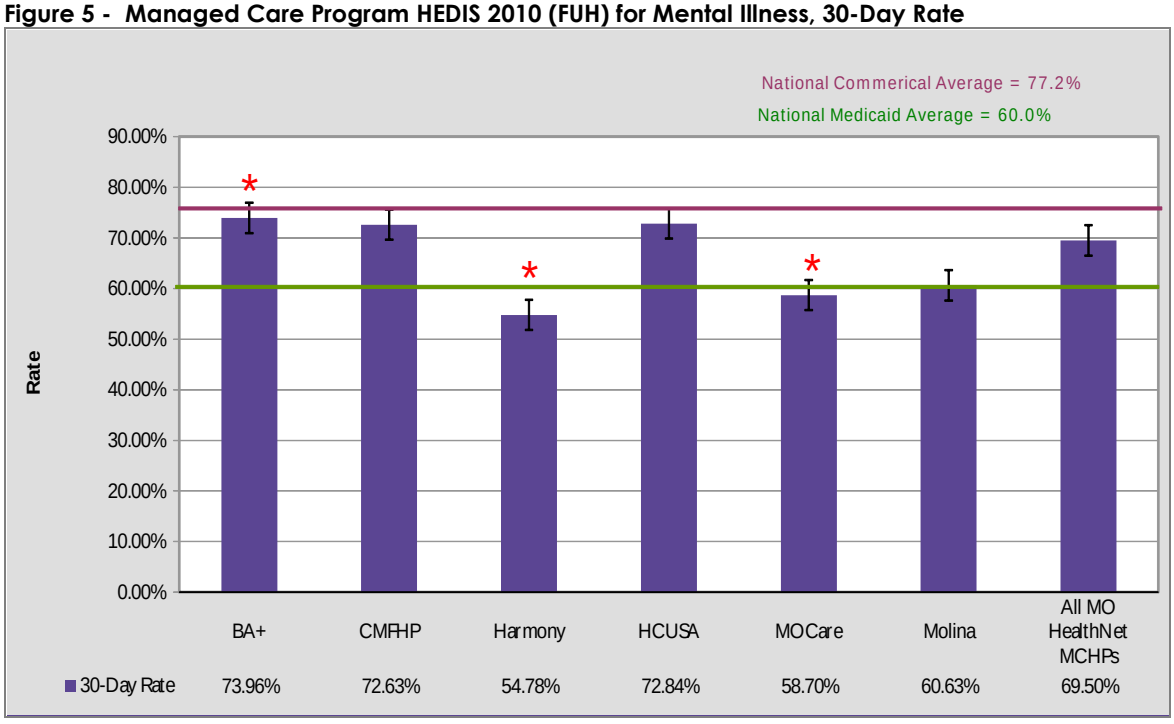
This measure was previously audited by the EQRO in audit years 2006, 2007, and 2009. The 7-Day reported rate for all MCHPs in 2010 (45.47%) was a 14.31% increase overall since the rate reported in 2006 (31.16%); it is 3.88% higher than the rate reported in 2009 (41.59%).

Figure 4 – FUH 7-Day, All MCHPs



For the 30-day follow up rate, four MCHPs (BA+, CMFHP, HCUSA, and Molina) all reported rates (73.96%, 72.63%, 72.84% and 60.63%, respectively) that were at or above the National Medicaid Average (60.0%) for this measure. The overall MO MCHP rate (69.50%) was also higher than the National Medicaid Average.

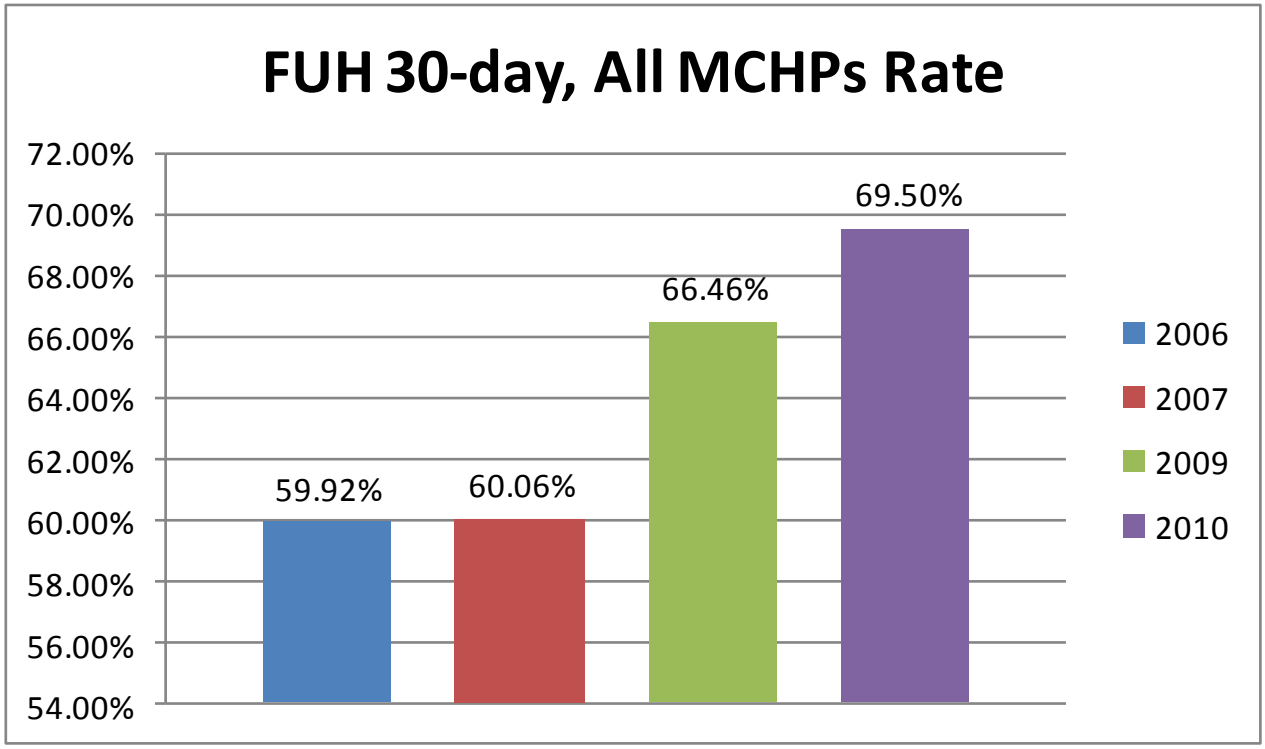
Figure 5 - Managed Care Program HEDIS 2010 (FUH) for Mental Illness, 30-Day Rate



Note: Error bars on the y-axis represent 95% confidence intervals.
Sources: MCHP HEDIS 2010 DST; National Committee for Quality Assurance (NCQA)

This measure was previously audited by the EQRO in audit years 2006, 2007, and 2009. The 30-day reported rate for all MCHPs in 2010 (69.50%) was a 16.58% increase overall since the rate reported in 2006 (52.92%); it is 3.04% higher than the rate reported in 2009 (66.46%).

Figure 6 – FUH 30-Day, All MCHPs



From examination of these rates, it can be concluded that 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 the quality of care received is not quite as high within the 7-day timeframe. In both timeframes, members are receiving a lower quality of care than the average National Commercial member. However, based on the upward trend in the rates reported from 2006 - 2010, the quality of care for Follow-Up After

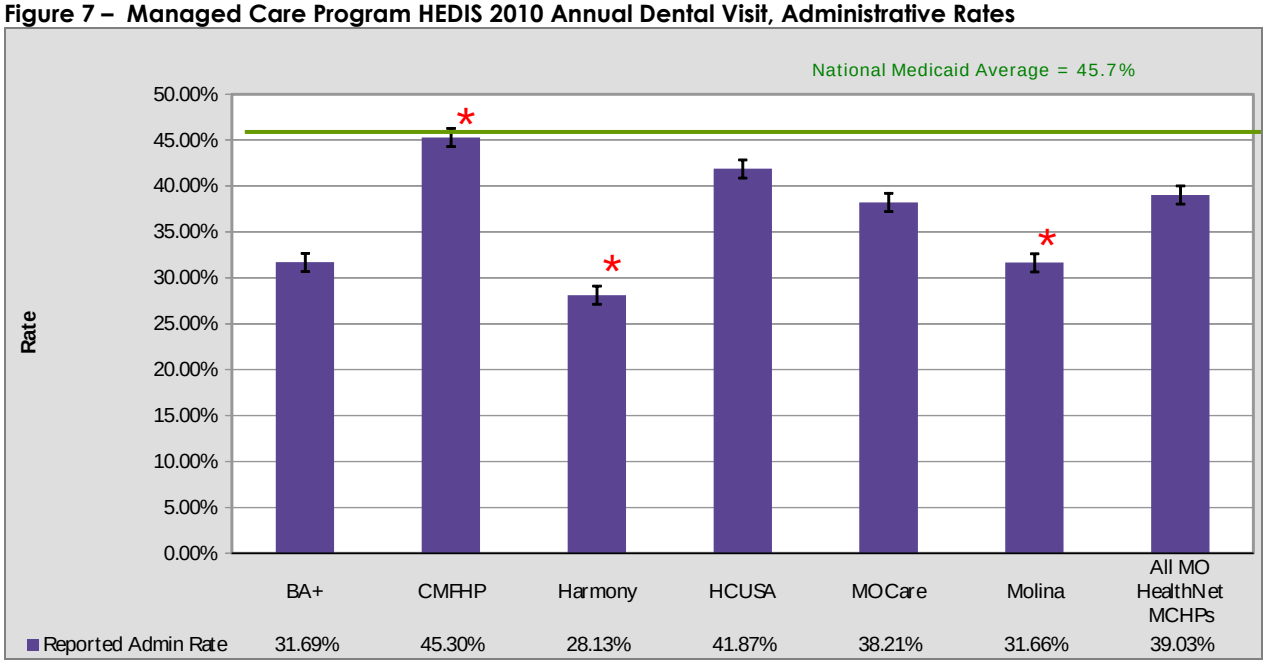
Hospitalization for Mental Illness has significantly increased over time in Missouri for both the 7-day and 30-day timeframes.

ACCESS TO CARE

The HEDIS 2010 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 MCHP's calculations were rated as not valid.

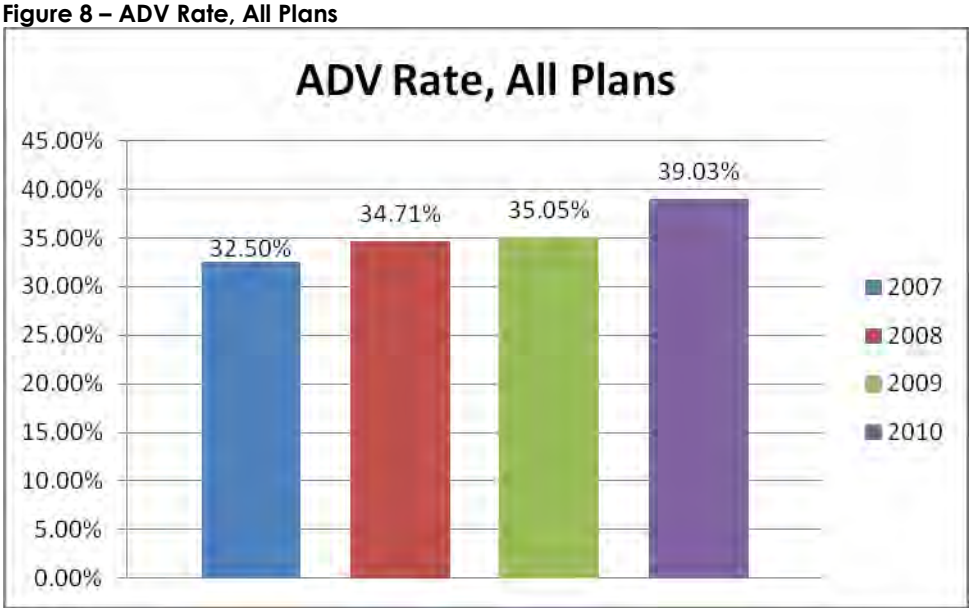
Figure 7 – Managed Care Program HEDIS 2010 Annual Dental Visit, Administrative Rates



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: MCHP HEDIS 2010 Data Submission Tool (DST); National Committee for Quality Assurance (NCQA).

The Annual Dental Visit measure has been audited in the 2007, 2008, 2009, and 2010 external quality reviews. Over the course of these review periods, the rates for all MCHPs have improved a total of 6.53% (see Figure 8); the rates reported were 32.50% in 2007, 34.71% in 2008, 35.05% in 2009 and 39.03% in 2010. Although the rates have increased for the Annual Dental Visit measure, Figure 7 details that none of the MCHPs reported a rate in 2010 higher than the National Medicaid Average of 45.74%, although one MCHP (CMFHP) was close at 45.30%.

Figure 8 – ADV Rate, All Plans



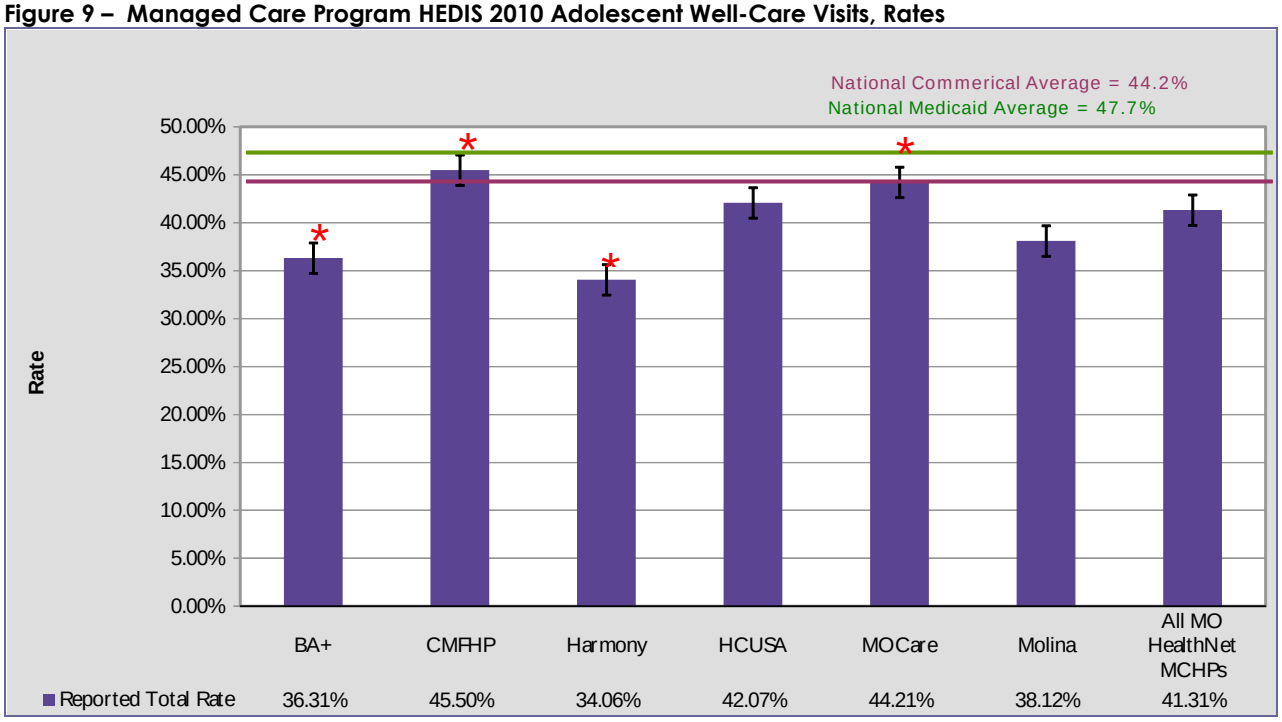
This trend shows an increased level of dental care received in Missouri by Managed Care members, illustrating an increased access to care for these services for the HEDIS 2010 measurement year.

TIMELINESS OF CARE

The HEDIS 2010 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 MCHPs were fully compliant with the specifications for calculation of this measure, and the remaining four MCHPs were substantially compliant with the measure's calculation.

Figure 9 – Managed Care Program HEDIS 2010 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: MCHP HEDIS 2010 Data Submission Tool (DST); National Committee for Quality Assurance (NCQA).

The Adolescent Well Care Visits (AWC) measure has been audited in the 2007, 2008, 2009 and 2010 external quality reviews. Over the course of these review periods, the rate for all MCHPs has increased overall (see Figure 10). The rate reported in 2010 (41.31%) is an improvement over the rates previously reported in each of the other three review years (34.81% in 2007, 38.59% in 2008, and 35.63% in 2009). However,

none of the MCHPs reported a 2010 rate higher than the National Medicaid Average of 47.7% (see Figure 9).

Figure 10 – AWC Rate, All MCHPs

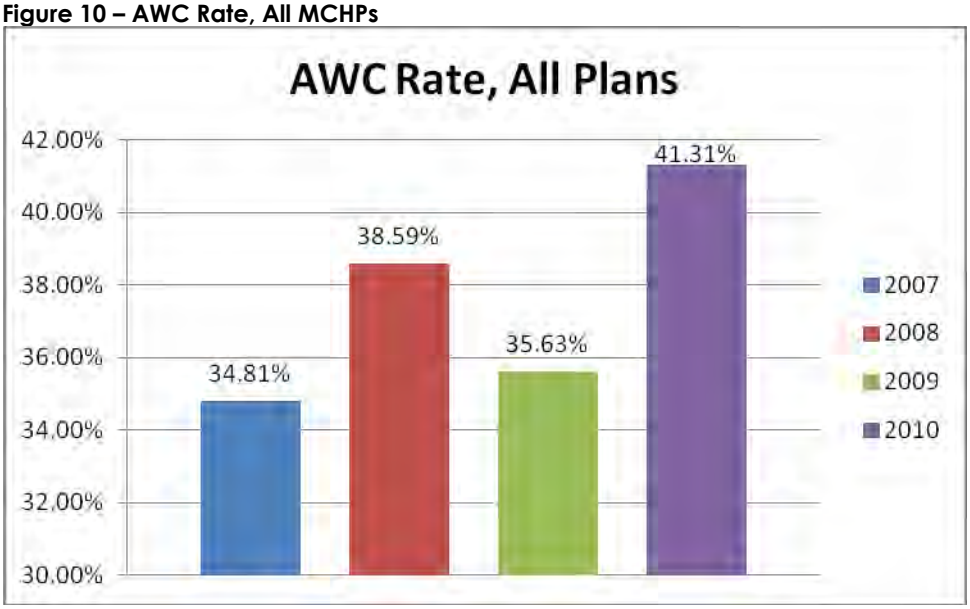


Figure 10 illustrates an increase in the timeliness of care for well care visits delivered to adolescents in Missouri during the HEDIS 2010 measurement year.

1.4 MO HealthNet MCHP Compliance with Managed Care Regulations

The purpose of the protocol to monitor MCHP Compliance with Managed Care Regulations is to provide an independent review of 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 MCHP personnel. This combination of information was designed to provide the SMA with a better understanding of organizational performance at each MCHP.

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

The 2009 report was a full compliance review. This year's compliance review is a follow up to that review and includes a follow up to the 2006 review which included a case review of Grievance and Appeal files. The SMA reviewed current policies and procedures to ensure 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 Grievance and Appeals and Case Management processes. The review included case record

reviews and interviews with Grievance and Appeal staff, Case Management staff, and Administrative staff.

The results of the Case Management review will be reported in another section of this report as a "Special Project". The interview tools were based on information obtained from each MCHPs' 2010 Annual Reports to the SMA and the SMA's Quality Improvement Strategy.

The review process included gathering information and documentation from the SMA about policy submission and approval, which directly affects each 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 MCHP'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. All thirteen were found to be 100% compliant by all MCHPs, and include:

- Communicating 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 MCHPs.
- The MCHPs recognized these requirements are essential to create an atmosphere of delivering quality healthcare to members.
- The MCHPs maintained an awareness of and appropriate responses to cultural and language barriers concerning communication in obtaining healthcare.
- The MCHPs responded to physical, emotional and cultural barriers experienced by members with diligence and creativity.
- The MCHPs demonstrated an awareness of Enrollee Rights and Protections by have standards and practices in place that were compliant and evident in discussions with staff who interact directly with members. The attention to ensuring quality care was apparent throughout each of the MCHPs.

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

- These regulations included provider selection, and network maintenance, subcontract relationships, and delegation.
- The MCHPs had active mechanisms for oversight of all subcontractors.
- The MCHPs 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 Managed Care members.

ACCESS TO CARE

There are seventeen (17) regulations pertaining to Access Standards. Twelve of these regulations were found to be 100% compliant by all of the MCHPs. None of the MCHPs were fully compliant with the 17 federal regulations concerning Access Standards. All MCHPs were non-compliant with the Care Coordination areas of these regulations. The twelve regulations found to be fully compliant included:

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

One area of concern is care coordination. Although all six MCHPs had all required policy in place, the MCHPs were unable to demonstrate that they had fully compliant care coordination processes in place. All six MCHPs 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. Eight of these were found to be 100% compliant by all of the MCHPs.

- All six MCHPs adopted, disseminated and applied practice guidelines to ensure sound and timely healthcare services for members.
- The MCHPs used their health information systems to examine the appropriate utilization of care using national standard guidelines for utilization management.
- The MCHPs 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 MCHPs 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 MCHPs.
- 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 quality service, decision-making, and sound healthcare practices occurred on behalf of MCHP members.

The EQR was asked by the SMA to focus more closely on the area of Grievances and Appeals during this follow-up Compliance review. 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 members and providers.

The EQR developed a methodology whereby, a sample of Grievance and Appeal files were reviewed on-site by the EQR Project Director. A listing of all Grievance

and Appeals, as reported by the MCHPs to the SMA, was obtained for 1Q2010 and 3Q2010. A number of these files were then randomly selected for review at the on-site visit. Each MCHP was provided a listing of the files to be reviewed one week prior to the on-site reading day (1/2 day of review).

Once on-site, these files were reviewed for compliance with Subpart F of the regulatory provisions for Medicaid Managed Care (Grievances and Appeals) and the MCHPs' contract for the provision of services with the SMA.
All six MCHPs experienced some level of noncompliance with the regulations related to grievances and appeals. Although all plans had policy and procedures that were complete and approved by the SMA, at most of the MCHPs, a review of the files showed a lack of adherence to those policies and procedures (see Table 1). Additionally, it was determined that some of the mandatory language required by the Managed Care contract did not rise to meet the requirements of the regulatory provisions outlined in the Federal Protocols. Specifically: 1) the language included in each MCHPs' member handbook, does not delineate the MCHPs' availability to assist members in filing a Grievance and/or Appeal, and 2) the mandatory language included in each MCHPs' member handbook, does not indicate that the MCHP will supply the member with the State or Federal regulations that support any action the MCHP may have taken.

Table 1 – Grievance and Appeals Records Reviewed (by MCHP)

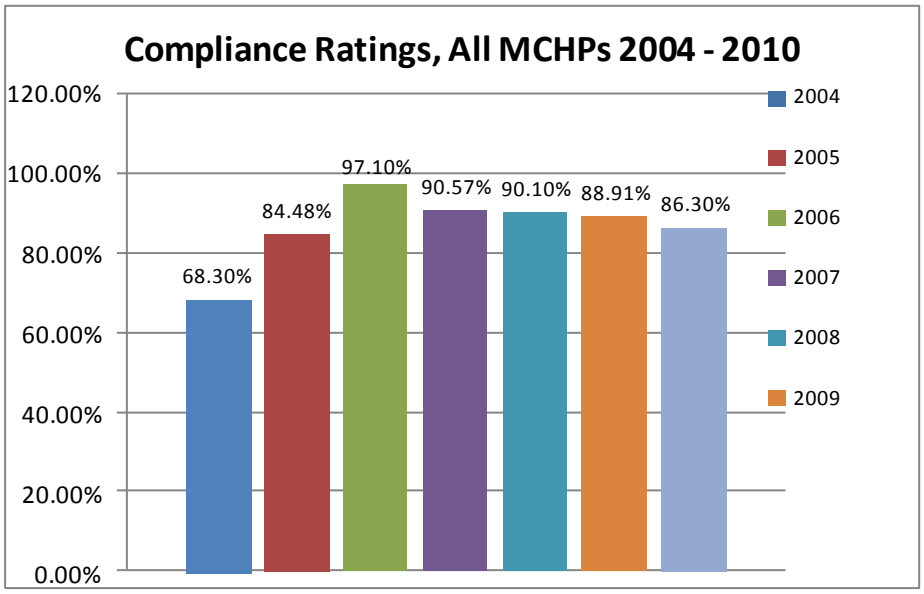
MCHP	# of records reviewed	# with issues	% with issues	% Correct
Blue-Advantage Plus	30	7	23.33%	76.67%
CMFHP	42	0	0.00%	100.00%
Harmony	29	19	65.52%	34.48%
HCUSA	35	4	11.43%	88.57%
MO Care	35	5	14.29%	85.71%
Molina	30	6	20.00%	80.00%
Statewide rate	*201*	*41*	*20.40%*	*79.60%*

CONCLUSIONS

The MCHPs have shown significant improvement in their ability to meet the requirements of compliance with the federal regulations. Initially in 2004 the MCHPs did not have complete and approved written policies and procedures and MCHP processes did not exhibit compliance with contractual and regulatory requirements. In subsequent measurements, the MCHPs made concerted efforts to complete policy and procedural requirements. In 2007-2010, 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 MCHP (Harmony), which has not yet completed required policy, and is continuing to develop compliant organizational processes, continued improvement was observed. The MCHPs have used previous EQRs to ensure that compliant policies are in place, and continue their efforts to ensure compliant and member focused procedures.

A downward trend in the Compliance Ratings, as detailed inFigure 11, can be attributed to the MCHPs inability to demonstrate that they had fully compliant care coordination and/or grievance and appeals processes in place. All six MCHPs state that complete care coordination is an area where they seek improvement. Additionally, all six MCHPs experienced some level of noncompliance with the regulations related to grievances and appeals. Although all plans had policy and procedures that were complete and approved by the SMA, at most of the MCHPs, a review of the grievance and appeals files showed a lack of adherence to those policies and procedures.

Figure 11 – Summary of MCHP Compliance with Federal Regulations



1.5 MO HealthNet MCHP Special Project – Case Management Performance Review

INTRODUCTION

The Division asked the EQRO to conduct a special study as part of the 2010 review in order to analyze and evaluate the Managed Care Health Plans' compliance with federal regulations regarding quality, timeliness and access to health care services related to the provision of case management services. In the previous review year (2009) case management records were reviewed as part of the Compliance Section of the EQRO. The objective of the Special Study is to complete an in-depth follow-up review to assess the MCHPs' improvement in Case Management Services and recording keeping and to evaluate compliance with the federal regulations and their contract.

The focus of this review was the following:

- The MCHPs' response to referrals from State systems regarding Lead Case Management and Children with Special Healthcare Needs;
- The MCHPs' attention and performance in providing case management to pregnant members;
- Evaluating compliance with the MHD Managed Care contract; and
- Exploring the effectiveness of case management activities provided by the MCHPs on cases open in their system.

OBSERVATIONS AND CONCLUSIONS

- Case management in OB cases often ends right after the baby is born. The case managers report an awareness that the case should remain open for at least sixty (60) days, or until the member loses eligibility. However, they report that the member often loses contact with them. The case manager will make attempted contacts, but the member fails to return calls/changes

addresses or phone numbers and the CM no longer has access to the member.

- Case managers report that they are often unable to create a useful transition plan with the member when it appears the case should be closed. As members' health care needs are met they lose interest in case management and no longer return calls or respond to letters requesting they contact the case manager.
- Case managers reflect that they have access to a great deal of information in their case management systems but all of this documentation was not shared with the EQRO when case records were produced for review. Reviewers explained they can only look at what they receive, but understand that additional information may exist. This was particularly true regarding care plans.
- At several MCHPs, reviewers were told that completing the assessment process, in the system, automatically produces a care plan. Even at these MCHPs, reviewers found assessments in the case files while no care plan was included in the record.
- Complex case management and care coordination is different for each MCHP. It either occurs rarely or is not documented in progress notes. How each MCHP defines and executes complex case management is unclear.
- It is noted that Missouri Care members receive complex case management and intense care coordination. This is done in an integrated manner and it appears very seamless to the member. Some of the requirements of the Lead Case Managers inhibit a strong case management process. This is a dedicated group of case managers across all the MCHPs. Arbitrarily maintaining open cases, even when the elevated blood lead level is low (below 15dL for example), and requiring the tracking of members through PCP contacts and health department contacts is time consuming and may not be an efficient use of their time.
- A lack of commitment to members who are difficult to locate or contact was observed. The case managers earnestly provide services to members who

are interested and are actively participate in the process. These same case managers exhibit a loss of interest in unresponsive members.

- The case managers from one MCHP (Harmony) are in a remote location. It should be noted that these case managers do not demonstrate an essential understanding of the members they serve. They discuss members in terms of the "market," rather than individuals in need of guidance or services. Responses to questions do not reflect an intrinsic knowledge of the cultural or geographic idiosyncrasies that exist and are important to adequate member services. These case managers focus on the "St. Louis market" and have little knowledge of the remainder of the Managed Care Eastern Region. These facts create a vacuum in services, referrals, and ancillary resources for MCHP members.

1.6 MO HealthNet MCHP Initiatives

The EQRO obtained self-reported information from each MCHP for inclusion in the Annual EQR Report. Below are summaries of one initiative that was submitted by each MCHP.

Blue-Advantage Plus of Kansas City	ER Utilization Initiative
Children's Mercy Family Health Partners	Cervical Cancer Screening Initiative
Harmony Health Plan of Missouri	Harmony Hugs Program
HealthCare USA	Condition Management Programs
Missouri Care Health Plan	Breast Cancer Telephone Campaign
Molina Healthcare of Missouri	ER Short Interval Overuse Program

BLUE ADVANTAGE PLUS

ER Utilization Initiative

BA+ has an ongoing project to identify members with non-emergent reasons for visiting the ER and address these root causes with specific interventions. Results to date indicate a significant decrease in the number of ER visits by these targeted members.

On a bi-weekly basis, BA+ members who visit the ER for non-emergent reasons are sent an ER magnet mailer. The ER magnet mailer provides PCP contact information, transportation information, and Nurse Advice Line contact information. In addition, the magnet mailer provides a list of the three closest urgent care centers near the member's residence.

- During 3Q10, BA+ sent 109 ER Magnet Mailers
- During 4Q10, BA+ sent 137 ER Magnet Mailers

On a weekly basis, BA+ Nurse Case Managers provide telephonic outreach calls to members who visit the ER for non-emergent reasons.

- During 3Q10, 20 members received ER case management
- During 4Q10, 85 members received ER case management

ER Initiative Success

In 2009, BA+ continued to implement interventions focusing on reducing non-emergent ER visits.

The ER Magnet Mailer intervention focused on the ER case management outreach efforts implemented in 2008. The ER Magnet Mailer and ER Case Management interventions have shown great success in reducing non-emergent ER visits.

In 2009, BA+ mailed 2,252 Magnet Mailers to members who utilized the ER for non-emergent reasons. Twelve (12) months pre-intervention date, there were 5,707 non-emergent visits generated by the members who received the Magnet Mailer. Twelve (12) months post intervention date results show an annualized 18% reduction in non-emergent ER visits for the members who received the Magnet Mailer.

In 2009, 135 members (0 to 6 years old) received case management services due to frequent non-emergent ER visits. Twelve (12) months pre-intervention date, there were 519 non-emergent visits generated. Post intervention results show an annualized 36% reduction in non-emergent ER visits for members who received case management outreach in 2009. Due to the success of the ER Case Management intervention, BA+ has plans to start providing outreach to the entire BA+ population.

CHILDREN'S MERCY FAMILY HEALTH PARTNERS

Cervical Cancer Screening Initiative

After implementing the Cervical Cancer Screening Initiative, member screening rates increased from 0% to 37% for study population. The HEDIS 2010 rate for the Cervical Cancer Screening (CCS) measure improved 5.08% from 2006 (67.19%) to 2010 (70.6%). In addition, customer service calls for Well Woman were implemented during 3rd quarter 2010. The distribution of Well Woman Mailers began in September 2010.

HARMONY HEALTH PLAN OF MISSOURI

Harmony Hugs

- The Harmony Hugs Coordinator completed 17 home visits. 323 maternity notifications were received and 15.8% of members were enrolled in Harmony Hugs through member outreach.
- Harmony had 152 deliveries and 88% of those deliveries had birth weights above 2500 grams remaining consistent with 1st and 2nd quarter 2010 statistics. The health plan foresees continued improvement in birth weights by providing members enrolled in Harmony Hugs personalized case management. Two (2) Hugs members were referred to High Risk.
- The Harmony Hugs Program description is being revised to include additional support to members considered high risk. The lower and moderate risk members will also receive Harmony Hugs Coordinator support that is more comprehensive. It is the health plans intent that these changes will take effect in the 4th quarter of 2010, resulting in better birth outcomes through increased member participation in prenatal care.

HUGS Success

The Hugs Coordinator has been working with health plan member, RS since April of 2010. In this time, she has ended her domestically violent relationship and sought behavioral health therapy. She utilized referrals given by the Hugs Coordinator, continues to meet with a therapist, and attends a support group weekly for victims of domestic violence. She also meets regularly with the St. Louis County Public Health Nursing Program for first time moms, Building Blocks, to which she was referred by the Hugs Coordinator.

RS suffered financial setback in July of 2010. The apartment complex where she resides experienced significant flooding. Her apartment was one of many deemed uninhabitable by the St. Louis County Health Department. The Hugs Coordinator provided RS with advocacy and support throughout her trials and tribulations with the property management company. Additionally, at the prompting of the Hugs Coordinator, she worked closely with her providers to ensure the health of her

unborn baby through receiving a tetanus shot, asthma treatment, and an additional OB visit after her exposure to flood related toxins.

Upon first meeting with RS, she and the Hugs Coordinator developed short and long-term goals. Ultimately, RS was interested in, primarily, having a healthy baby. She also wanted to work toward securing more gainful employment, moving to a new apartment so her former abuser would not know where to locate her, and getting a car. She was forced to move into a new apartment in the same complex after the flooding due to her lease agreement. RS is working to save money for a security deposit and first month's rent at a new apartment. Saving is becoming easier for RS as she recently found a new job and is making more money. The Hugs Coordinator has worked with RS to develop a budget that includes savings. Additionally, RS was able to purchase a car which has helped her tremendously as she formerly had a 2 hour commute to and from work via public transportation. RS is not due to deliver until the end of October. RS, her OB provider, and the Hugs Coordinator are all pleased with the progression of this pregnancy as she is at great risk for preterm delivery due to stress and a pre-existing reproductive tract condition.

HEALTHCARE USA

Condition Management Programs

In 3Q 2010 Coventry rolled out their newly developed condition management programs: High-Risk OB, High-Cost Neonate, and Asthma. These programs standardized the disease management efforts across all Coventry Medicaid plans. The new corporate programs are very similar in make-up to HealthCare USA's previous disease management programs for these conditions.

Condition Management Programs Success

For the second year in a row, HealthCare USA was chosen to present best practices storyboards at the annual URAC conference. For the first time in the history of URAC, a single HMO (HealthCare USA) was selected for three best practice awards. HCUSA's programs in High-Risk OB, NICU, and Asthma were presented at the URAC Best Practices in Health Care Consumer Protection and Empowerment Awards held in Chicago October 5-7, 2010. There were 30 finalist chosen from across the nation from at least 200 entries

Missouri Care Health Plan

Breast Cancer Telephone Campaign

The Quality Department started a Breast Cancer telephone campaign in August targeting female members 40 years and older, by telephone who have not had a mammogram this year. Missouri Care started with a list of 91 members to target. Since August there have been several members MO Care has spoken to that have said they will make an appointment before the end of this year to get a mammogram and two members that have already scheduled and had appointments.

Breast Cancer Campaign Success

During one of the first contacts the Quality Representative had with a member, the member said she had a mammogram scheduled by her PCP a couple of months ago, right after her yearly women's health check-up. She did not go to the appointment because she did not feel she was at risk for breast cancer and did not see a need for a mammogram. The Quality Representative explained to the member that being over 40 alone put her at a greater risk for breast cancer even if she does not have a family history and that her risk increases each year with age. The Quality Representative reminded the member that a mammogram was a no cost benefit of her insurance and she did not need a referral to get one. The Quality Representative gave the member the telephone numbers to both Ellis Fischel Cancer Center and the University of Missouri Hospital in Columbia and advised the member to call either facility and ask to be transferred to Central Scheduling to set up an appointment. The member said she would. The Quality Representative told the member she would call her back in a couple of weeks to see if the member had made her appointment and would help her set an appointment at that point if she had not.

When the Quality Representative called the member back as she said she would, she was quite surprised when the member remembered who she was and why she was calling. The member had ended up scheduling herself another appointment to get a mammogram and went! The member thanked the Quality Representative for

taking the time to make these calls and was very excited to tell her that her mammogram came back normal and going forward, she will be getting a mammogram every year.

MOLINA HEALTHCARE OF MISSOURI

Automated HEDIS Alert System

In July 2010, Molina implemented an automated alert system that identifies members who have not met specified HEDIS measures when opening a member's profile in the system. Training was provided to all appropriate employees about the use and purpose of the alerts. Molina is collecting data to determine the effectiveness of the alerts. Molina formulated a report of missed HEDIS services for providers to refer to when treating Molina members. Molina continues to use the member and provider newsletters as a means for educating members and providers about benefits, services and how to improve members' healthcare.

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 MCHP which have been initiated, are underway, were completed during the reporting year, or some combination of these three stages. The SMA elected to examine projects that were underway during the preceding calendar year 2010. This selection included evaluating the Statewide PIP entitled Improving Oral Health. The aggregate report was evaluated, and each individual MCHP'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 Managed Care contract describes the following requirements for MCHPs relative to conducting PIPs:

> Performance Improvement Projects: The MCHP shall conduct performance improvement projects that are designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and nonclinical care areas that are expected to have a favorable effect on health outcomes and member satisfaction. As requested, the MCHP shall report the status and results of each performance improvement project to the state agency, which must include state and/or MCHP designated performance improvement projects… The performance improvement projects must involve the following:
>
> - Measurement of performance using objective quality indicators.
> - Implementation of system interventions to achieve improvement in

quality.

- Evaluation of the effectiveness of the interventions.
- Planning and initiation of activities for increasing or sustaining improvement.

- Completion of the performance improvement project in a reasonable time period so as to generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year.
- Performance measures and topics for performance improvement projects specified by CMS in consultation with the state agency and other stakeholders.

2.2 Purpose and Objectives

The purpose and objectives of the present review were to evaluate the soundness and results of PIPs implemented by MCHPs during the calendar year 2010. The MCHPs are required 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 2010 included the initial and ongoing methods utilized in the Statewide PIP, which was the non-clinical PIP evaluated for each MCHP for the remeasurement year. Each MCHP developed individualized interventions to create improved outcomes for their members.

2.3 Performance

Table 2 – Performance Improvement Project Validation Findings by MCHP

Step	Item	MO HealthNet Managed Care Health Plans											
		Molina		HCUSA		Harmony		MOCare		CMFHP		BA+	
		Members at High Risk of Cesarean Wound Infection	Improving Oral Health	Decreasing Non-Emergent/Avoidable ED Utilization	Improving Oral Health	Improving Asthma Management	Improving Oral Health	Increased Use of Controller Meds for Members w/ Asthma	Improving Oral Health	Improving Childhood Immunizataions	Improving Oral Health	Little Stars Programs for Teens	Improving Oral Health
	1.1	2	2	2	2	1	1	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	1	2	2	2	2	2	2	2
Step 2: Study Questions	2.1	2	2	2	2	2	1	2	2	2	2	2	2
	3.1	2	2	2	2	1	0	2	2	2	2	2	2
Step 3: Study Indicators	3.2	2	2	2	2	1	0	2	2	2	2	2	2
	4.1	2	2	2	2	1	1	2	2	2	1	2	2
Step 4: Study Populations	4.2	2	2	2	2	1	1	2	2	2	1	2	2
	5.1	NA	NA	NA	NA	0	0	NA	NA	NA	NA	NA	NA
	5.2	NA	NA	NA	NA	0	0	NA	NA	NA	NA	NA	NA
Step 5: Sampling Methods	5.3	NA	NA	NA	NA	UNK	UNK	NA	NA	NA	NA	NA	NA
	6.1	2	2	2	2	1	0	2	2	2	2	2	2
	6.2	2	2	2	2	1	0	2	2	2	2	2	2
	6.3	2	2	2	2	0	0	2	2	2	2	2	2
	6.4	2	2	2	2	0	0	2	2	2	2	2	2
	6.5	2	1	2	2	0	0	2	2	2	2	2	2
Step 6: Data Collection Procedures	6.6	2	2	2	2	2	0	2	2	2	2	2	2
Step 7: Improvement Strategies	7.1	2	1	2	2	1	0	2	2	1	1	2	2
	8.1	2	2	2	2	NA	NA	2	2	NA	2	2	2
	8.2	2	2	2	2	NA	NA	2	2	NA	2	2	2
Step 8: Analysis and Interpretation of Study Results	8.3	1	1	2	2	NA	NA	2	2	NA	2	2	2
	8.4	2	1	2	1	NA	NA	2	2	NA	2	2	2
	9.1	2	1	2	2	NA	NA	2	2	NA	2	2	2
	9.2	2	1	2	2	NA	NA	2	2	NA	2	2	2
	9.3	2	1	2	2	NA	NA	2	2	NA	2	2	2
Step 9: Validity of Improvement	9.4	2	1	2	2	NA	NA	2	2	NA	2	2	2
Step 10: Sustained Improvement	10	2	1	NA	NA	NA	NA	NA	NA	NA	NA	2	2
Number Met		23	15	23	22	3	2	23	23	14	20	24	24
Number Partially Met		1	9	0	1	9	4	0	0	1	3	0	0
Number Not Met		0	0	0	0	5	11	0	0	0	0	0	0
Number Applicable		24	24	23	23	17	17	23	23	15	23	24	24
Rate Met		95.8%	62.5%	100.0%	95.7%	17.6%	11.8%	100.0%	100.0%	93.3%	87.0%	100.0%	100.0%

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

2.4 Findings

Below are the PIPs identified for validation at each MCHP:

Blue Advantage Plus	Little Stars Program for Teenagers Improving Oral Health
Children' Mercy Family Health Partners	Improving Childhood Immunizations Improving Oral Health
Harmony Health Plan	Improving Asthma Management – Ages 5-50 Improving Oral Health
HealthCare USA	Decreasing Non-Emergent/Avoidable Emergency Department Utilization Improving Oral Health
Missouri Care	Increased Use of Controller Medication for Members with Persistent Asthma Improving Oral Health
Molina HealthCare of Missouri	Members at High Risk of Cesarean Wound Infection Improving Oral Health

STEP 1: SELECTED STUDY TOPICS

Study topics were selected through data collection and the analysis of comprehensive aspects of member needs, care, and services. Study topics should 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 care of members with asthma; one addressed members at risk of cesarean wound infection; one addressed avoiding non-emergent use of emergency departments; one addressed improving prenatal care for pregnant teens; and one emerging PIP focused on improving the

number of children receiving immunizations. All six non-clinical PIPs addressed improving oral health through MCHP specific interventions, as extensions of the Statewide PIP.

Table 2 shows the ratings for each item and PIP by MCHP. Ten (10) PIPs provided rationale demonstrating the extent of the need for the PIP and provided information to support selection of the study topic. One MCHP's (Harmony Health Plan) PIP did not present a MCHP specific study topic, narrative that was complete, or provided a sound argument for choosing the topic. Most PIPs discussed literature or research supporting the activities to be undertaken, and provided some benchmark comparison data. This section met the criteria required 83.33% of the time. All of the MCHPs addressed a broad spectrum of key aspects of member care and services (100.0%). One MCHP (Harmony Health Plan) did not present a clear picture of who they were serving in their clinical PIP, or if they were meeting the requirements of their contract in providing member services. . 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 descriptions of the member populations targeted for intervention in the PIPs. During 2010, the PIPs submitted reflected projects that were focused on the Missouri MO Managed Care population with one exception where the PIP referenced data and members from a neighboring state (Harmony Health Plan references data from Illinois). In addition, PIPs should specifically indicate whether all enrolled populations within the Managed Care Program were included in the interventions. Finally, age and demographic characteristics should be described. Eleven of the PIPs (91.67%) "Met" these criteria (Step 1.3).

STEP 2: STUDY QUESTIONS

Study questions are statements in the form of a question that describe the potential relationship between the intervention, the intended outcome, and the data to be obtained and analyzed. They should be specific enough to suggest the study methods and the outcome measures. The 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. Eleven (91.67%) 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 MCHP (Harmony Health Plan) did include a study question for its non-clinical PIP, but it was unclear and did not connect the interventions to the study topic.

Table 3 - Summary of Performance Improvement Project Validation Ratings by Item, All MCHPs

	All MCHPs					
Step	Item	Number Met	Number Partially Met	Number Not Met	Total Number Applicable	Rate Met
Step 1: Selected Study Topics	1.1	10	2	0	12	83.33%
	1.2	12	0	0	12	100.00%
	1.3	11	1	0	12	91.67%
Step 2: Study Questions	2.1	11	1	0	12	91.67%
Step 3: Study Indicators	3.1	10	1	1	12	83.33%
	3.2	10	1	1	12	83.33%
Step 4: Study Populations						
	4.1	9	3	0	12	75.00%
	4.2	9	3	0	12	75.00%
Step 5: Sampling Methods	5.1	0	0	2	2	0.00%
	5.2	0	0	2	2	0.00%
	5.3	0	0	2	2	0.00%
Step 6: Data Collection Procedures	6.1	10	1	1	12	83.33%
	6.2	10	1	1	12	83.33%
	6.3	10	0	2	12	83.33%
	6.4	10	2	2	12	83.33%
	6.5	9	1	2	12	75.00%
	6.6	11	0	1	12	91.67%
Step 7: Improvement Strategies	7.1	7	4	1	12	58.33%
Step 8: Analysis and Interpretation of Study Results						
	8.1	9	0	0	9	100.00%
	8.2	9	0	0	9	100.00%
	8.3	7	2	0	9	77.78%
	8.4	7	2	0	9	77.78%
Step 9: Validity of Improvement	9.1	8	1	0	9	88.89%
	9.2	8	1	0	9	88.89%
	9.3	8	1	0	9	88.89%
	9.4	8	1	0	9	88.89%
Step 10: Sustained Improvement	10.1	3	1	0	4	75.00%
Number Met		**216**	**30**	**18**	**262**	**82.44%**

Note: Percent Met = Number Met/Number Applicable; Item refers to the Protocol specifications.
Source: BHC, Inc., 2010 External Quality Review Performance Improvement Project Validation

STEP 3: STUDY INDICATORS

In the past several EQR reviews most MCHPs produced PIPs that "Met" the criteria for defining and describing the calculation of study indicators. In 2010 only 10 (83.33%) of the PIPs met the criteria for using objective, clearly defined, measurable indicators (Step 3.1). In these PIPs the calculation of measures was described and explained. Even when well-known measures were used (e.g., Healthcare Effectiveness Data and Information Set—HEDIS), there was a detailed description of the methods (e.g., Administrative or Hybrid Method) and formulas for calculating the measures. Because MCHPs vary in their method of calculation, details regarding the measures and methods of calculating those measures should be included in PIPs. Harmony Health Plan did not provide indicators for either of their PIPs and conflicting information was presented and never clarified. Ten of the 12 PIPs (83.33%) 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. One is considered as "Partially Met" and one was rated as "Not Met." The link between the intervention and the outcomes measured by the PIP should be explicit in the narrative.

STEP 4: STUDY POPULATIONS

The MCHPs made an attempt to meet the criteria for adequately defining the study population. The evaluation examines if all the Managed Care members to whom the study question(s) and indicator(s) were relevant are included. Ten MCHPs did include adequate information to make this determination (Step 4.1). One MCHP (Harmony Health Plan) "Partially Met" this criteria, as they did not adequately explain how the study question or indicators related to the population being served by their PIPs. Ten 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 populations included in the PIP and their demographic characteristics. Ten of the 12 PIPs (83.33%) 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 MCHP (Harmony Health Plan) failed to define the population or provide narrative on how the study methodology would capture the population.

STEP 5: SAMPLING METHODS

Ten PIPs stated did not employ 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 the two (2) PIPs submitted by Harmony Health Plan included documentation stating that they were conducting a random sample in an effort to conduct case record reviews at provider offices. The presentation for each PIP was slightly different. Both are coded as "Not Met." The description, in both cases, is baffling and cannot be assessed as meeting sampling method requirements that would relate any valid or reliable data.

STEP 6: DATA COLLECTION PROCEDURES

Ten of the 12 PIPs (88.33%) described the data to be collected with adequate detail and description of the units of measurement (Step 6.1). Ten of the 12 (83.33%) PIPs clearly specified the sources of data (e.g., claims, members, providers, medical records) for each measure (Step 6.2). The evaluation is looking for a methodology which provides a structure for reporting measures and data sources. In some instances there is more than one source of data. It is important that the MCHP specifically state the sources of data for each measure. The MCHPs generally provided adequate narrative and explanation to allow for validation of the PIP, thereby allowing the EQRO to validate each element. Ten of the 12 PIPs (83.33%) 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. Ten of the PIPs used a data collection instrument that was described in detail. This step requires data be presented that utilizes instruments which allow consistent and accurate data collection over time (Step 6.4). Ten of the PIPs (83.33%) met this element of the required study submissions. One MCHP (Harmony Health Plan) did not include a study design in either 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 Not Met for specifying a plan (Step 6.5). Two of the PIPs (Harmony Health Plan) 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 MCHP (Molina) did not address the need to test for data reliability in its non-clinical PIP presentation. The prospective data analysis plan did not address how data will be reported.

In the narrative submitted, eleven of the 12 (91.67%) PIPs identified the project leader, qualifications of that individual, and who was involved in or provided oversight for the design, implementation, data analysis, and interpretation of the PIP (Step 6.6). MCHP staff interviewed on-site also included team members who were involved and knowledgeable about the PIPs and methods. With the exception of one PIP (Harmony Health Plan), 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. Four of the PIPs were Partially Met in this requirement. One of the PIPs submitted by Harmony Health Plan was coded as Not Met. The nature of identification of the barriers, a description of barriers, and a plan for addressing barriers should be described. In all cases the interventions should be presented clearly. Narrative must be available that explains how the interventions are related to the goals of the study, how they are expected to impact the study outcomes, and why they were specifically chosen to address the barrier or problems defined.

STEP 8: DATA ANALYSIS AND INTERPRETATION OF STUDY RESULTS

Nine of the PIPs were mature enough to have data to analyze. The MCHPs conducted the analyses according to the data analysis plan (Step 8.1) in all nine of the PIPs (100.0%) and there was a complete and thorough analysis of the data presented. These nine 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). 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.

Of the nine PIPs that presented at least one re-measurement period, seven (77.78%) indicated the
re-measurement period for all of the measures identified in the study (Step 8.3) and described the extent to which the intervention was effective (Step 8.4).

STEP 9: VALIDITY OF IMPROVEMENT

Eight of the nine PIPs (88.89%), with re-measurement periods used the same method of 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. Eight of the nine PIPs (88.89%) 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. Eight of nine (88.89%) 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 MCHPs. 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. Eight of the nine PIPs (88.89%) 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). 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

Four of the PIPs were able to make an assessment regarding sustained improvement. Three of the four (75.00%) PIPs demonstrated repeated measurements over time reflecting confidence in the sustainability of the

improvements achieved. These PIPs used statistical significance testing to demonstrate improvement. The PIPs reaching this level of maturity provided arguments for continuing the improvement efforts that lead to success, and their reasoning for maintaining sustainability. All three MCHPs stated that they would be incorporating the processes developed during the PIP into their routine operations to ensure that continued success could be achieved.

2.5 Conclusions

Across all MCHPs, the range in proportion of criteria that were "Met" for each PIP validated was 11.8% through 100%. Across all PIPs validated statewide, 82.44% of criteria were met In most of the 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 MCHP intended to use this process to improve organizational functions and the quality of services available or delivered to members. In at least four cases the performance improvement project had already been incorporated into MCHP daily operations. PIPs should be ongoing, with periodic re-measurement points. At least quarterly re-measurement is recommended to provide timely feedback to the MCHP regarding the need to address barriers to implementation. MCHP personnel involved in PIPs had experience in clinical service delivery, quality improvement, and monitoring activities. It was clear in at least ten of the PIPs that the MCHP had made a significant investment in designing valid evaluation studies using sound data collection and analysis methods. This requires technical expertise in health services research and/or program evaluation design.

Based on the PIP validation process, at least five MCHPs (Children's Mercy Family Health Partners, Blue-Advantage Plus, HealthCare USA, Molina and Missouri Care)

had active and ongoing PIPs as part of their quality improvement programs. One MCHP (Harmony Health Plan) submitted PIPs for review which lacked depth. They did not demonstrate an understanding of the purpose of the PIP and did not provide any convincing evidence that the PIP process was an integral aspect of the MCHP's Quality Improvement Program. They stated commitment to develop quality programming although their projects have repeatedly exhibited a lack of understanding of this process.

An improved commitment to the quality improvement process was observed during the on-site review at most of the MCHPs.

Table 4 - Validity and Reliability of Performance Improvement Project Results

PIP Name	Rating
Members at High Risk for Cesarean Wound Infection	High Confidence
Improving Oral Health (Molina)	Low Confidence
Decreasing Non-Emergent/Avoidable Emergency Department Utilization	Moderate Confidence
Improving Oral Health (HCUSA)	Moderate Confidence
Improving Asthma Management – Ages 5-50	Low Confidence
Improving Oral Health (Harmony)	Low Confidence
Increased Use of Controller Medication for Members with Persistent Asthma	High Confidence
Improving Oral Health (Missouri Care)	Moderate Confidence
Improving childhood Immunizations	Moderate Confidence
Improving Oral Health (CMFHP)	High Confidence
Little Stars Program for Teenagers	High Confidence
Improving Adolescent Well Care (BA+)	Moderate 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 quality, access, and timeliness of care assessed during this review, and recommendations based on the findings of the Validation of Performance Improvement Projects activity is summarized below.

Access to Care

Access to care was an important theme addressed throughout most of the PIP submissions reviewed. The statewide non-clinical PIP attempted to impact the Managed Care members' access to dental care. In the clinical PIPs reviewed, one MCHP focused on education and support to obtain appropriate pre and postnatal care in an effort to avoid re-hospitalization (Molina). This PIP had a significant focus on providing access to in-home health care. All the projects reviewed used the format of the PIP to improve access to care for members. Two of the projects focused on ensuring members had adequate and timely access to asthma management services with the goal of avoiding more serious medical interventions including the use of the hospital emergency department (Missouri Care and Harmony Health Plan). One PIP focused on decreasing the use of non-emergent/avoidable emergency department care (HealthCare USA). One focused on obtaining appropriate services for teenage pregnant members. The on-site discussions with MCHP staff indicated they realize improving access to care is an ongoing aspect of all projects that are developed.

Quality of Care

Topic identification was an area that provided evidence of the MCHPs' attention to providing quality services to members. Intervention development for PIPs also focused on the issue of quality services. The PIPs reviewed focused on topics that needed improvement, either in the internal processes used to operate the MCHP, 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 MCHPs 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 (Missouri Care and Harmony Health Plan), improved access to childhood immunizations (Children's Mercy Family Health Partners), one project focused on improved access to timely treatment to prevent the need for non-emergent use of the emergency department (Healthcare USA), and one focused on engaging pregnant teens in timely and necessary pre and post natal services (BA+). All addressed the need for timely access to preventive and primary health care services. The MCHPs all related their awareness of the need to provide not only quality, but timely services to members. Projects reflected this awareness by addressing internal processes and direct service improvement.

The PIPs related to improving Annual Dental Visits 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 MCHPs 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, MCHPs need to use generally accepted practices for program evaluation to conduct PIPs
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. Next steps should be included in the narrative and planning for all on-going PIPs.

4. Efforts to continue to improve outcomes related to the Statewide PIP topic should be continued. Several MCHPs provided results indicating improvement in their HEDIS measure. A number of innovative approaches were used to impact this issue. The MCHPs should continue with their individualized interventions and their individual approaches to obtaining positive outcomes when working on a statewide topic.
5. It appears that most of the MCHPs 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 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 2010 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 2009 and HEDIS 2007 evaluation periods, and two of these (Annual Dental Visits and Adolescent Well-Care Visits) were reviewed for the HEDIS 2008 period. The Follow-Up After Hospitalization for Mental Illness measure was also reviewed in 2006. Protocol activities performed by the EQRO for this audit included: 1) Review of the processes used by the MCHPs 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 MCHPs 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 the MCHPs; and 2) determine the extent to which MCHP-specific performance measures calculated by the MCHPs (or by entities acting on behalf of the MCHPs) 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

The method of calculation used by each MCHP is detailed in Table 5, this information was taken from the MCHPs' self-report to the EQRO.

Table 5 - Summary of Method of Calculation Reported and Validated by MCHPs

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	Hybrid	Administrative	Administrative
Healthcare USA	Administrative	Administrative	Administrative
Molina Healthcare	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 2010 Annual Dental Visit

Data Integration and Control

The objective of this activity was to assess the 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 2010 Annual Dental Visit measure, the sources of data included enrollment, eligibility, and claim files. The rate of items that were met was calculated across MCHPs and from the number of applicable items for each MCHP. All the MCHPs that calculated the measure met all criteria for every audit element. As such, each MCHP Met 100% of the criteria for data integration and control.

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

All MCHPs (100.0%) met the applicable criteria for applying appropriate data and processes for the calculation of the HEDIS 2010 Annual Dental Visit measure.

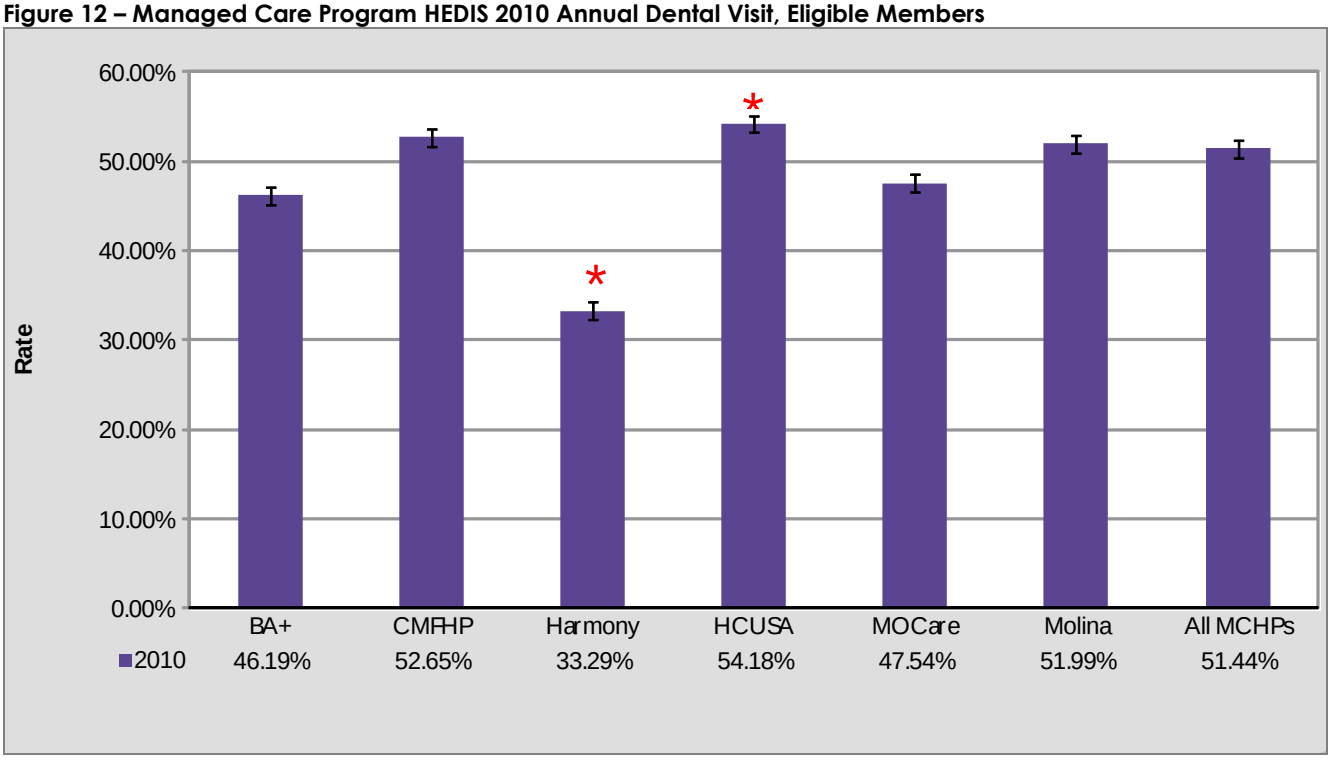
Processes Used to Produce Denominators

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. All six of the MCHPs reviewed met 100% of the applicable criteria for producing denominators according to specifications.

When determining the denominator, it was expected that all MCHPs would identify similar percentages of their total population as eligible for this measure. The identification of eligible members for the HEDIS 2010 Annual Dental Visit measure is dependent on the quality of the enrollment and eligibility files. The rate of eligible

members (eligible population identified / total enrollment) was calculated for all MCHPs and is illustrated in Figure 12. Two-tailed z-tests of each MCHP were conducted comparing the MCHPs to the rate of eligible members for all MCHPs at the 95% level of confidence. The percentage of eligible members identified by Healthcare USA (54.18%) showed a statistically higher rate when compared to the group average. Harmony showed statistically lower rate (33.29%) 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 12 – Managed Care Program HEDIS 2010 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 MCHP average at the 95% level of significance. Enrollment as of the last week in December 2009 (the measurement year) was used to calculate the rate.

Sources: MCHP HEDIS 2010 Data Submission Tool (DST); Missouri Department of Social Services, MO HealthNet Division, State MPRI Session Screens, enrollment figures for all Waivers, December 31, 2009.

Processes Used to Produce Numerators

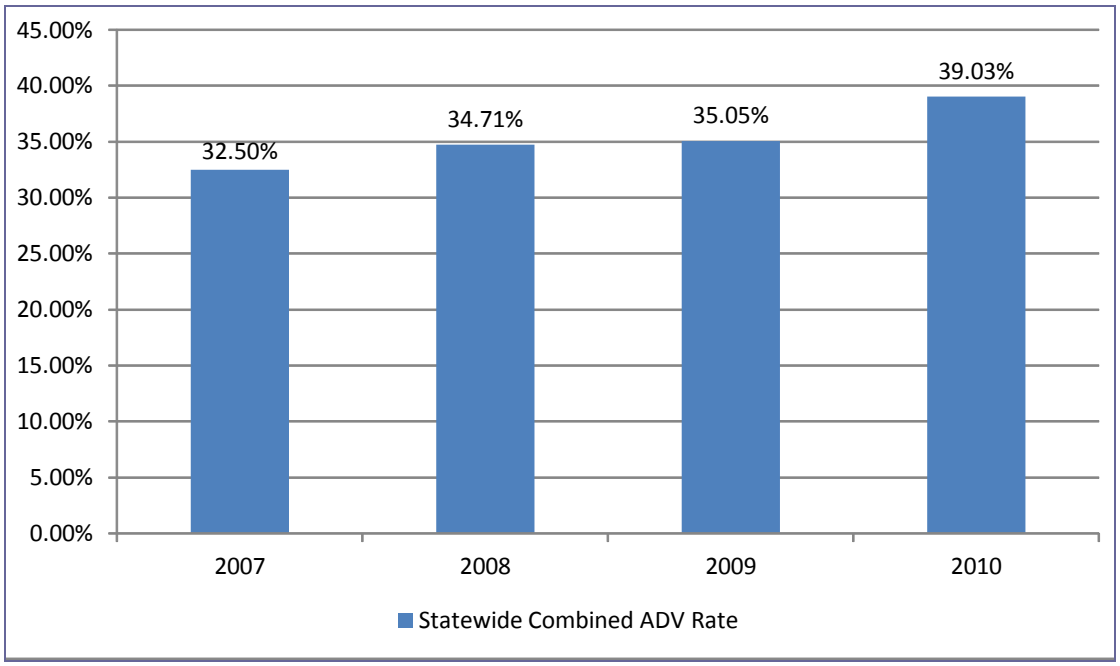
The objectives of this activity were to evaluate the MCHPs' ability to accurately identify medical events, evaluate the ability to identify events from other sources, evaluate procedures for non-duplicate counting of multiple events, review time parameters and the use of non-standard code maps, and assess the processes and procedures for collecting and incorporating medical record review data. The Technical Specifications for the HEDIS 2010 Annual Dental Visit measure required the measure be calculated using the Administrative Method; the Hybrid Method procedures do not apply. Table 6 shows the numerators, denominators, and rates submitted by the MCHPs to the SPHA on the DST for the HEDIS 2010 Annual Dental Visit measure. It is the task of the EQRO to compare MCHP to MCHP on a statewide level. Therefore, for all MCHPs who reported rates by region (e.g. HCUSA, MOCare, and Molina), the regional numbers were combined to create a plan-wide rate.

Table 6 - Data Submission and Final Validation for HEDIS 2010 Annual Dental Visit (combined rate)

Managed Care 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	14,284	4,527	31.69%	4,524	31.67%	0.02%
Childrens Mercy Family Health Partners	29,033	13,151	45.30%	13,130	45.22%	0.07%
Harmony Health Plan	5,503	1,548	28.13%	1,546	28.09%	0.04%
HealthCare USA	105,068	43,995	41.87%	43,995	41.87%	0.00%
Missouri Care	21,642	8,270	38.21%	8,248	38.11%	0.10%
Molina Healthcare	40,530	12,830	31.66%	12,815	31.62%	0.04%
All MCHPs	**216,060**	**84,321**	**39.03%**	**84,258**	**39.00%**	**0.03%**

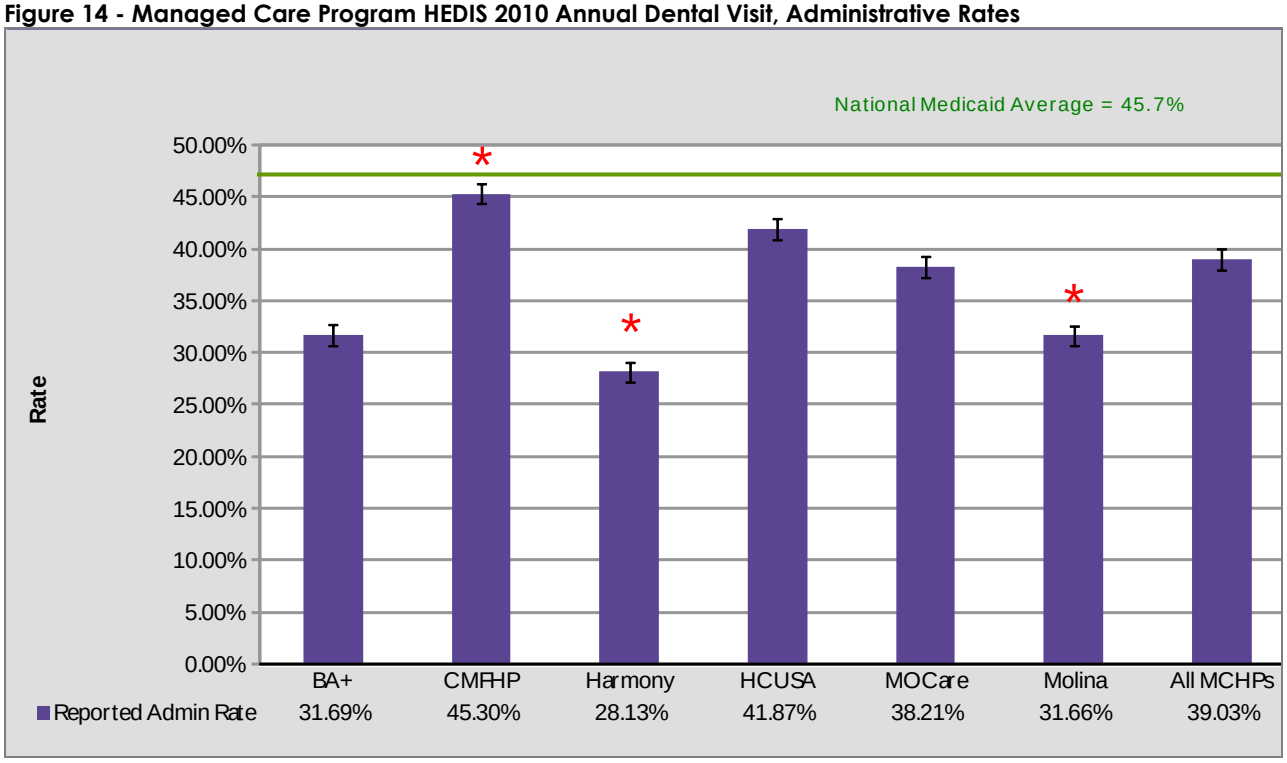
Note: DST = Data Submission Tool; NA = Not Applicable; EQRO = External Quality Review Organization (Behavioral Health Concepts, Inc.); LCL = 95% Lower Confidence Limit; UCL = 95% Upper Confidence Limit. Rate Validated by EQRO = Administrative Hits Validated by EQEO / Eligible Population. Estimated Bias = Rate Reported by MCHP (DST) - Rate Validated by EQRO. Positive bias indicates an overestimate.
Source: MCHPs' HEDIS 2010 Data Submission Tools (DST).

Figure 13 –Managed Care Program Statewide Rate Comparison for HEDIS Measure: Annual Dental Visit



The Annual Dental Visit measure has been reviewed for the last four audit years: 2007, 2008, 2009 and 2010 (see Figure 13). In all four of these audits, the 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 MCHPs. The 2010 MCHP rates ranged from 28.13% (Harmony) to 45.30% (CMFHP; see Table 6 and Figure 14). Harmony and Molina reported significantly lower rates than the average combined rate for all MCHPs; the rate reported by CMFHP was significantly higher than the average. The rate for all MCHPs was 32.50%, 34.71%, 35.05%, and 39.03% in 2007, 2008, 2009, and 2010 respectively. This indicates an increase in access to dental visits over time within the Managed Care population.

Figure 14 - Managed Care Program HEDIS 2010 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 MCHP average at the 95% level of significance.

Sources: MCHP HEDIS 2010 Data Submission Tool (DST); National Committee for Quality Assurance (NCQA).

Submission of Measures to the State

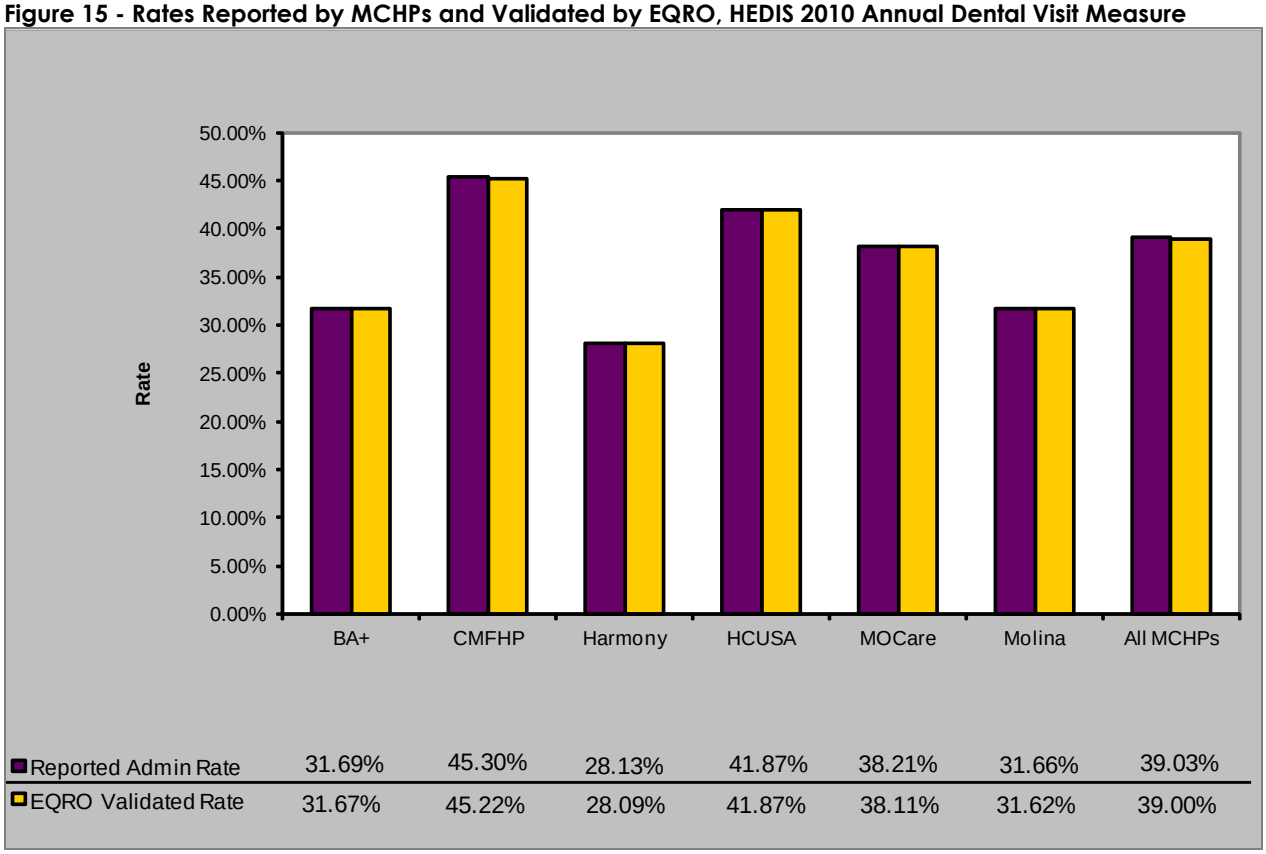
Reports from the SPHA were obtained regarding the submission of the HEDIS 2010 Annual Dental Visit measure. All six MCHPs calculated and submitted the measure to the SPHA and SMA. All MCHPs in the State of Missouri are required to calculate and report the measure to the SPHA, and MCHPs are required to report the measure to the SMA.

Final Validation Findings

Table 6 on page 69 shows the final data validation findings and the total estimated bias calculation based on the validation and review of the MCHPs' extract files for calculating the HEDIS 2010 Annual Dental Visit measure. Figure 15 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 39.00%, while the rate reported by MCHPs was 39.03%, a 0.03% overestimate.

Figure 15 - Rates Reported by MCHPs and Validated by EQRO, HEDIS 2010 Annual Dental Visit Measure



	BA+	CMFHP	Harmony	HCUSA	MOCare	Molina	All MCHPs
Reported Admin Rate	31.69%	45.30%	28.13%	41.87%	38.21%	31.66%	39.03%
EQRO Validated Rate	31.67%	45.22%	28.09%	41.87%	38.11%	31.62%	39.00%

Sources: MCHP HEDIS 2010 Data Submission Tool (DST); BHC, Inc. 2010 External Quality Review Performance Measure Validation.

HEDIS 2010 Adolescent Well-Care Visits

Data Integration and Control

The objective of this activity was to assess the MCHPs' ability to link data from multiple sources for the calculation of the HEDIS 2010 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 2010 Adolescent Well-Care Visits measure, the sources of data included enrollment, eligibility, and claim files. The rate of items that were Met was calculated across MCHPs and from the number of applicable items for each MCHP. No data integration and control issues were discovered by the EQRO. All MCHPs (100.0%) met the criteria for all areas of data integration and control.

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 2010 Adolescent Well-Care Visits measure. Each MCHP calculating the measure met 100.0% of the criteria for processes used to calculate and report the HEDIS 2010 Adolescent Well-Care Visits measure.

Processes Used to Produce Denominators

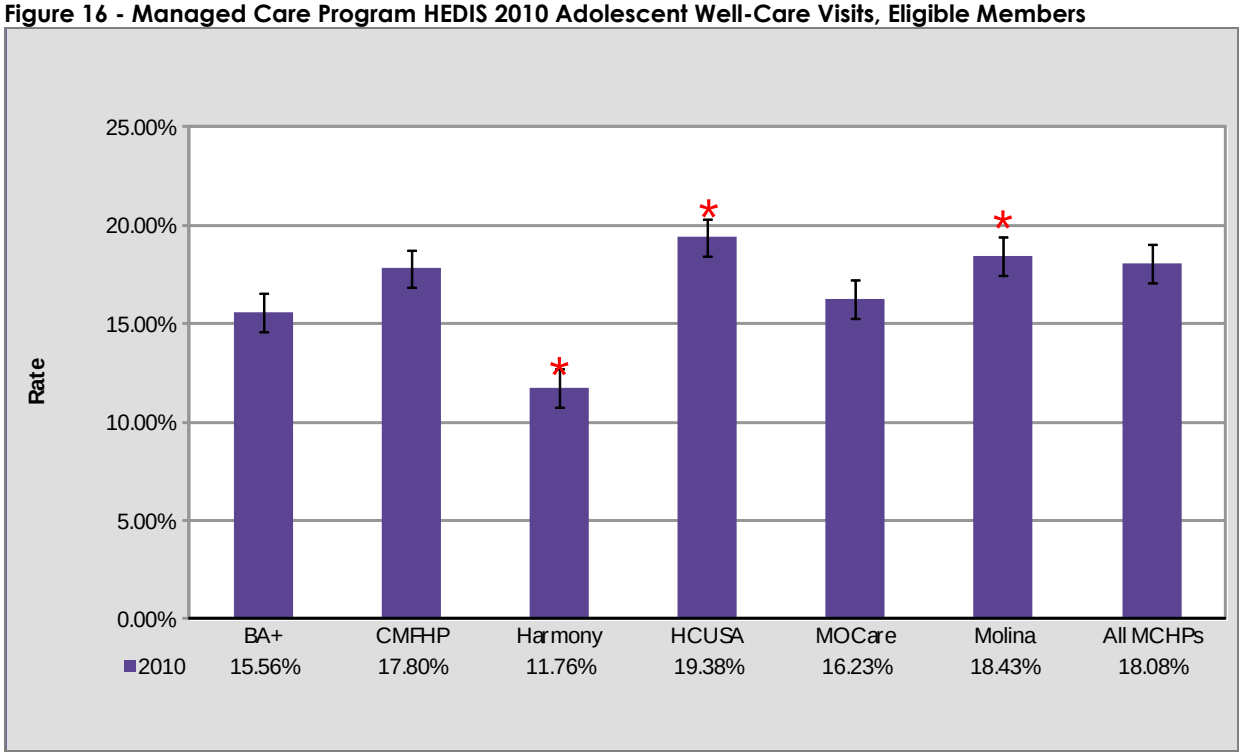
The objective of this activity was to determine the extent to which all eligible members were included in the denominator, evaluate the programming and logic source codes, and evaluate the specifications for each measure. For the HEDIS 2010 Adolescent Well-Care Visits measure, the sources of data include enrollment, eligibility, and claim files. Overall, 100% of the criteria were met for the processes used to produce denominators.

Figure 16 illustrates the rate of eligible members identified by each MCHP, based on the enrollment of all Managed Care members as of December 31, 2009. It was

expected that MCHPs would identify similar proportions of eligible members for the HEDIS 2010 Adolescent Well-Care Visits measure. The rate of eligible members (percent of eligible members divided by the total enrollment) was calculated for all MCHPs and two-tailed z-tests of each MCHP compared to the state rate of eligible members were conducted at the 95% level of confidence. Harmony (11.76%)

identified a rate that was significantly lower than the MCHP average (18.08%). The percentage of eligible members identified by HCUSA (19.38%) and Molina (18.43%) were significantly higher than the Managed Care average.

Figure 16 - Managed Care Program HEDIS 2010 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 MCHP average at the 95% level of significance. Enrollment as of the last week in December 2009 (the measurement year) was used to calculate the rate.

Sources: MCHP HEDIS 2010 Data Submission Tool (DST); Missouri Department of Social Services, MO HealthNet Division, State MPRI Session Screens, enrollment figures for all Waivers, December 31, 2009.

Processes Used to Produce Numerators

The objectives of this activity were to evaluate the 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 2010 Adolescent Well-Care Visits measure, the sources of data included enrollment, eligibility, and claim files. Table 7 shows the numerators, denominators, and rates submitted by the MCHPs to the SPHA on the DST. The "combined" rates for HCUSA, MO Care, and Molina were calculated by the EQRO based on reported rates for each region (Central, Eastern, and Western). The rate for all MCHPs was 41.31%, with MCHP rates ranging from 34.06% (Harmony) to 45.50 % (CMFHP).

Table 7 - Data Submission for HEDIS 2010 Adolescent Well-Care Visits Measure

Managed Care Health Plan	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	4,811	1,747	NA	1,747	36.31%
Childrens Mercy Family Health Partners	Hybrid	411	172	15	187	45.50%
Harmony Health Plan	Hybrid	411	133	7	140	34.06%
HealthCare USA	Administrative	37585	15811	NA	15811	42.07%
Missouri Care	Hybrid	432	174	17	191	44.21%
Molina Healthcare	Hybrid	1359	414	104	518	38.12%
All MCHPs		**45,009**	**18,451**	**143**	**18,594**	**41.31%**

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 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: Managed Care Organization HEDIS 2010 Data Submission Tools (DST)

The Adolescent Well Care Visits measure has been audited in the 2007, 2008, 2009, and 2010 external quality reviews (see Figure 17). Over the course of these review periods, the rates for all MCHPs has fluctuated, but the rate reported in 2010 (41.31%) is an improvement over the rates previously reported in 2007, 2008, and 2009 (34.81%, 38.59%, and 35.63% respectively).

Figure 17–Managed Care Program Statewide Rate Comparison for HEDIS Measure: Adolescent Well Care Visit

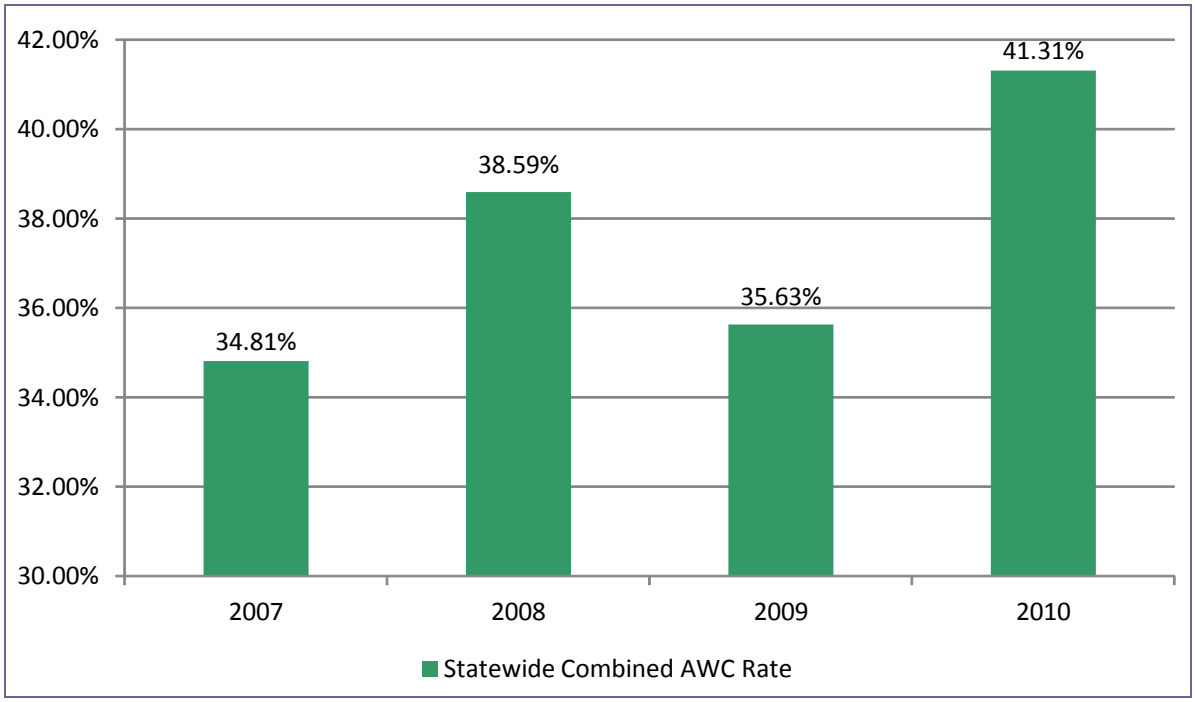
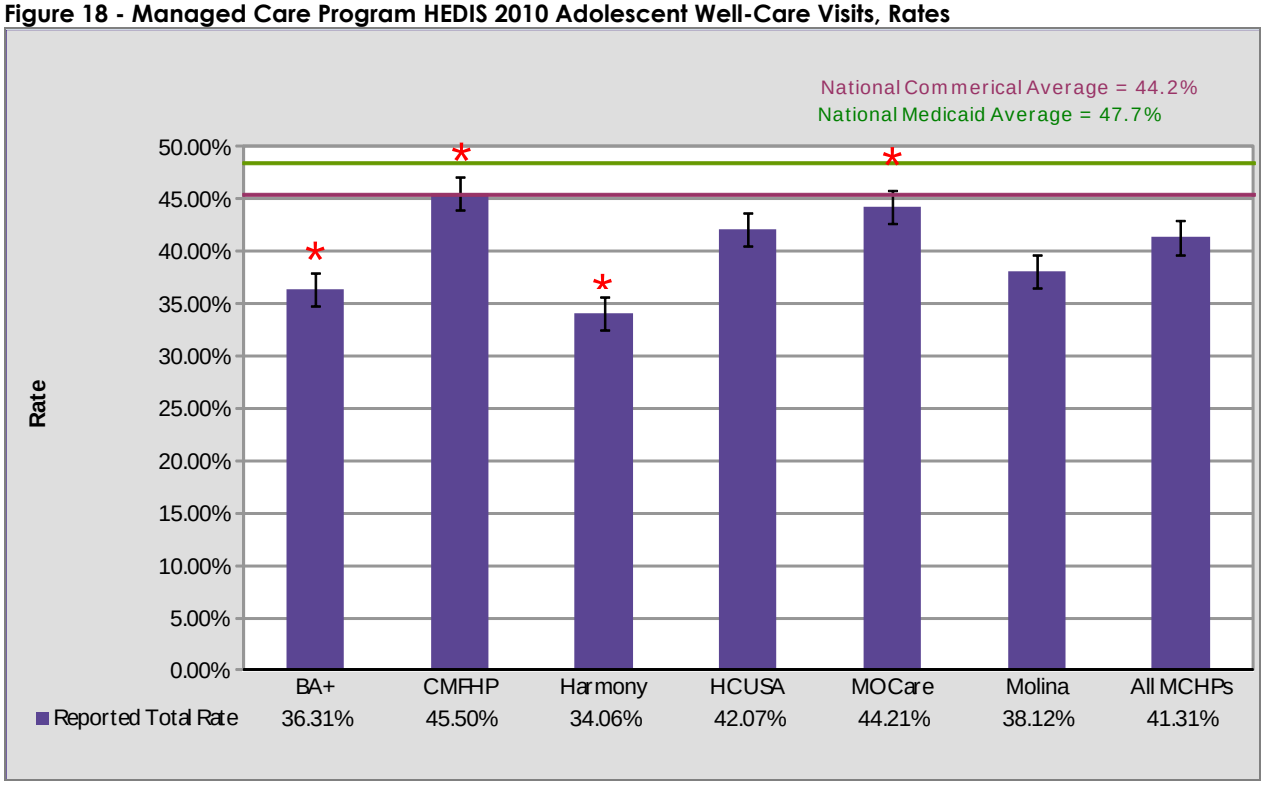


Figure 19 and Figure 20 illustrate the rates reported by the MCHPs and the rates of administrative and hybrid hits for each MCHP. The rate reported by each MCHP was compared with the rate for all MCHPs. Two-tailed z-tests of each MCHP comparing each MCHP to the rate for all MCHPs were calculated at the 95% confidence interval.

The rate for all MCHPs (41.31%) was lower than both the National Medicaid rate (47.7%) and the National Commercial Rate (44.2%). This was also found to be true in the 2007, 2008, and 2009 External Quality Review audits. This rate is higher, however,

than the rates reported in 2007 (34.81%), 2008 (38.59%), and 2009 (35.63%). The rates for CMFHP (45.50%) and MO Care (44.21%) were significantly higher than the overall MCHP average. These rates were also higher than the National Commercial Rate. BA+ and Harmony reported rates of 36.31% and 34.06% respectively, both of which were significantly lower than the statewide rate for all MCHPs.

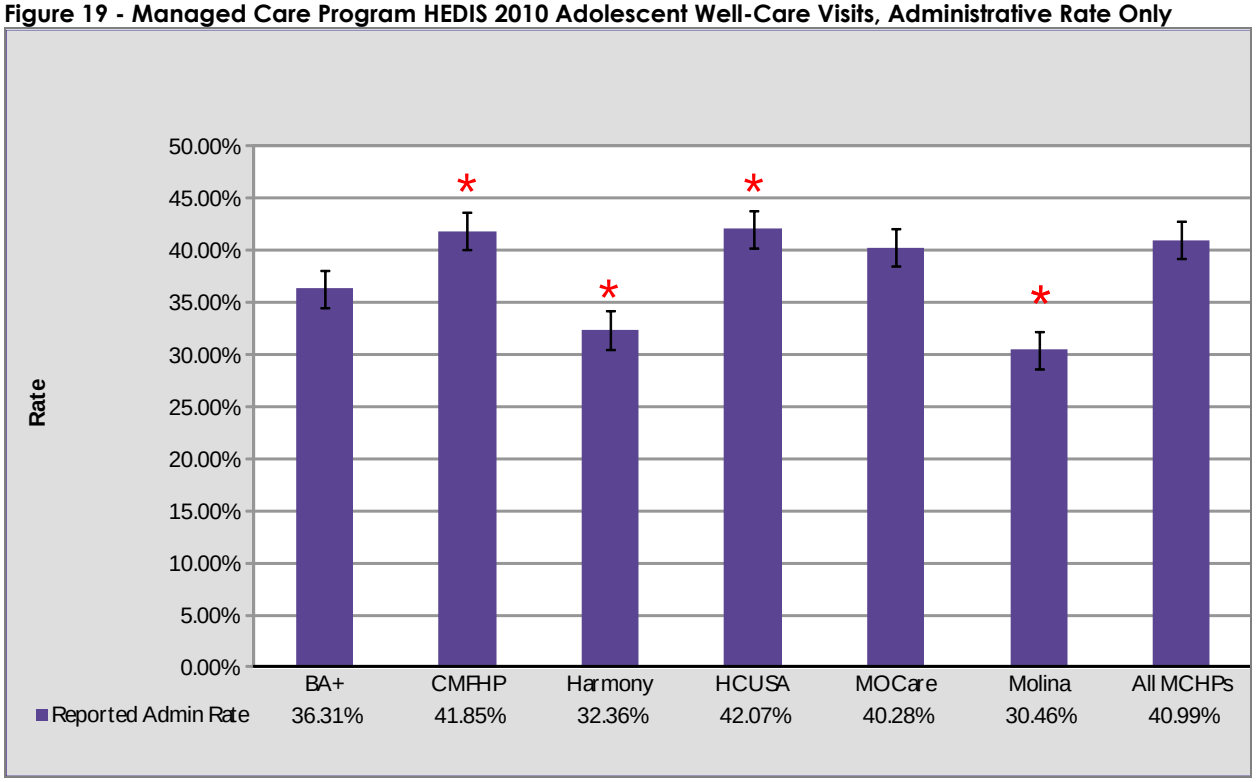
Figure 18 - Managed Care Program HEDIS 2010 Adolescent Well-Care Visits, Rates



Note: Error bars on the y-axis represent 95% confidence intervals; * indicates values are significantly lower or higher than the MCHP average at the 95% level of significance.
Sources: MCHP HEDIS 2010 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 MCHPs from the administrative rate for all MCHPs (40.99%). Rates ranged from 30.46% (Molina) to 42.07% (HCUSA). Statistically, the rates reported by Harmony and Molina were significantly lower than the statewide rate for all MCHPs, while the rates for CMFHP and HCUSA were significantly higher than the average rate.

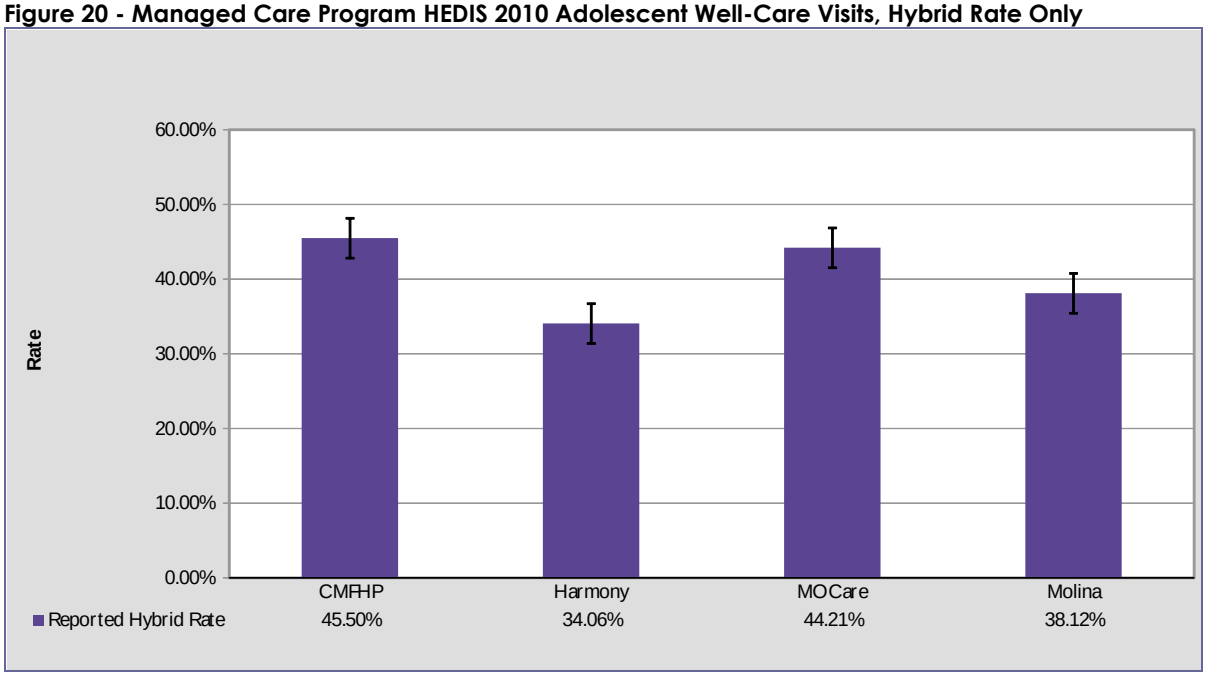
Figure 19 - Managed Care Program HEDIS 2010 Adolescent Well-Care Visits, Administrative Rate Only



Note: Error bars on the y-axis represent 95% confidence intervals; * indicates values are significantly lower or higher than the MCHP average at the 95% level of significance.
Sources: MCHP HEDIS 2010 Data Submission Tool (DST); National Committee for Quality Assurance (NCQA).

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

Figure 20 - Managed Care Program HEDIS 2010 Adolescent Well-Care Visits, Hybrid Rate Only



Note: Error bars on the y-axis represent 95% confidence intervals
Sources: MCHP HEDIS 2010 Data Submission Tool (DST); National Committee for Quality Assurance (NCQA)

Table 8 and Table 9 summarize the findings of the EQRO medical record review validation and Attachment XII (Impact of Medical Record Findings) of the CMS Protocol. Four of the MCHPs used the Hybrid Method of calculation: CMFHP, Harmony, 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. Molina operates in multiple regions; therefore, the sample sizes selected for each region were combined to represent the overall MCHP rate. Molina selected a sample of 453 eligible members in each region. These samples are consistent with HEDIS technical specifications. A total of 69 of the 143 medical record hybrid hits reported by MCHPs were sampled for validation by the EQRO. Of the records requested, all 69 were received for review. The EQRO was able to validate all 69 of the records received, resulting in an Error Rate of 0% across all MCHPs. The number of False Positive Records (the total amount that could not be validated) was 0 of the 143 reported hits. This shows no bias in the estimation of hybrid rates for the MCHPs based upon medical record review. Table 9 shows the impact of the medical record review findings.

Table 8 - Medical Record Validation for HEDIS 2010 Adolescent Well-Care Visits Measure

MCHP Name	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	15	15	15	15	100.0%	100.0%	0.0%	0.002	0	0.0%
Harmony Health Plan	411	7	7	7	7	100.0%	100.0%	0.0%	0.002	0	0.0%
Missouri Care	432	17	17	17	17	100.0%	100.0%	0.0%	0.002	0	0.0%
Molina Healthcare	1359	104	30	30	30	100.0%	100.0%	0.0%	0.001	0	0.0%
All MCHPs	2,613	143	69	69	69	100.0%	100.0%	0.0%	0.0004	0	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: MCHP Data Submission Tools (DST); BHC, Inc. 2010 External Quality Review Performance Measures Validation.

Table 9 - Impact of Medical Record Findings, HEDIS 2010 Adolescent Well-Care Visits Measure

Audit Elements	MCHP Name					
	BA+	CMFHP	Harmony	HCUSA	MOCare	Molina
Final Data Collection Method Used (e.g., MRR, hybrid,)	Administrative	Hybrid	Hybrid	Administrative	Hybrid	Hybrid
Error Rate (Percentage of records selected for audit that were identified as not meeting numerator requirements)	NA	0.00%	0.00%	NA	0.00%	0.00%
Is error rate < 10%? (Yes or No)	NA	Yes	Yes	NA	Yes	Yes
If yes, MCHP/PIHP passes MRR validation; no further MRR calculations are necessary.	NA	Passes	Passes	NA	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
Denominator (The total number of members identified for the denominator of this measure, as identified by the MCHP/PIHP)	4811	411	411	37585	432	1,359
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
Total Number of MRR Numerator Positives identified by the MCHP/PIHP using MRR.	NA	NA	NA	NA	NA	NA
Expected Number of False Positives (Estimated number of medical records inappropriately counted as numerator positives)	NA	NA	NA	NA	NA	NA
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 MCHP; Administrative Method was used by the 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. 2010 External Quality Review Performance Measure Validation.

Across MCHPs, 100% of the applicable criteria for calculating numerators were met. All six (100%) of the MCHPs 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. Four of the six MCHPs calculated this measure using the Hybrid Method (CMFHP, Harmony, MO Care, and Molina), and all five met all criteria (100.0%) relating to medical record reviews and data. The MCHPs met 100% of criteria for calculating the numerator for the HEDIS 2010 Adolescent Well-Care measure.

Sampling Procedures for Hybrid Method

The objectives of this activity were to evaluate the MCHPs' ability to randomly sample from the eligible members for the measure when using the Hybrid Method of calculation. Across all MCHPs, the criteria for sampling were met 100.0% of the time. The four MCHPs (CMFHP, Harmony, MO Care, and Molina) using the Hybrid Method of calculating the HEDIS 2010 Adolescent Well-Care Visits measure met 100.0% of the criteria for proper sampling.

Submission of Measures to the State

Reports from the SPHA were obtained regarding the submission of the HEDIS 2010 Adolescent Well-Care Visits measure. All MCHPs reported the measure to the SPHA and SMA.

Final Validation Findings

Table 10 shows the final data validation findings for the calculation of the HEDIS 2010 Adolescent Well-Care Visits measure and the total estimated bias in calculation based on the validation of medical record data and review of the MCHP extract files.

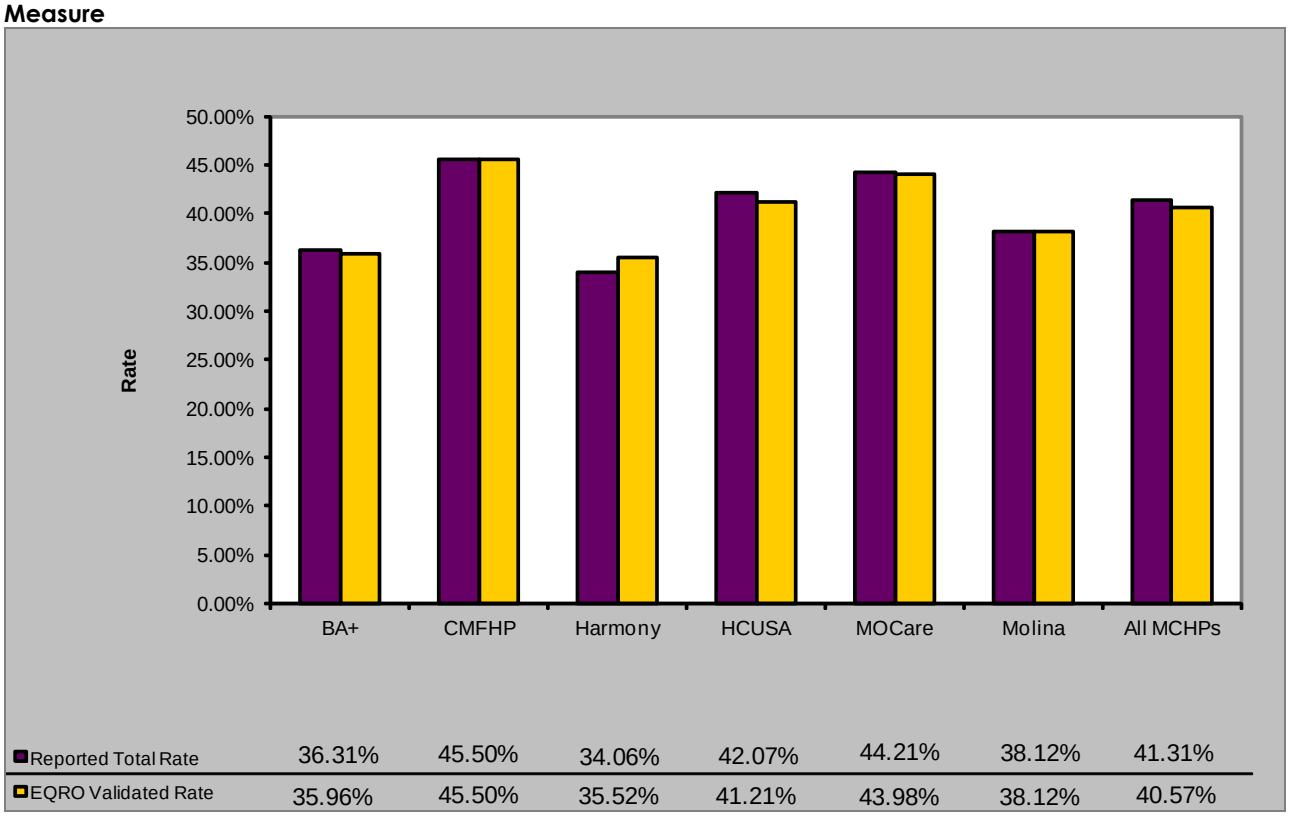
Table 10 - Final Data Validation for HEDIS 2010 Adolescent Well-Care Visits Measure

Managed Care Health Plan	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	1730	NA	1730	36.31%	35.96%	0.35%
Childrens Mercy Family Health Partners	172	100.00%	187	45.50%	45.50%	0.00%
Harmony Health Plan	139	100.00%	146	34.06%	35.52%	-1.46%
HealthCare USA	15490	NA	15490	42.07%	41.21%	0.86%
Missouri Care	173	100.00%	190	44.21%	43.99%	0.22%
Molina Healthcare	414	100.00%	518	38.12%	38.12%	0.00%
All MCHPs	**18118**	**100.00%**	**18261**	**41.31%**	**40.57%**	**0.74%**

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 MCHP - Rate Validated by EQRO. Positive numbers represent an overestimate by the MCHP.

Figure 21 illustrates the differences between the rates reported to the SPHA and those calculated by the EQRO. The rate for all MCHPs calculated based on data validated by the EQRO was 40.57%, while the rate reported by all MCHPs was 41.31%, a 0.74% overestimate.

Figure 21 - Rates Reported by MCHPs and Validated by EQRO, HEDIS 2010 Adolescent Well-Care Visits Measure



	BA+	CMFHP	Harmony	HCUSA	MOCare	Molina	All MCHPs
Reported Total Rate	36.31%	45.50%	34.06%	42.07%	44.21%	38.12%	41.31%
EQRO Validated Rate	35.96%	45.50%	35.52%	41.21%	43.98%	38.12%	40.57%

Sources: MCHP HEDIS 2010 Data Submission Tool (DST); BHC, Inc. 2010 External Quality Review Performance Measure Validation.

HEDIS 2010 Follow-Up After Hospitalization for Mental Illness

Data Integration and Control

The objective of this activity was to assess the 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 2010 Follow-Up After Hospitalization for Mental Illness measure, the sources of data included enrollment, eligibility, and claim files. The rate of items that were Met was calculated across MCHPs and from the number of applicable items for each MCHP. Across all MCHPs, 100.0% of the criteria were met. Each MCHP calculating the measure met 100.0% of the criteria for data integration and control.

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.All MCHPs met 100.0% of the applicable criteria for calculating and reporting performance measures.

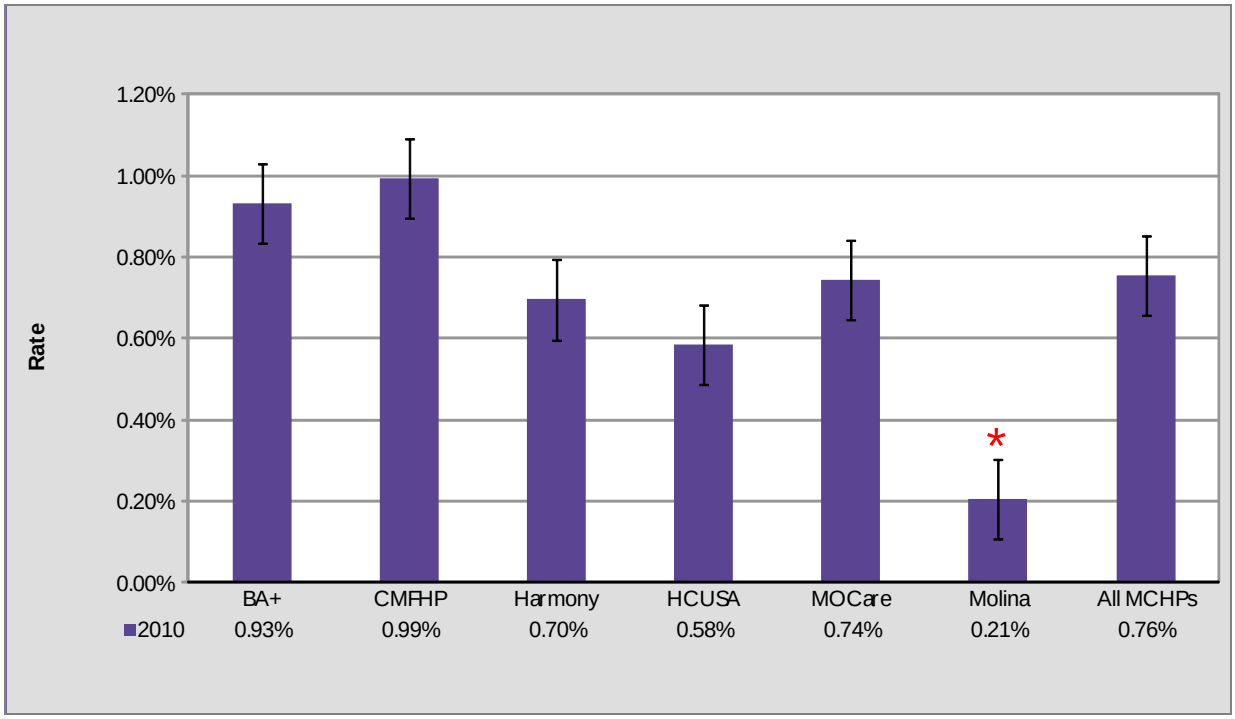
Processes Used to Produce Denominators

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 2010 Follow-Up After Hospitalization for Mental Illness measure, the sources of data include enrollment, eligibility, and claim files. Across all MCHPs, 100% of criteria for calculating and reporting performance measures were met. The MCHPs met 100% of the applicable criteria for the process used to produce denominators.

Figure 22 illustrates the rate of eligible members per MCHP based on the enrollment of all Managed Care Waiver Members as of December 31. It was expected that 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 MCHPs. Two-tailed z-tests of each MCHP comparing each MCHP to the state rate of eligible members for all MCHPs were calculated at the 95% level of confidence. Molina (0.21%) identified a significantly lower rate than the average. This variability could be due to difference in the composition of this particular MCHP's population.

Figure 22 - Managed Care Program HEDIS 2010 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 MCHP average at the 95% level of significance. Enrollment as of the last week in December 2009 (the measurement year) was used to calculate the rate.
Sources: MCHP HEDIS 2010 Data Submission Tool (DST); Missouri Department of Social Services, MO HealthNet Division , State MPRI Session Screens, enrollment figures for all Waivers, December 31, 2009.

Processes Used to Produce Numerators

The objectives of this activity were to evaluate the 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 2010 Follow-Up After Hospitalization for Mental Illness measure, the procedures for the Hybrid Method did not apply, as HEDIS 2010 technical specifications allow only for the use of the Administrative Method of calculating the measure.

Table 11 and Table 12 show the numerators, denominators, rates, and confidence intervals submitted by the 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.

The 7-Day reported rate for all MCHPs was above the National Medicaid Rate of 42.6% and below the National Commercial Rate of 59.2%. The 7-Day reported rate for all MCHPs has continued to rise, from 31.16% in 2006 to 35.52% in 2007 to 41.59% in 2009 to 45.47% in 2010. This shows a 14.31% increase in the rate over the last five years.

For 2010, the 30-Day reported rate for all MCHPs was 69.50%, higher than the National Medicaid rate (60.0%) but lower than the National Commercial average (77.2%). Across MCHPs, the 30-day rate has also continued to increase by a total of 16.58% from the 2006 (52.92%) to the 2010 (69.50%) reporting years.

Table 11 - Data Submission and Final Data Validation for HEDIS 2010 Follow-Up After Hospitalization for Mental Illness Measure (7 days)

Managed Care 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	288	145	50.35%	145	50.35%	0.00%
Childrens Mercy Family Health Partners	548	284	51.82%	279	50.91%	0.91%
Harmony Health Plan	115	43	37.39%	41	35.65%	1.74%
HealthCare USA	1,134	549	48.41%	538	47.44%	0.97%
Missouri Care	339	99	29.20%	99	29.20%	0.00%
Molina Healthcare	160	55	34.38%	55	34.38%	0.00%
All MCHPs	**2,584**	**1,175**	**45.47%**	**1,157**	**44.78%**	**0.70%**

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: Managed Care Organization HEDIS 2010 Data Submission Tools (DST).

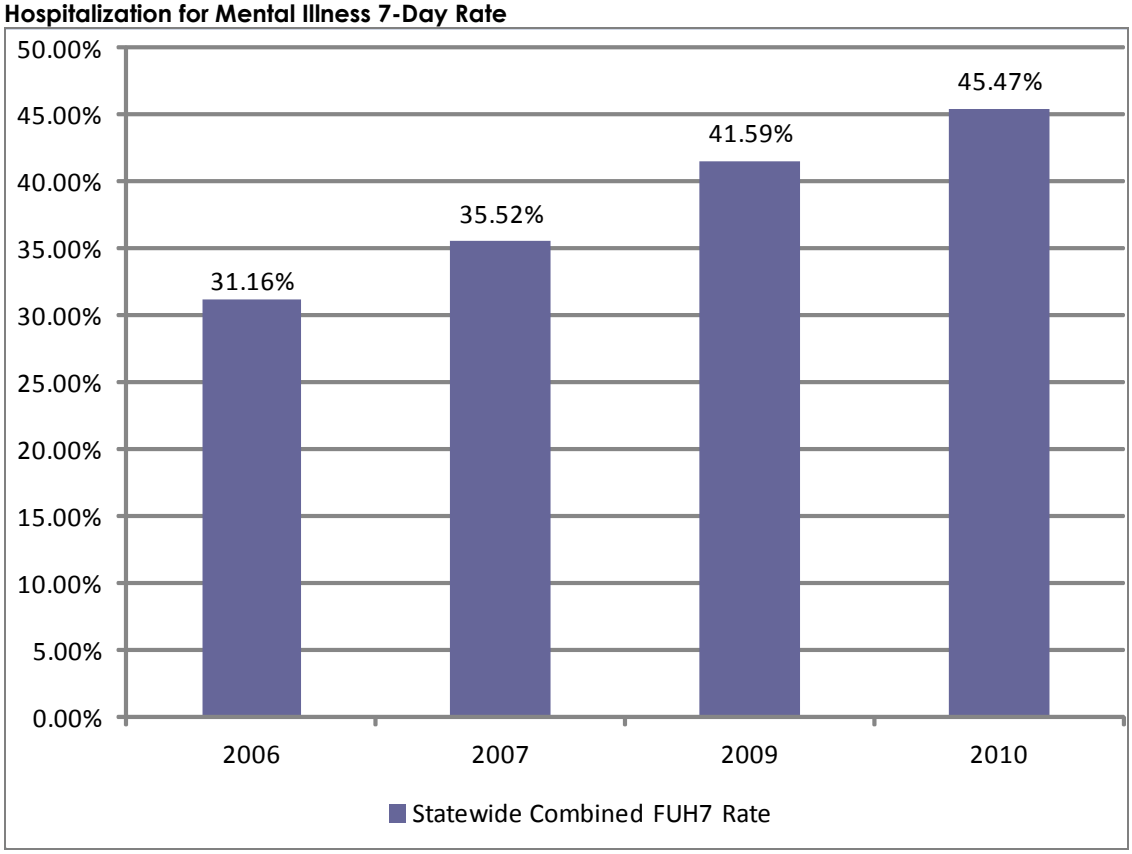
Table 12 - Data Submission and Final Data Validation for HEDIS 2010 Follow-Up After Hospitalization for Mental Illness Measure (30 days)

Managed Care 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	288	213	73.96%	209	72.57%	1.39%
Childrens Mercy Family Health Partners	548	398	72.63%	394	71.90%	0.73%
Harmony Health Plan	115	63	54.78%	60	52.17%	2.61%
HealthCare USA	1,134	826	72.84%	820	72.31%	0.53%
Missouri Care	339	199	58.70%	199	58.70%	0.00%
Molina Healthcare	160	97	60.63%	97	60.63%	0.00%
All MCHPs	**2,584**	**1,796**	**69.50%**	**1,779**	**68.85%**	**0.66%**

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: Managed Care Organization HEDIS 2010 Data Submission Tools (DST).

This measure was previously audited by the EQRO in audit years 2006, 2007, and 2009 (see Figure 23). The 7-Day reported rate for all MCHPs in 2010 (45.47%) was a 14.31% increase overall since the rate reported in 2006 (31.16%); it is 3.88% higher than the rate reported in 2009 (41.59%).

Figure 23 –Managed Care Program Statewide Rate Comparison for HEDIS Measure: Follow-Up After Hospitalization for Mental Illness 7-Day Rate



The Follow-Up After Hospitalization measure was previously audited by the EQRO in audit years 2006, 2007, and 2009 (see Figure 24). The 30-Day reported rate for all MCHPs in 2010 (69.50%) was a 16.58% increase overall since the rate reported in 2006 (52.92%); it is 3.04% higher than the rate reported in 2009 (66.46%).

Figure 24 –Managed Care Program Statewide Rate Comparison for HEDIS Measure: Follow-Up After Hospitalization for Mental Illness 30-Day Rate

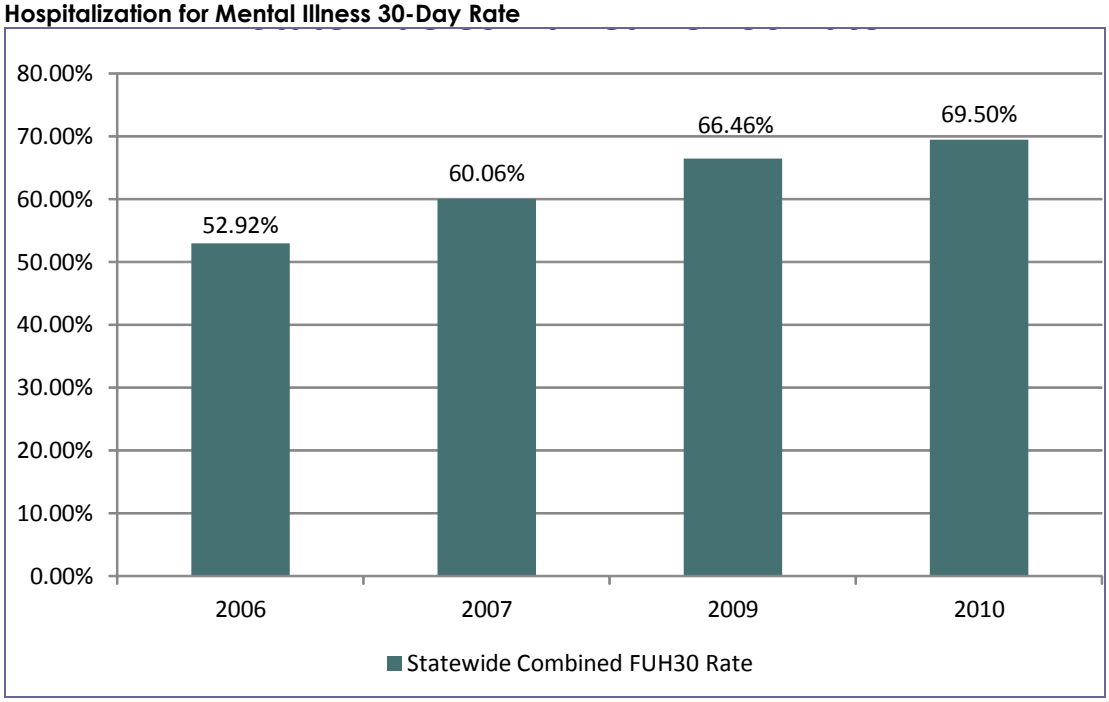
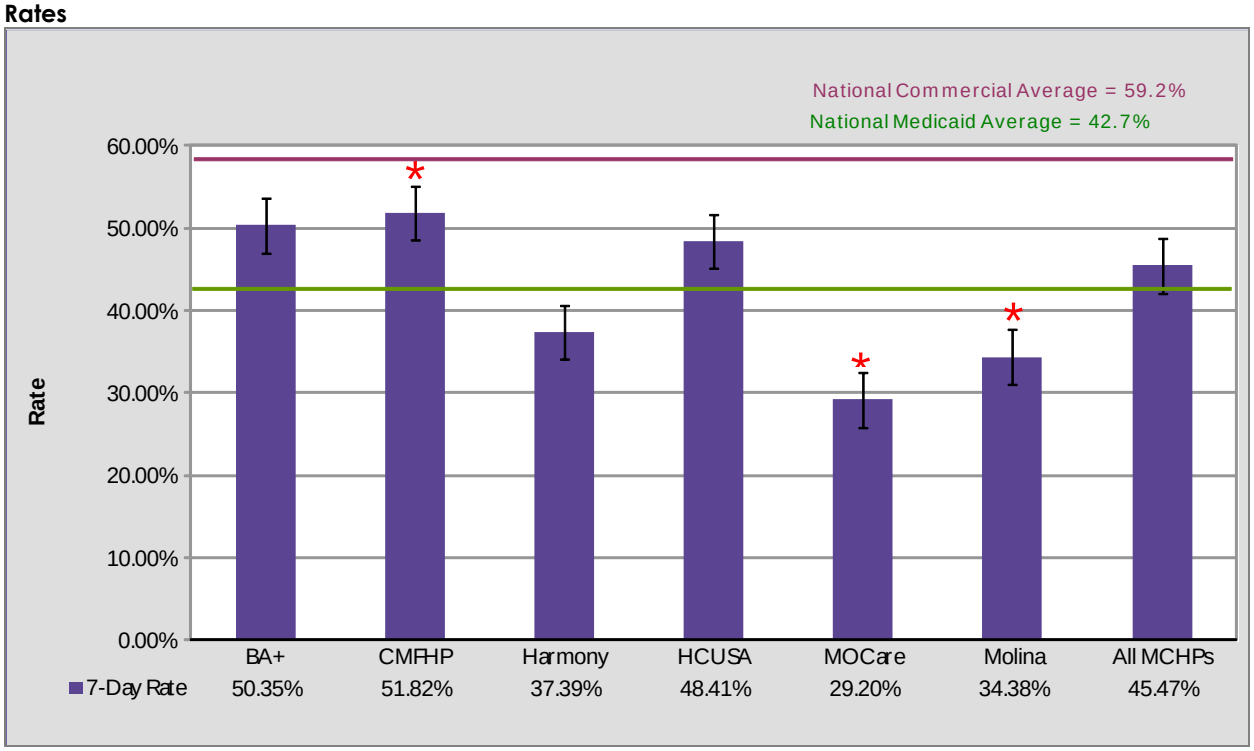


Figure 25 and Figure 26 illustrate the 7-Day and 30-Day rates reported by the MCHPs. The rate reported by each MCHP was compared with the rate for all MCHPs, with two-tailed z-tests conducted at the 95% confidence interval to compare each MCHP with the rate for all MCHPs.

The 7-Day rates reported by MOCare (29.20%) and Molina (34.38%) were significantly lower than the statewide rate (45.47%) for all MCHPs. CMFHP reported a rate (51.82%) significantly higher than the average. BA+, CMFHP, and HCUSA all reported rates higher than the National Medicaid Rate (42.7%), although all MCHPs were below the National Commercial Rate (59.2%).

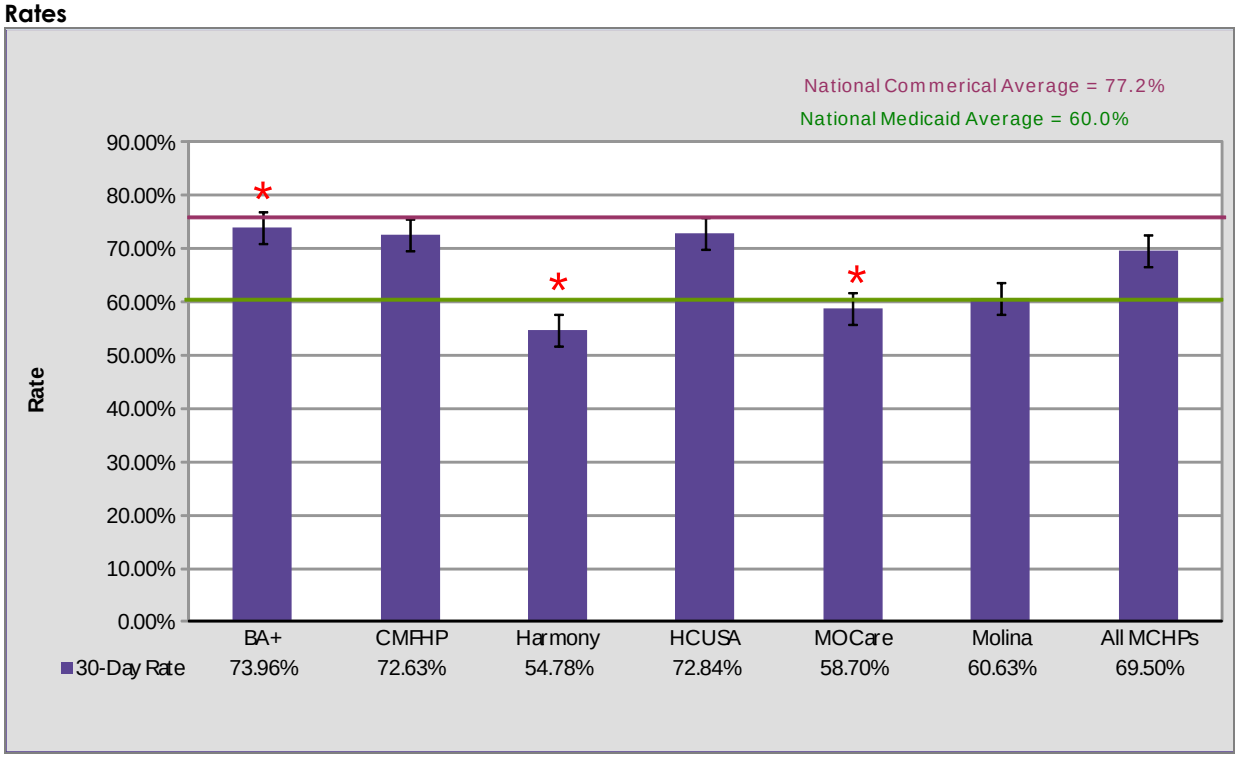
Figure 25 - Managed Care Program HEDIS 2010 Follow-Up After Hospitalization for Mental Illness, 7-Day Rates



Note: Error bars on the y-axis represent 95% confidence intervals; * indicates values are significantly lower or higher than the MCHP average at the 95% level of significance.
Sources: MCHP HEDIS 2010 DST; National Committee for Quality Assurance (NCQA).

The 30-Day rate reported for BA+ (73.96%) was significantly higher than the statewide rate (69.50%). Although all MCHPs reported rates lower than the National Commercial Average (77.2%), all MCHPs with the exception of Harmony and MO Care were at or above the National Medicaid Rate of 60.0%. Harmony and MO Care reported rates (54.78% and 58.70% respectively) significantly lower than the statewide rate (69.50%) for all MCHPs.

Figure 26 - Managed Care Program HEDIS 2010 Follow-Up After Hospitalization for Mental Illness, 30-Day Rates



Note: Error bars on the y-axis represent 95% confidence intervals.
Sources: MCHP HEDIS 2010 DST; National Committee for Quality Assurance (NCQA)

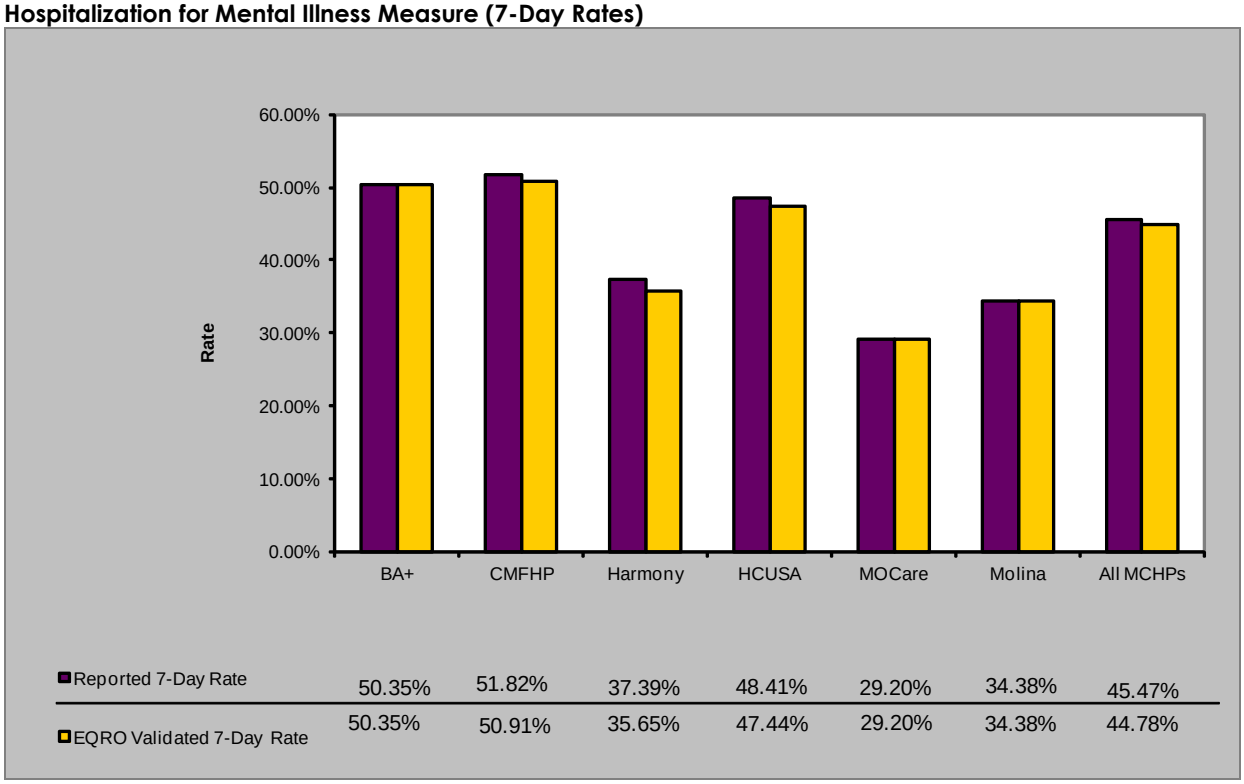
Across all MCHPs, 100% of the criteria for calculating numerators were met. Each of the MCHPs met 100.0% of criteria for the calculation of the numerator.

Submission of Measures to the State

Reports from the SPHA were obtained regarding the submission of the HEDIS 2010 Follow-Up After Hospitalization for Mental Illness Measure. All MCHPs calculated and submitted the measure to the SPHA and SMA.

The 7-Day rates reported by MCHPs ranged from 29.20% (MO Care) to 50.35% (BA+). The rate of all MCHPs calculated based on data validated by the EQRO was 44.78%. The MCHPs reported an overall rate of 45.47%, a 0.69% overestimate (see Figure 27).

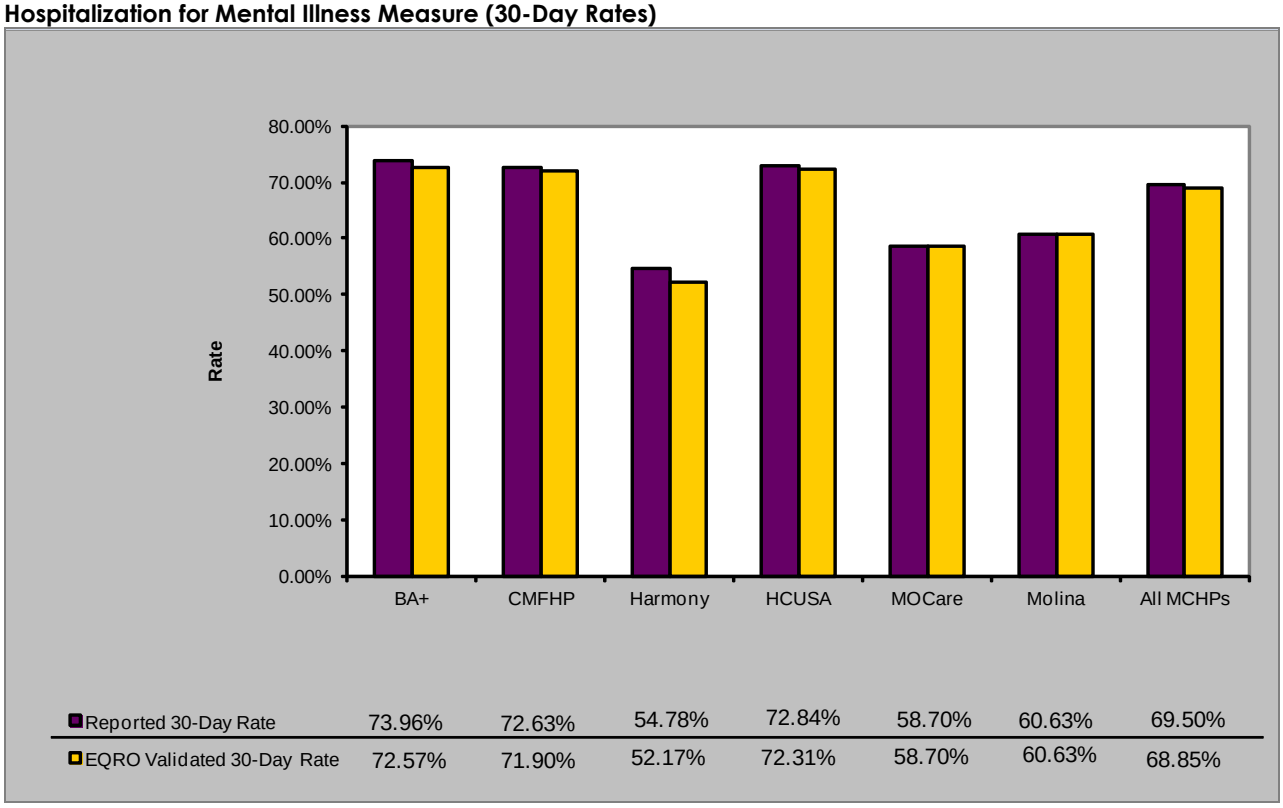
Figure 27 - Rates Reported by MCHPs and Validated by EQRO, HEDIS 2010 Follow-Up After Hospitalization for Mental Illness Measure (7-Day Rates)



Sources: MCHP HEDIS 2010 Data Submission Tool (DST); BHC, Inc. 2010 External Quality Review Performance Measure Validation.

The 30-Day rate reported by MCHPs ranged from 54.78% (Harmony) to 73.96% (BA+). The rate of all MCHPs calculated based on data validated by the EQRO was 68.85%. The rate reported by MCHPs was 69.50%, a 0.65% overestimate (see Figure 28).

Figure 28 - Rates Reported by MCHPs and Validated by EQRO, HEDIS 2010 Follow-Up After Hospitalization for Mental Illness Measure (30-Day Rates)



	BA+	CMFHP	Harmony	HCUSA	MOCare	Molina	All MCHPs
Reported 30-Day Rate	73.96%	72.63%	54.78%	72.84%	58.70%	60.63%	69.50%
EQRO Validated 30-Day Rate	72.57%	71.90%	52.17%	72.31%	58.70%	60.63%	68.85%

Sources: MCHP HEDIS 2010 Data Submission Tool (DST); BHC, Inc. 2010 External Quality Review Performance Measure Validation.

Final Validation Findings

Table 13, Table 14, and Table 15 provide summaries of ratings across all Protocol Attachments for each MCHP and measure validated. The rate of compliance with the calculation of each of the three performance measures across all MCHPs was 99.4%, 100%, and 100% for ADV, AWC, and FUH respectively.

Table 13 - Summary of Attachment Ratings, HEDIS 2010 Annual Dental Visit Measure

	All MCHPs						
All Audit Elements	**BA+**	**CMFHP**	**Harmony**	**HCUSA**	**MOCare**	**Molina**	**All MCHPs**
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. 2010 EQR Performance Measure Validation

Table 14 - Summary of Attachment Ratings, HEDIS 2010 Adolescent Well-Care Measure

	All MCHPs						
All Audit Elements	**BA+**	**CMFHP**	**Harmony**	**HCUSA**	**MOCare**	**Molina**	**All MCHPs**
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. 2010 EQR Performance Measure Validation

Table 15 - Summary of Attachment Ratings, HEDIS 2010 Follow-Up After Hospitalization for Mental Illness Measure

	All MCHPs						
All Audit Elements	**BA+**	**CMFHP**	**Harmony**	**HCUSA**	**MOCare**	**Molina**	**All MCHPs**
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. 2010 EQR Performance Measure Validation

Table 16 summarizes the final audit ratings for each of the performance measures and 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 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 MCHPs on the DST.

Table 16 - Summary of EQRO Final Audit Ratings, HEDIS 2010 Performance Measures

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	Fully Compliant	Substantially Compliant
Children's Mercy Family Health Partners	Substantially Compliant	Fully Compliant	Substantially Compliant	Substantially Compliant
Harmony Health Planof Missouri	Substantially Compliant	Substantially Compliant	Substantially Compliant	Substantially Compliant
Healthcare USA	Not Valid	Substantially Compliant	Substantially Compliant	Substantially Compliant
Missouri Care	Substantially Compliant	Substantially Compliant	Fully Compliant	Fully Compliant
Molina Healthcare of Missouri	Substantially Compliant	Fully Compliant	Fully Compliant	Fully Compliant

CMFHP and Molina reported rates for the HEDIS 2010 Adolescent Well-Care Visit measure that were able to be fully validated by the EQRO, garnering ratings of Fully Compliant. Likewise, the HEDIS 2010 Follow-Up After Hospitalization for Mental Illness 7-day rate for BA+ was Fully Compliant. Both the 7-day and 30-day Follow-Up After Hospitalization for Mental Illness rates for Missouri Care and Molina 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.

HEALTH PLAN INFORMATION SYSTEMS CAPABILITIES ASSESSMENT

In 2011, Behavioral Health Concepts, Inc. conducted an ISCA for each MCHP through electronic surveys, document review, and onsite interviews with the MCHPs and their contracted provider agencies. As a group, the MCHPs fully met the CMS standards for hardware systems, integrating vendor Medicaid data, and CMS standards in other areas.

The following highlights the strengths and opportunities for improvement for MCHPs in each section of the ISCA review.

Data Processing Procedures and Personnel - Strengths

Infrastructure

All six (6) MCHPs or their third-party administrator (TPA) employed robust mid-range machines for processing data.

Programming/Report Development

Among MCHPs that maintained in-house database systems, including commercial systems, each incorporated quality assurance processes for application development and software upgrades.

Security

All MCHPs had processes in place to meet HIPAA standards for protecting enrollee, encounter, and claims data from unauthorized access.

The majority of the MCHPs' contracted providers submitted encounter data electronically in encrypted and/or password-protected files each month.

All MCHPs that maintained in-house database systems had good maintenance contracts in place for hardware and software to ensure timely support.

Data Acquisition Capabilities - Strengths

Encounter data

All MCHPs could track the history of enrollees with multiple enrollment dates and whether enrollees were dually enrolled in Medicare and Medicaid.

All MCHPs or their TPA had formal documentation for processing claims and encounter data.
The majority of MCHPs or their TPA had instituted multiple checkpoints for validation of encounter data.

Auditing
All MCHPs or their TPA had a documented process for training claims and billing personnel, which included auditing the performance of new employees to ensure accuracy.

Staffing

This section of the protocol applies to the MCHP or TPA staff assigned to process encounter and claims data. A "Fully met" score reflects adequate numbers of trained staff for processing accurate, complete, and timely encounter data; a comprehensive, documented training process for new hires and seasoned employees; established and monitored productivity goals for data processing; and low staff turnover. All six of the MCHPs fully met these criteria.

Hardware Systems

Quality and maintenance of computer equipment and software are important in ensuring the integrity and timeliness of encounter data submitted to the state. Desirable features include robust server equipment; hardware redundancy in terms of data storage devices and other key components; premium hardware maintenance contracts; software maintenance contracts for commercial database systems; and a standby server as a backup to the main production server. All six of the MCHPs fully met these criteria.

Security of Data Processing

Behavioral Health Concepts, Inc. evaluated the physical security of each MCHP's data as well as the MCHP's backup systems and methods for protecting the database from corruption.

All MCHPs substantially met requirements. Each MCHP provided good physical security, a documented security policy, good internal controls, and an effective batching procedure. A secure offsite storage facility is used to store backup tapes; backup tapes are encrypted and transported in compliance with HIPAA.

3.3 Conclusions

In calculating the measures, MCHPs have adequate information systems for capturing and storing enrollment, eligibility, and claims information for the calculation of the three HEDIS 2010 measures validated.

Among MCHPs there was good documentation of the HEDIS 2010 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 rate of medical record submission for the one measure allowing the use of the Hybrid Methodology was excellent, with the EQRO receiving all of the medical records requested.

QUALITY OF CARE

The HEDIS 2010 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 MCHP members.

Two MCHPs were Fully Compliant with the specifications for calculation of this measure. The four remaining MCHPs were substantially complaint with the specifications for calculation of this measure.

For the 7-day follow up rate, three MCHPs (BA+, CMFHP and HCUSA) reported rates (50.35%, 51.82% and 48.41%, respectively) that were higher than the National Medicaid Average (42.7%) for this measure.

This measure was previously audited by the EQRO in audit years 2006, 2007, and 2009. The 7-Day reported rate for all MCHPs in 2010 (45.47%) was a 14.31% increase overall since the rate reported in 2006 (31.16%); it is 3.88% higher than the rate reported in 2009 (41.59%).

For the 30-day follow up rate, four MCHPs (BA+, CMFHP, HCUSA, and Molina) all reported rates (73.96%, 72.63%, 72.84% and 60.63%, respectively) that were at or above than the National Medicaid Average (60.0%) for this measure. The overall MO MCHP rate (69.50%) was also higher than the National Medicaid Average.

This measure was previously audited by the EQRO in audit years 2006, 2007, and 2009. The 30-Day reported rate for all MCHPs in 2010 (69.50%) was a 16.58% increase overall since the rate reported in 2006 (52.92%); it is 3.04% higher than the rate reported in 2009 (66.46%).

From examination of these rates, it can be concluded that 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 the quality of care received is not quite as high within the 7-day timeframe. In both timeframes, members are receiving a lower quality of care than the average National Commercial member. However, passed on the upward trend in the rates reported, the quality of care for Follow-Up After Hospitalization for Mental Illness has significantly increased over time in Missouri for both the 7-day and 30-day timeframes.

Access to Care

The HEDIS 2010 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 Visits measure, five of the six MC HealthNet MCHPs reviewed were substantially compliant with the calculation of this measure. One MCHP's calculations were rated as not valid.

The Annual Dental Visits measure has been audited in the 2007, 2008, 2009, and 2010 external quality reviews. Over the course of these review periods, the rates for all MCHPs have improved a total of 6.53%; the rates reported were 32.50% in 2007, 34.71% in 2008, 35.05% in 2009 and 39.03% in 2010. Although the rates have increased for the Annual Dental Visit measure, none of the MCHPs reported a rate in 2010 higher than the National Medicaid Average of 45.74%, although one MCHP (CMFHP) was close at 45.30%.

This trend shows an increased level of dental care received in Missouri by members, illustrating an increased access to care for these services for the HEDIS 2010 measurement year.

Timeliness of Care

The HEDIS 2010 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 MCHPs were fully compliant with the specifications for calculation of this measure, and the remaining MCHPs were substantially compliant with the measure's calculation.

The Adolescent Well Care Visits measure has been audited in the 2007, 2008, 2009 and 2010 external quality reviews. Over the course of these review periods, the rate for all MCHPs has increased overall. The rate reported in 2010 (41.31%) is an improvement over the rates previously reported in each of the other three review years (34.81% in 2007, 38.59% in 2008, and 35.63% in 2009). However, none of the MCHPs reported a rate in 2010 higher than the National Medicaid Average of 47.7%.

This illustrates an increase in the timeliness of care for well care visits delivered to adolescents in Missouri during the HEDIS 2010 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. MCHPs with significantly lower rates of eligible members (Annual Dental Visit (Harmony), Adolescent Well Care Visits (Harmony) and Follow-Up After Hospitalization for Mental Illness (Molina)) should closely examine the potential reasons for fewer members identified.

3. MCHPs with significantly lower administrative hits [Annual Dental Visit (Harmony, Molina), Adolescent Well Care Visits (Harmony, Molina) and Follow-Up After Hospitalization for Mental Illness (Harmony, MO Care, Molina)] 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. 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 MCHPs should continue to carefully review both the EQRO data request formats and the MCHP 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.

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4.0 MO HealthNet MCHP SPECIAL PROJECT CASE MANAGEMENT PERFORMANCE REVIEW

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4.1 Purpose and Objectives

The MO HealthNet Division (MHD) asked the EQRO to conduct a special project as part of the 2010 review in order to analyze and evaluate the Managed Care Health Plans' (MCHP) compliance with federal regulations regarding quality, timeliness, and access to health care services related to the provision of case management services. In the previous review year (2009) case management records were reviewed as part of the Compliance Section of the EQRO. The objective of this special project is to complete an in-depth follow-up review of Case Management by assessing the MCHPs' improvement in Case Management service delivery and recording keeping. The EQRO also evaluated the MCHP's compliance with the federal regulations and their managed care contract specific to Case Management.

The focus of this review was:

- The MCHPs' response to referrals from MHD systems regarding Lead Case Management and Children with Special Health Care Needs;
- The MCHPs' attention and performance in providing case management to pregnant members;
- Evaluating compliance with the Managed Care contract; and
- Exploring the effectiveness of case management activities provided by the MCHPs on cases open in each MCHP's system.

METHODOLOGY

The review included the following components:

- Review of each MCHP's case management policy and procedures;
- Case record reviews from the first quarter 2010 SMA listing of referrals for lead exposed children, and children with special healthcare needs;
- Case record reviews from a listing in the first quarter 2010 of members receiving services related to pregnancy;

- Case record reviews from listings received from the MCHPs of all open and active cases in the third quarter of 2010; and
- On-site interviews with case management staff and MCHP administrative staff.

The MHD Managed Care staff reviews and approves all MCHP policy. Questions developed by the EQRO in the case record review process focused on compliance with the requirements of case management as set out in the Managed Care contract. The MCHP case manager interviews related to compliance with the MCHP's policy and also included questions that arose after the EQRO case reviews were completed. Case review results reflected how well individual files met both the MCHP's requirements and those of the Managed Care contract.

CASE RECORD REVIEWS

Two separate requests were submitted to the MCHPs:

The first request was abstracted from case listings supplied by the SMA and included:

- All cases related to lead referrals for the first quarter 2010;
- A random sample of thirty (30) cases per MCHP from the first quarter 2010 listing of special health care needs (SHCN) cases; and
- A random sample of thirty (30) cases per MCHP (or all cases when the total was less than 30) from the first quarter of 2010 for all members whose financial records indicated a pregnancy related service.

At the time of the case record request described in #1, the MCHPs were also requested to submit a listing of all open and active case management cases contained in their case management systems from the third quarter of 2010. A case sample of thirty (30) were pulled randomly from the listings provided for each MCHP. These records were requested at the end of February 2011.

The case records from both case pulls were reviewed by EQRO Consultant Myrna Bruning, R.N, and EQRO Assistant Project Director, Mona Prater. A case review form, pre-approved by the SMA, was used to assess the quality of the medical case records received.

On-Site Interviews

The purpose of the on-site interviews was to:

- Evaluate the case managers' knowledge of the MHD contractual requirements of their position; and
- Determine how the case managers operationalized policy in their daily activities.

The interviews occurred at each MCHP, as follows:

1. Interviews were conducted during the on-site review. Interview questions were based on the Managed Care contract requirements and the outcomes of the record reviews. Each interview tool addressed issues specific to the MCHP's review results and included general questions for each MCHP's staff based on contract requirements.

2. Interviews were conducted with direct service staff at each MCHP. Each interviewee's presence was requested prior to the date of the on-site review. If staff was not available, substitutions were accepted.

Document Review

Case Management Record Review

The case management record review was designed to verify that case management activities were conducted in compliance with the Managed Care contract and with all applicable federal policies. The case management review tool that was used is found in the EQRO Supplemental Report. Case record requests were sent to each MCHP on January 12, 2011. The case records requested were from three sources:

- State produced lead referrals – 1st quarter of 2010
- State produced special needs report – 1st quarter of 2010
- State listing of members during the 1st quarter of 2010 that had an ME code signifying a pregnancy related health care need

First Quarter Case-Pull Results

The responses received to this request are:

Lead						
Number of Case Requested	8	11	11	22	13	30
Number of Cases Received	8	11	10	22	13	25
Number of Cases with Content to Review	8	11	10	18	13	25
Percent of Cases Reviewed	100%	100%	90%	100%	100%	83.33%
Maternity						
Number of Cases Requested	30	30	30	30	30	31
Number of Cases Received	26	27	24	30	30	12
Number of Cases with Content to Review	9	4	3	10	7	7
Percent Reviewed	30%	13.33%	1%	33.33%	23.33%	38.71%
SHCN						
Number of Cases Requested	30	30	30	30	30	30
Number of Cases Received	7	16	30	22	30	7
Number of Cases with Content to Review	7	12	1	8	8	7
Percent Reviewed	23.33%	4%	.3%	26.67%	100%	23.33%

BLUE-ADVANTAGE PLUS OF KANSAS CITY

- Maternity – 4 cases not provided were noted "not opened in BA+ system in 2010." Seventeen (17) case files were not sent and a note on the EQRO case-pull listing stated "assessed – no case management indicated or required." No information verifying contacts or assessments were provided.
- SHCN – 7 case files were provided. Three (3) were contacted, sent information, with no response from the member. These cases are coded as "unable to contact."

CHILDREN'S MERCY FAMILY HEALTH PARTNERS

- Lead – In two (2) cases the members were not located. Required attempts were made, including follow-up with the county health department(s) involved.
- Maternity – 4 case files were noted "no notification of member's pregnancy." Two (2) case files noted "No notification of the child's birth." These six case files included no information that indicated any attempt at case management.
    - Maternity – 20 case files included a "screening." There was no indication of case management.
- SCHN – 14 folders included the member's name, but no evidence of case management, contact letters, or other information indicating attempts to engage the member.
    - Four (4) additional case files included attempted telephone and letter contacts. In these four cases there was no response from the member.

HARMONY HEALTH PLAN OF MISSOURI

- Lead – One case files contained no information or attempted contacts.
- Maternity -- 15 of the cases requested had no member contact until after the MCHP received the EQRO case-pull listing in January 2011. No services were provided.
    - Six (6) additional case files had no contact until after the baby's birth, and had no reported services provided.
- SHCN – 23 case files included information indicating an attempted telephone contact, mailing of an Unable to Contact (UTC) letter, with no services provided.
    - Three (3) additional case files included notes stating that no services were provided, parents declined.

- Three (3) additional case files indicated that the member "did not meet criteria" for case management after telephone screening – no assessment or discussion with a case manager occurred.

HEALTHCARE USA

- Lead – 3 case files were considered "unable to contact." Notes and verification were provided indicating attempted contacts, including with the referring public health department. In one (1) case file the blood lead level was below the level of 10 dl, requiring case management.
- Maternity – 20 case files indicated no contacts with members and no services.
  - In five (5) additional case files there were attempted contacts. The cases were closed after attempts were made without speaking to the member.
- SCHN – 14 case files indicated no attempted contacts and no services to members.
  - Six (6) additional case files contained information on contacts and case management services. Information pertained to case management in previous years and was not related to the referrals received in 2010.
  - In two (2) case files three or more attempts were made to contact the member prior to case closure.

MISSOURI CARE

- Maternity – 23 case files included sufficient information to determine that although active case management did not occur, three or more attempts were made to contact the member to provide services.
- SHCN – 22 case files included sufficient information to determine that attempts were made to contact member through a variety of sources. The MCHP was unable to establish contact.

MOLINA HEALTHCARE OF MISSOURI

- Lead – 2 case files were listed as never being Molina members.
    - In three (3) additional case files the MCHP reported that they never received referrals on these members and had no information on their need for lead case management services.
- Maternity – 5 case files indicated attempted contacts to locate and engage the member without success, leading to case closure.
- SCHN – 21 case files on the EQRO case-pull listing indicated "unable to reach/postcard sent." No case record was received validating attempts to contact these members.
    - Two (2) additional cases were listed as "termed." No records were received explaining this comment.
    - Five (5) additional case files included sufficient evidence that a variety of contacts were made in an effort to contact or engage the member, without success.

Third Quarter Case-Pull Results

The second sample was composed of cases that the MCHPs identified as open, in their systems during the third quarter 2010 for case management services. Thirty cases were requested as the result of a random pull from each MCHP's list. The cases requested were received. The case files were evaluated based on the Case Management section of the October 1, 2009 Managed Care contract. These contract provisions require that case management include the following:

- Identifying information that would inform the case manager on how to make initial and on-going contacts with the member.
- Introduction of case management services, the member's right to accept or reject these services, the reason for case management, and the circumstances under which information will be disclosed to third parties.

- A care plan, and a process to ensure that the primary care provider, member, parent or guardian, and any specialists treating the member, are involved in the development of the care plan.
- An assessment for case management services.
- Face to face contacts for the initial case management and admission encounter for all pregnant members that includes the assessment of the member's needs.
- A minimum of three (3) member/family encounters, all face-to-face for all children with elevated blood lead levels. In addition there are specific time frames for the offer of case management to children with elevated blood lead levels, based on the degree of elevation.
- Appropriate referrals to providers, specialists, and community resources.
- Regular progress notes.
- Contacts with the PCP.
- Criteria for closing a case, including written notification to the PCP and the reason for discharge.
- Recognition of the need for complex case management and a description of what occurs.
- A process for coordination of care.
- A plan for the transition of care at the time of case closure.

4.2 Findings

The findings include the results of the case reading and on-site interviews for each MCHP. The tables in this section include the results of the case record reviews. These results are followed by a summary of the information shared during each case management interview.

CASE RECORD REVIEW RESULTS

1st Quarter 2010

Number of Cases Reviewed	24	27	14	36	28	35
% Including Identifying Information	85.71%	70.37%	85.71%	50.00%	100%	71.43%
% Including Case Management Introduction and Explanation	47.61%	78.95%	28.57%	67.74%	60.00%	72.73%
% Including a Care Plan	23.80%	26.32%	50.00%	48.39%	60.00%	59.09%
% Documenting Member Involvement in Care Plan Development	14.28%	52.63%	7.00%	25.81%	16.00%	22.73%
% Including an Assessment	76.19%	52.63%	71.42%	58.06%	56.00%	81.82%
% Including Case Manager Referrals: Providers Ancillary Services # of Cases when Member Declined/or Services Not Indicated	 60.00% 60.00% 12 cases	 75.00% 75.00% 7 cases	 21.43% 21.43% 0 cases	 35.48% 41.94% 7 cases	 40.00% 40.00% 8 cases	 40.91% 31.82% 2 cases
% Including Face to Face Contacts as Required	46.66%	100%	42.86%	60.00%	63.16%	56.25%
% Including Progress Notes	78.94%	78.95%	71.43%	64.52%	72.00%	77.27%
% Including PCP Contacts	44.44%	63.16%	28.57%	37.71%	72.00%	40.91%
% Including PCP Closing Notification	46.15%	66.67%	50.00%	28.00%	60.00%	45.00%
% Including Transition at Closing	38.46%	66.67%	28.57%	24.00%	45.45%	10.00%

Blue-Advantage Plus

- 68 cases were requested
- 31 cases were returned
- 21 cases contained sufficient information for review
- Zero (0) cases were closed as "unable to contact" and included documentation supporting efforts at written and telephone attempts to contact the members
- Three (3) cases were closed as "unable to contact" and did not include evidence of required attempts to contact the members
- Five (5) cases included information indicating receipt of complex case management
- Five (5) cases indicated that care coordination occurred during the case management process

Children's Mercy Family Health Partners

- 71 cases were requested
- 54 cases were returned
- 27 cases contained sufficient information for review
- Seven (7) cases were closed as "unable to contact" and included documentation supporting efforts at written and telephone attempts to contact the members
- One (1) case was closed as "unable to contact" and did not include evidence of required attempts to contact the member
- Two (2) cases included information indicating receipt of complex case management
- Two (2) cases indicated that care coordination occurred during the case management process

Harmony Health Plan

- 71 cases were requested
- 65 cases were returned

- 14 cases contained sufficient information for review
- Zero (0) cases were closed as "unable to contact"
- Zero (0) cases included information indicating receipt of complex case management
- One (1) case indicated that care coordination occurred during the case management process

HealthCare USA

- 82 cases were requested
- 74 cases were returned
- 36 cases contained sufficient information for review
- Five (5) cases were closed as "unable to contact" and included documentation supporting efforts at written and telephone attempts to contact the members
- Zero (0) cases were closed as "unable to contact" that did not include evidence of required attempts to contact members
- Six (6) cases included information indicating receipt of complex case management
- Four (4) cases indicated that care coordination occurred during the case management process

Missouri Care

- 73 cases were requested
- 73 cases were returned
- 28 cases contained sufficient information for review
- Two (2) cases were closed as "unable to contact" and included documentation supporting efforts at written and telephone attempts to contact the members
- One (1) case was closed as "unable to contact" that did not include evidence of required attempts to contact the member
- Zero (0) cases included information indicating receipt of complex case management

- One (1) case indicated that care coordination occurred during the case management process

Molina Health Care of Missouri

- 91 cases were requested
- 44 cases were returned
- 35 cases contained sufficient information for review
- Eight (8) cases were closed as "unable to contact" and included documentation supporting efforts at written and telephone attempts to contact the members
- Five (5) cases were closed as "unable to contact" that did not include evidence of required attempts to contact the member
- Four (4) cases included information indicating receipt of complex case management
- Four (4) cases indicated that care coordination occurred during the case management process

3rd Quarter 2010

Number of Cases Reviewed	30	30	30	30	30	30
% Including Identifying Information	86.66%	100%	70.00%	63.33%	100%	90.00%
% Including Case Management Introduction and Explanation	66.67%	86.96%	42.86%	80.77%	85.96	75.00%
% Including a Care Plan	66.67%	43.47%	67.86%	80.77%	56.52%	62.50%
% Documenting Member Involvement in Care Plan Development	37.50%	39.13%	21.43%	50.00%	43.48%	41.67%
% Including an Assessment	95.83%	86.96%	67.86%	65.38%	91.30%	87.50%
% Including Case Manager Referrals: Providers Ancillary Services # of Cases Where Member Declined/or Services Not Indicated	83.33% 94.44% 6 cases	93.75% 87.50% 7 cases	23.81% 23.81% 7 cases	70.00% 70.00% 8 cases	72.22% 94.44% 5 cases	75.00% 55.00% 4 cases
% Including Face to Face Contacts as Required	66.66%	66.67%	60.00%	31.58%	6.25%	62.50%
% Including Progress Notes	83.33%	86.96%	78.57%	76.92%	86.96%	70.83%

% Including PCP Contacts	54.17%	47.82%	17.86%	42.31%	34.78%	45.83%
% Including PCP Closing Notification	20.83%	47.37%	34.78%	45.45%	42.86%	15.79%
% Including Transition at Closing	16.66%	47.37%	34.78%	28.57%	33.33%	47.37%

Blue-Advantage Plus of Kansas City

- 30 cases were requested
- 30 cases were returned
- Two (2) cases were closed as "unable to contact" and included documentation supporting efforts at written and telephone attempts to contact the members
- Two (2) cases were closed as "unable to contact" and did not include evidence of required attempts to contact the members
- Five (5) cases included information indicating receipt of complex case management
- Seven (7) cases indicated that care coordination occurred during the case management process

Children's Mercy Family Health Partners

- 30 cases were requested
- 30 cases were returned
- Seven (7) cases were closed as "unable to contact" and included documentation supporting efforts at written and telephone attempts to contact the members
- Zero (0) cases was closed as "unable to contact" and did not include evidence of required attempts to contact the member
- 10 cases included information indicating receipt of complex case management
- 10 cases indicated that care coordination occurred during the case management process

Harmony Health Plan of Missouri

- 30 cases were requested
- 30 cases were returned
- One (1) case was closed as "unable to contact" and included documentation supporting efforts at written and telephone attempts to contact the members
- One (1) case was closed as "unable to contact" and did not include evidence of required attempts to contact the member
- Nine (9) cases included information indicating receipt of complex case management
- Nine (9) cases indicated that care coordination occurred during the case management process

HealthCare USA

- 30 cases were requested
- 30 cases were returned

- Two (2) cases were closed as "unable to contact" and included documentation supporting efforts at written and telephone attempts to contact the members
- Two (2) cases were closed as "unable to contact" that did not include evidence of required attempts to contact members
- 11 cases included information indicating receipt of complex case management
- 10 cases indicated that care coordination occurred during the case management process

Missouri Care

- 30 cases were requested
- 30 cases were returned
- Seven (7) cases were closed as "unable to contact" and included documentation supporting efforts at written and telephone attempts to contact the members
- Zero (0) cases were closed as "unable to contact" that did not include evidence of required attempts to contact the member
- Six (6) cases included information indicating receipt of complex case management
- Eight (8) cases indicated that care coordination occurred during the case management process

Molina HealthCare of Missouri

- 30 cases were requested
- 30 cases were returned
- One (1) case was closed as "unable to contact" and included documentation supporting efforts at written and telephone attempts to contact the members
- Five (5) cases were closed as "unable to contact" that did not include evidence of required attempts to contact the member
- Eight (8) cases included information indicating receipt of complex case management
- 10 cases indicated that care coordination occurred during the case management process

CASE MANAGEMENT INTERVIEW RESULTS

BLUE-ADVANTAGE PLUS OF KANSAS CITY

Case Assignment

Cases are assigned by specialty.

- The lead case manager follows all children ages six and below with any lead involvement, and with other case management needs. This case manager is allowed to maintain cases of children in the caseload as they reach age six and their case management needs continue. Children are not arbitrarily reassigned as they reach age seven.
- The maternal/child case manager follows all members ages 7 to 17, including pregnant teens and children with special health care needs (SHCN).
- Pregnant adult members are served by three case managers.
- High risk pregnant members and members choosing to participate in the "Little Stars" program are the responsibility of a single case manager. The Little Stars program is offered to any pregnant member. This case manager describes her role as that of a nurse educator.

Referrals

Case managers describe a variety of methods to identify members who are pregnant or who might need any type of case management. They discussed:

- Receipt of risk forms from some providers;
- Review of claims reports and identify ME codes that indicate services related to pregnancy and other case management needs;
- Self-referrals from members;
- Referrals from utilization management nurses and the nurse call line.

Case managers report that they then contact members to complete an assessment to determine the members' service needs. The case managers explained that MCHP staff conducts outreach efforts to physician groups and

other organizations to ensure that the referral process is a relevant part of the array of services offered. MCHP members receive newsletters that contain articles encouraging requests for case management. MCHP staff attends school fairs and other community activities to introduce available services including case management.

Case Management Introduction

The case managers state they conduct assessments of any member referred to them. When speaking to teens involved in any case management, the case managers request the name of another person, such as a family member, with whom case management issues can be discussed. This allows them to maintain contact and develop a complete assessment of the young person's needs. The case managers describe significant efforts to obtain the member's agreement to accept services. If a member declines, educational materials are provided, with contact information, so a future request for case management can occur. The case managers report that members do call back and ask for intervention.

Outreach

The case managers report using an array of tools to locate and contact members. They have relationships with area hospitals, clinic staff, Children's Division, and Family Support Division staff. They utilize these resources in addition to direct member contact. When it is necessary the case managers meet members in these agency offices, or in physician's offices, to explain and offer case management services. They find this method to be very effective in engaging members. The case managers operate under strict policy requirements for making initial and continued efforts to contact members. The time they have to attempt to contact a member is dictated by the case management specialty, but all make their first attempts within days of receiving a referral. The Lead Case Manager has specific requirements based on the reported lead toxicity and acts within the specified time frames. This was validated in the case record review.

Assessment and Member Engagement

Case managers report that they being the assessment process at the time of the first contact with a member. They identify problems and barriers and develop measureable goals in collaboration with the member. Follow-up and adjustments to goals occur as necessary. Self-management plans are developed and the case managers described the necessity of obtaining the member's agreement to the goals. Resource lists are created which are specific to individual member needs and are shared with the member. As the case manager works with the member through this process the care plan is created. The case manageres practice is to ensure that the member participates and is aware of the care plan. A letter is sent to the PCP providing the

case manager's name and informing them of the case managers involvement. The case managers also send a packet of information to the member describing the case management process in detail.

The case managers utilize a number of strategies to maximize their ability to work with different populations. They meet with the Children's Services staff in Jackson County to develop rapport and ensure that the medical needs of children in foster care are met. Another agency, Cornerstones of Care, coordinates most case management services for foster children. As children change placements the BA+ staff work with the agency placing the child. The case managers provide oversight to ensure that member's medical information follows them and appropriate care is maintained. The BA+ case manager does provide case management if it is requested by the Children's Division staff or foster parent.

Case/Care Coordination

The case managers report attending patient care conferences and meeting with members at PCP offices. If infants or young children are hospitalized, the case managers meet with parents and physicians to ensure that all their medical needs are met. They ensure that in-home services are available upon release as required. The Lead Case Manager partners with home health agencies and the Kansas City Health and Environmental Assessment Department to ensure that members have all the care required. The Lead Case Manager ensures that home health providers are available to make home visits for the members requiring these services. The case management staff reports coordinating conference calls with physicians' offices that include all health service providers and those who provide in home medical equipment and home health.

The case managers were asked about their response to evidence or suspicion that a child is being abused or neglected. They were aware of their responsibility to call the Child Abuse and Neglect Hotline. However, if the child is involved with the Children's Division, or New Directions Behavioral Health, the case

managers try to provide information to those agencies. The case managers take their responsibility as mandated reporters seriously and immediately make a report if a child's safety is in question.

Documentation

The case managers were asked about progress notes and how their case management system operates. They reported keeping case notes on all contacts with members. The BA+ requirement for case notes is based on case acuity. The case managers discussed the new case management system, Alineo, which is under development. This system is currently available to Disease Management staff. The case managers report that it will greatly expand the information immediately available to them, including medical history and all services received by each member. Alineo, is reported to also develop customized treatment plan goals, based on the member's physical and behavioral health needs. The case managers expect that the new system will be fully operational in the first quarter of 2012.

Case Closure

The case managers report closing cases when there has been improvement in the member's health care and the member exhibits the ability to manage on their own. Case Managers review the care plan, how the member has met long and short term goals, and how far they have come in meeting their self-management plan. The case managers ensure that the member is aware that they can request additional case management in the future. The case managers describe case closing as a collaborative process when they have access to the member. The case managers relate that cases are sometimes closed because the member no longer responds to letters or telephone contact. In those instances, BA+'s practice is to send educational material and letters explaining that case management can resume at the member's request.

Conclusion – Evaluation of Record Review

The BA+ case managers were asked about the poor results of the case record reviews, specifically about the lack of assessments found in the case records. The case managers explained that they do assessments and this creates the care plans for members. The case managers believe they are following BA+

policy and protocol with the members they serve. The case managers report that they believe the EQRO reviewers did not receive all the information that is in their system case record. What was included for review was often incomplete because the entire electronic record wasnot printed. The EQRO reviewers explained that they had requested all information pertinent to the member and can therefore only review what was made available.

CHILDREN'S MERCY FAMILY HEALTH PARTNERS

Case Assignment

Cases are assigned to case managers by specialty and then alphabetically. This system, has been in operation since April 2010. The case managers report that the system has a positive effect on engaging members, continuity of care, and keeping members' interested in case management services.

Referrals

Case managers report that all members seen in an Emergency Department are contacted and may be referred for case management. Case managers often find that truly emergent situations are not the cause of the visit and continued case management provides families the support they need to obtain health care in the appropriate setting. All members who have three emergency department visits in one quarter are provided additional educational materials and are strongly encouraged to utilize case management services.

The case managers described other referral sources which include:

- Receipt of risk forms from some providers;
- Referrals from community groups and agencies serving children and families;
- Self-referrals from members; and
- Referrals from utilization management nurses and the nurse call line.

The case mangers explained that in complex cases the prevailing condition dictates who becomes the primary case manager. The case manager from any specialty the family needs may maintain interest in the situation, but becomes

more of a consultant to the primary case manager. In cases where children are under the jurisdiction of the Jackson County Juvenile Court they are often case managed by Cornerstones of Care. In these cases, Cornerstones of Care provides the primary case management services and the MCHP staff coordinates with them to ensure that all medical needs are provided. MCHP policy directs staff to designate one person as the primary case manager, with others coordinating their efforts through that person, always ensuring that families get all the services they need.

Case Management – Introduction

Case managers supplement any initial information they have concerning a member by reviewing pharmacy information, claims, and treatment regimens. Case managers also make contact with PCPs, home health providers, and other family members if appropriate. If a member is hospitalized, the case manager often visits them in the hospital to make a first contact and develop a relationship with the member. The case managers shared that the more contact they have with the member, allowing the member to get to know them, the more success they have in engaging members and maintaining a relationship with them. They recognize that members in the hospital, such as mothers with infants in the NICU (neonatal intensive care unit), are inundated with information and follow-up appointments. When these mothers meet their case manager in person, they are relieved to have someone to assist them in understanding all the information provided.

Outreach

The case managers provided an overview of the various case management programs available through the MCHP. For example, the lead case manager provides a one-hour education program in the PCP offices. She goes into the home for visits with the family. She often identifies other problems and makes additional referrals for families to ensure that they have needed services and interventions with other specialties. She related that Jackson County is moving to

the Healthy Homes program which is an initiative to assist with lead abatement and is a significant resource for most families.

In 2009 and 2010 the MCHP implemented a case management software, the CARE system has enhanced their outreach capabilities. Telephone contacts are initiated with members in a one to three day time frame from the referral date. This outreach call introduces the members to all services available including case management. This process is completed by four outreach care coordinators. Documentation of any conversation with the member is captured in the CARE system and is accessible to the case managers. The CARE system is utilized to contact members and complete enrollment into case management. The outreach staff makes telephone calls, sends letters, and utilizes all available methods to contact members if they are difficult to reach.

Assessment and Member Engagement

When new cases are assigned, the case managers report contacting the member and completing an assessment with the member's input. Based on the assessment information, the system creates a corresponding care plan. This plan is then discussed with the member for their approval. Goals are established with the member. A letter is then sent to the member's PCP advising them of the reason for case management and sharing the plan of care. The case managers report that this occurs in all cases where contact is established.

Care/Case Coordination

The Case Management and Disease Management programs are under the umbrella of the Health Services section at the MCHP. The case managers report, when a member is being served by a case manager, disease management does not open a separate case. If a family has multiple issues, such as an illness, complicated by asthma, the case manager sends out educational materials. The case managers report often going to Disease Management staff for

consultations, but do not complicate the families by increasing the number of MCHP staff intervening in their lives.

Lead case management is part of the MCHP's Disease Management section. The MCHP contracts with the Kansas City Department of Health for direct case management in Jackson County. The MCHP lead case manager takes all cases in the remainder of the counties in the Western Managed Care region. This case manager makes home visits and provides follow-up services to members, maintaining a strong working relationship with the Health Department in each county served. The lead case manager coordinates her efforts with other case managers when families have multiple needs.

The NICU case manager makes home visits and tries to visit each home before the infant leaves the hospital. The case manager and parents agree on a plan of care and ensure that the home environment is safe for these babies who often have complex medical needs. Referrals to community resources are often an integral factor in ensuring these babies remain healthy.

When questioned about working with families with multiple needs, the case managers provided several examples to illustrate how they attempt to provide multiple services in a method that appears seamless to the family. In one case, case managers were co-case managing a family with New Directions Behavior Health (NDBH). In this case a Moslem child/member was hospitalized and acting out. The case manager worked with Children's Hospital staff and the parents. NDBH found an in-home therapist who was culturally sensitive and assisted in communicating all arrangements for psychiatric interventions, appropriate medications, and correct care for the child's medical issues. They also involved the PCP and ensured that the family had necessary information throughout the child's hospitalization and an appropriate transition home.

In another situation, a child was diagnosed with autism and a seizure disorder. This child was injuring his brother who was experiencing problems including head-banging, incontinence, and not sleeping. The case manager contacted the Regional Center who got a psychologist involved. A decision was made to move one of the children to a different school where their needs could be more appropriately met. The child with autism showed improved behavior and the medical staff involved dealt with the seizure disorder. Through the efforts of the case manager, staff at Children's Mercy Hospital, the University of Kansas Medical Center (KUMC), and the Kansas City Regional Center worked together to provide parental care assistance, in-home care and respite, and the medical services this family needed to resolve serious problems.

The case managers described a thorough knowledge of community resources and the sources they utilize to maintain knowledge of the newest and most available resources for the members they serve. Main sources of information come from the United Way, Salvation Army, and Legal Aide of Western Missouri. Lists with resources related to specific issues, such as those for pregnant women, also exist and the case managers share new information with one another.

All the case managers make home visits, or face-to-face contacts, in a manner that is acceptable to the member. They attend meetings at PCP offices, go to appointments with member, and share information with physician's office staff as appropriate.

Documentation

Case Managers reported progress notes are recorded after each contact with or regarding a member.

Case Closure

Case managers report they often have problems with closing a case. Transition plans are difficult to coordinate because members fail to maintain contact after

their primary issues are resolved. The decision to close cases occurs when goals are met, when a member leaves the MCHP, when they lose eligibility, and/or when they are no longer able to make contact. The case managers do send letters with contact information when cases are closed.

HARMONY HEALTH PLAN OF MISSOURI

Case Assignment

Case management and disease management are located in the Tampa, Florida offices of Harmony's parent company, Well Care. The Tampa staff are to coordinate with Missouri staff. At the time of the on-site review the MCHP reported that there were no local case managers or nurses working directly with members. Cases are assigned by the supervisors. There is one case manager who accepts all of the lead involved cases. The case managers did not relate any other specific criteria for case assignment.

When a referral is received, it is assessed by the MCHP's Member Engagement section and if deemed appropriate the case goes to a supervisor for assignment to a case manager.

Referrals

Harmony case managers report that members who are appropriate for case management are identified through a health risk assessment completed by a member engagement specialist. Referrals are received from utilization management staff and a variety of referral sources that were not specified. Pre-screening of all referrals occurs with the Member Engagement unit, located in Tampa, using a standardized tool to assess the member's perception of health and wellness issues. This form also screens for issues such as depression. Referrals for behavioral health services can occur directly from the Member Engagement unit. The Member Engagement staff report that they make three attempts to contact a member by telephone, send an Unable To Contact (UTC) letter, and only pass on cases to the Case Management Supervisor if they are able to complete an assessment.

Outreach

The case managers were asked about their efforts to contact members after they receive an open case. They stated that they contact PCP offices, WIC offices, and other health and social services providers. When asked what their understanding is of the criteria to offer case management, they explained that there is an algorithm in their system to identify members who need services. This algorithm is based on the initial assessment entered into EMMA, their case management system. This system also assigns the acuity level for all cases. The case managers could not explain how this algorithm works, but they did explain that they can change the acuity level after working with the member. The case managers explained that they are located in the same facility as Disease Management. If a Disease Manager is working with a member, and their situation escalates, they make direct referrals to case management for more assistance and complex case management services.

Assessment and Member Engagement

Staff, both case managers and Engagement Unit, contact PCP offices primarily to obtain contact information. If contacts were made, and case management did occur, the case managers report that they do not normally share additional information with physicians' offices.

The case managers were asked about the need to contact members within specific time frames, since Member Engagement often takes a week or more to determine if a member will receive case management. Time frames for contact, particularly for lead cases, were discussed. The case managers were unaware of the requirements. Case managers reported that MCHP policy states that they have three to four days to contact the members.

The actual time frames for contacting a member with an elevated blood lead level, as stipulated in the Managed Care contract are as follows:

1. 10 to 19 ug/dL within 1-3 days
2. 20 to 44 ug/dL within 1-2 days
3. 45 to 60 ug/dL within 24 hours
4. 70 ug/dL or greater – immediately

The case managers were not familiar with this information and could not articulate how they would meet this requirement as they do not receive cases within these time limits.

The case manager begins a more in-depth assessment and care plan development after case assignment. The case managers were asked who participates in care plan development and who receives information about the care plan. Interviewers were told, "It is not required in Missouri to share the care plan with the member or provider." The case managers were asked about needing to share this information in the members' best interest. There was little recognition about using this as a method to engage the member, to maintain interest in case management services, or to improve health outcomes.

Care/Case Coordination

Case managers were asked about face-to-face contacts by "market nurses." The case managers explained that previously this was done by the Hugs social worker. This no longer occurs. They stated that no one is currently making home visits or having direct contact with members.

Questions were asked about handling cases with multiple service needs. The case managers reported that if a member, such as a child in a lead case, has other family members needing co-case management, a referral for an in-home visit may occur. The case managers responded that if a family has other benefits from sources outside of the MCHP, there is an effort to coordinate services.

Case managers were asked to discuss the Harmony Hugs program. They explained that in the past there was a good relationship with the program. If a case manager could not make contact with a pregnant member, they would work with the local Hugs staff person. The program had a local social worker, all pregnant members are referred to Harmony Hugs. The case managers reported that there is no local contact at this time. They explained that the program was being restructured. Case managers are currently making referrals to other local agencies when members request this service.

When members request assistance with referrals to community resources the case managers stated that they would do what they could to make appropriate or needed referrals. The case managers reported having a shared website with a resource area available. They are linked to data from agencies such as Nurses for Newborns and can obtain information in this way.

Case managers were asked what they did if they suspected a member (child) was being abused or neglected. They explained that they have made referrals to the local child welfare agency. They have had mixed success with this process. In some cases the local child welfare agency believed reports were

unfounded even when the case manager had serious concerns. In several cases, they have received feedback and support regarding problems reported.

Documentation

Case managers state that they chart every encounter with members and all attempted encounters. The member's defined acuity level determines the attempted contacts made before closing a case. The case managers report they revise the care plan and chart member progress every time a contact occurs. They make attempted contacts at least every thirty days. The case managers report that members, such as pregnant members, may only be contacted every trimester depending on the level of risk assigned.

In lead cases, the case managers communicated with the Department of Health and Senior Services, state agency head for lead cases. They are required to document and access information in the Department of Health and Senior Services MOHSAIC System, however the case manager cannot do this themselves due to system constraints. Presently, a MCHP staff person in the St. Louis office is required to cut and paste notes or data into the MOHSAIC system for the case managers to ensure that required updates are completed.

Case Closure

Case management cases are closed when they are unable to contact a member, the PCP office is contacted and no new contact information is available, and when members reach their goals. When cases are closed the member is given, in their closing letter, the option to have case management reopened if future problems arise.

Case Review Finding Discussion

In one case reviewed it was noted that a member was contacted and agreed to a screening. During this process the member did not indicate they wanted case management services, however the member was pregnant and had

diabetes. There was no documentation in the case file that any further contact was made with this member. There was an enrollment form in the case file for the HUGS program, indicating the member expressed a concern about fetal movement and that she had been hospitalized for bleeding. The next entry, over a month later, indicated that the member requested a referral to prenatal classes. The next entry, 4 months later, contained a postpartum assessment showing signs of anxiety. The member was given contact information, but there was no follow-up and no indication of case management services. No referrals for behavioral health services were evident. The case was closed. The case managers responded that if the member initially stated they were not interested in case management no additional services are provided.

In another case, a member called the MCHP with concern that she was being contacted by three different case managers and a social worker. This member was given "contact information" regarding her health issues and no follow-up or actual case management or care coordination occurred. The case manager who handled this referral was not available. No explanation was provided about how this type of case is resolved.

HEALTHCARE USA

Case Assignment

Cases at HealthCare USA are assigned by region, specialty, and then alphabetically in all three regions. Case managers are physically located in all three regions. In some situations the assigned case manager may not be in the region of the member's residence, but information and resources for the area of residence are shared with the member.

Referrals

Case managers list their main referral sources as:

- PCP and Obstetrician offices;

- Disease and utilization management staff;
- Hospital staff; and
- Self-referrals

The case managers report reviewing all global OB forms sent to the MCHP by physicians to assess any potential risk and offer case management to all pregnant members. The case managers explained there are specific cases where the nurse providing case management may actually be a disease manager. This may occur if a member is receiving ongoing information regarding a problem with asthma or diabetes and then becomes pregnant. In these cases, the case manager who has a primary relationship with the member continues to provide case management services.

Outreach

Case managers report that they have success in locating members and introducing them to case management through a system of information sharing with local agencies, other case managers, providers, transportation providers, home health agency staff, and the MCHP's concurrent review nurses. If a member is without a phone, contact may be made with a relative or neighbor to ask for the best method to make a personal contact with the member. Any time the case manager has a telephone number that is answered with a message, "no incoming calls allowed", they immediately send a post card to encourage the member to make contact with them. Members are also sent letters requesting they contact the case manager. Provider contacts are made and community resources are called, prior to ever giving up on finding a member referred for case management.

Case managers reported attending meetings in Franklin, Warren, Jefferson, and St. Louis Counties to learn about available resources, primarily for children and their families. Outreach staff go into the communities throughout each region and bring back information or resource lists that are made available to all case managers. Social workers are also on the staff and work in the local

communities. These social workers attend community meetings and share information with the case managers. When the staff observes an urgent need, they contact the appropriate case managers in the appropriate region(s) to request help. Case managers can authorize a home health social worker to go into a home and do an assessment as needed and the home health social worker too can make referrals. In a number of cases the home health visit enabled the case manager to learn of the member's more extensive needs. In one example, when the member was contacted and a home visit was arranged, an interpreter accompanied the MCHP staff to the home to ensure that it was cleaned correctly and that all other needs were being addresses.

Assessment and Member Engagement

The reported case management assessment process is comprehensive, from obtaining general information to diagnosis specific documentation. Letters are sent to PCPs and specialists with the assessment and care plans included. The member receives a letter about beginning case managed and a copy of the care plan. These care plans are developed with the member's input and the PCP whenever possible. The assessment is updated every ninety days and the case management system then automatically updates the care plan as required. Routine follow-up with a member whenever changes are made occurs at least every two weeks. Case managers report that as members stabilize, follow-up contacts occur as needed, but at least every two months. The care plans are updated no less than every three months. On all follow-up calls, the case manager does detailed charting with each category addressed in the assessment. The case managers in both the Eastern and Western Regions discussed working closely with the FQHC's as well. These contacts include member location, continued assessment, and care coordination.

Care/Case Coordination

The case managers reported that when members or families have multiple needs, cutting across a number of specialties, the case managers collaborate to

provide the appropriate services. For example, if a lead case is opened and the case manager learns the mother is pregnant, the initial assessment is completed by the lead case manager. The OB case manager may open a case and assist in the process by assuring the mother's needs are met, while the lead case manager remains the primary person working with the family and children.

Case managers do make home visits. HealthCare USA also contracts with home health agencies for additional help in providing members with face-to-face contacts. Home inspections, lead abatement, and additional in-depth services are also provided by county health departments. MCHP case managers are aware of all of these resources and have a strong relationship with these entities.

Case managers report that all members receive at least one in-home visit. The case manager will meet the member face-to-face and meet anywhere the member wishes. If there is a baby in the NICU, the visit may occur in the hospital. Home health and social workers may also conduct these home visits. If a member has personal care aides assigned, they report to the case managers regarding the member's care. Home health agencies do many of the home visits required in lead cases.

When an OB member delivers, the case manager may close out the case. However, another case manager, or social worker, carries these cases. These cases are not closed any earlier than sixty days after the child's birth. Whenever possible the case managers attempt to make a visit at the hospital to identify any needs the mom or infant may have upon discharge. This has been an effective intervention for prevention and ensuring that the infant's needs are addressed.

Case managers report they have many resources available when members request assistance best addressed by community based providers. The MCHP has created a relationship with an array of local agencies over the years. This

enables the case managers to can make referrals to many community contacts. The social worker based in the Eastern Region attends meetings of community providers and learns about new and enhanced programs that benefit members. This occurs in the St. Louis and more rural areas of the region.

Documentation

The case managers report that progress notes are completed in all cases when member contacts occur. Specific requirements are based on case acuity, but some information is usually recorded every two weeks. This can occur more frequently when a member or their family is having a crisis or less often as a situation is resolved. The case managers report that they make a number of contacts and attempt to provide detailed information during the assessment process. The case managers realize they must address every issue brought up during the assessment process and those included in the care plan.

Case Closure

The case managers report that cases are not routinely closed unless a member has left the MCHP, became ineligible, or clearly had all health issues resolved. It should be noted that during the case record reviews, the EQR staff noted some instances where the case management case remained open when it appeared the member was no longer returning calls or contacting the case manager. The case manager explained that in some cases, where complex problems existed, allowing a case to remain open allowed them to contact the member from time to time to ensure there were no new services needed. Cases would be closed at the member's request, or when it was apparent they could no longer provide assistance.

Conclusion

During the discussion with the case managers a positive and collaborative atmosphere was observed by the reviewers. The case managers were aware of issues in one another's cases,they assisted one another in resolving problems and

making referrals for members based on their knowledge of resources. A level of commitment to resolving member issues was observed during the EQR reviewers' discussion with the social worker and the nurses.

MISSOURI CARE

Case Assignment

Cases are assigned to one of three teams:

- Perinatal – each nurse case manager has between 80 and 100 cases.
- Adult – includes a licensed clinical social worker (LCSW), and a registered nurse (RN). These case managers carry approximately thirty (30) complex cases.
- Pediatrics – this team includes LCSWs and RNs. These case managers carry between 80 and 100 cases.
- One RN has all lead involved cases and NICU cases.

The case managers deal with both behavioral health and medical issues for the members they serve. Case assignment is driven by the criteria that "admitted" them into case management. If the presenting problem is a behavioral health issue, as an example, an LCSW will be assigned, but will also handle the member's medical issues. The MCHP finds that most cases are complex and this process allows for good care coordination by the primary case manager.

Referral

The MCHP utilizes a predictive modeling system called CORE. This system produces a report that identifies members with complex issues. This report is a key component of the MCHP's referral system. Case managers contact all members appearing on the CORE report and assess their case management needs. In addition to the CORE report, MCHP case managers receive referrals from the following sources:

- Emergency Department logs;
- Medical and/or behavioral rounds by MCHP staff, which occur three times per week;
- Providers;
- Member self-referrals;
- Other MCHP internal sources such as Utilization Management, Concurrent Review nurses, and Member Services.

The case managers receive assistance from, refer to, and receive referrals from Disease Management. The Disease Management staff provides education to members regarding specific disease processes. This service is provided from the

corporate offices, but the case managers believe they have adequate communication and get support as needed from the Disease Managers.

Case Management Introduction

The case managers reflect a sense of the importance of maintaining strong community ties, and using these partners to contact and locate members when other measures fail. If they have difficulties contacting members, the case managers contact physicians' offices, the Family Support Division, or the transportation sub-contractor to obtain member contact information. When a problem continues, the MCHP contracts with a company, Med Staff, to make home visits and locate the member and to obtain useful contact information.

The case managers use this information to become involved with the member and to engage them in the case management process.

Outreach

Missouri Care case managers are very involved with the members they serve. They actively seek to find all members referred for services and keep detailed records of all contacts and attempted contacts. They believe one key to their success is their involvement in community efforts. Through their Quality Council outreach efforts the MCHP is working in all three Managed Care regions to develop relationships with schools, FQHCs, and provider office staff to educate and promote MCHP services. This group works with community partners to identify issues and needs.

The MCHP has their own in-house approach to behavioral health services and this group is part of these outreach efforts. The approach of integrated case management has enabled the case managers to communicate with referral sources and engage them in actively working with the MCHP. This creates an atmosphere where members receive the most appropriate community resources, whether they are in need of physical and behavioral health services. The MCHP's Show-Me Smile and B-Fit programs reached over 11,000 individuals at community events during 2010. An emphasis for 2010 efforts was placed on the Kansas City region, specifically focusing on the Spanish speaking population.

The MCHP partnered with Samuel Rogers Clinic and the Mexican Council during health fairs and community events. At one event a Spanish speaking staff member handed out printed material and spoke to over 1000 individuals.

Assessment and Member Engagement

The case managers explained that a major factor in all open cases is completing the assessment process which automatically produces the care plan for each family. This normally occurs at the first contact with the member. The case management system automatically sends a copy of the care plan to the member and to the PCP upon completion. The case managers explained that this is a system upgrade that did not exist at the beginning of the 2010 calendar year and therefore was not reflected in the first set of case files reviewed by the EQR. The case managers may have more than one care plan open at one time when a member has complex needs.

Care/Case Coordination

The MCHP actively works with the Marion County (Hannibal, MO) and Pettis County (Sedalia, MO) health departments for interventions with lead related cases. These health departments work in their home county as well as a number of outlying counties. They perform lead abatement activities, assessments, and work with members to follow through when problems arise. Health Department staff assists the MCHP by making home visits and follow up with referred members to ensure that affected children's lead levels improve.

Lead case managers were asked if they focus solely on this issue with the families they serve. The case managers explain they work with the family in an integrated fashion. However, in lead cases the narrative documentation only reflects the work surrounding ameliorating the lead exposure issues. They are required to post their findings into the MOHSAIC system. Notes are required to be brief and related to the issues surrounding elevated lead levels. They explained that broader notes may exist, regarding these members, in the in-house case

management system. MOHSAIC must be case and issue specific. These case managers use several outside agencies to make face-to-face contacts with members throughout all three regions. The home visits are generally completed by Angels Care, Marion County Home Health, and Nurses for Newborns. A referral form is sent to one of the contracted agencies, these agencies complete the home visit and then send a report to the MCHP.

The case managers report that they ensure all lead cases receive regular in-person contact from a home-health provider. Lead cases receive at least three in-home visits. For perinatal cases, the subcontractor Med Staff makes monthly in-home contacts for high risk members. Lower risk members receive home visits each trimester. Another visit occurs when the baby is delivered. Home health visits are completed for members in the hospital or any time a referral is received from a physician who believes more complex health problems may exist with a member than is evident during an office visit.

The case managers do have a strategy for working with Children's Services staff when serving children in foster care. They provide any necessary education or assistance regarding medical care. The primary case management is performed by the public agency or one of their contractors, such as Cornerstones of Care in Jackson County. The MCHP case managers are informed when these children return home and they assist and follow the care plan in place. The MCHP case manager provides outreach and any useful services while the child remains eligible for Managed Care services.

Documentation

The case managers explain that their current case management system, Case Tracker, has improved their ability to manage cases effectively. The system captures the member's medical history, their current status, and activities. The system sends reminders of the services the member needs or requests. The system includes an assessment, which is a total health questionnaire, not simply

an assessment. The system is also able to do a predictive modeling history, which includes all previous and current diagnoses, health history and pharmacy utilization data. Case managers could not explain why this information was not included in the records received by the reviewers. They assert that their system contains a great deal of information that was not shared in the case files received for review by the EQRO.

Case Closure

Case managers report that when a need to close a case is observed, the member is transferred to another group that administers a satisfaction survey. The member is initially contacted by telephone and calls to complete the survey are made. The MCHP finds that this enables a final contact with members and assists in enhancement and improvement of their case management program. Case managers state they only close cases if contact is totally lost, they and the member agree that services are no longer needed, if a member loses eligibility, and/or if the member changes MCHPs. Case managers report they make attempts to create a transition plan if they can locate the member and engage them in the process.

MOLINA HEALTHCARE OF MISSOURI

Case Assignment

The case managers explain that they receive cases by specialty and alphabetically. One case manager handles all of the lead cases in all three Managed Care regions. All members who are hospitalized are triaged for case management services. When case management is called for, these cases are assigned to one nurse, who provides initial services. As the member stabilizes, they may be reassigned based on the type of services needed.

Referrals

The case managers receive referrals from a variety of sources including physicians' offices, hospitals, State listings, members, and internal MCHP sources. If a member has multiple needs, such as pregnancy and another physical or

behavioral health issue, the case is co-case managed. If a referral to Disease Management is appropriate for a member, the case manager stays involved while education and other supportive information are provided by that unit.

Case Management Introduction

Members are introduced to the case management process in a variety of methods. When a member has an elevated blood lead level (over 10 dl) the case manager completes an assessment and goes out to educate the member(s). Necessary services are determined and risk factors are assessed. A plan of care, including lead abatement and protection, for exposed children is defined. The case manager coordinates care with the PCP, the Department of Health case managers, and lead inspectors. The case manager reports maintaining contact with the member if they move and assisting in determining where the lead exposure exists.

The case managers all report that they explain the details of the case management program to the member and obtain their agreement to participate. The MCHP's computerized case management system prompts the case manager to explain that this agreement has been reached. If in any case a member cannot be located, it must be fully documented in their system before a case is actually closed. In a lead case situation, the case will remain open and the case manager will continue to attempt to make contacts. The case manager continues to contact the health department and the PCP to ensure that a child has returned and the blood lead level is checked. The only time a lead case, where they have lost contact with the family is closed, is when they can verify that the BLL is below the 10dl level. The local department of health will go to the family's home and will educate the family on the importance of continued checks. Information sharing continues between agencies to ensure that the child has no permanent negative effects from the lead exposure.

Outreach

The case managers describe persistent efforts to locate members. They utilize local health departments, advocates, cyber access, and transportation providers. They also review ME (Medical Eligibility) codes for members as claims may lead to a viable address or telephone number. The MCHP contracts with Bio Med to complete assessments and go into the field to locate members.

Case managers reported utilizing the assessments completed by BioMed, but enhancing these with the questions asked in their system. This process is enhanced and is made specific to each member and their needs. If a member has multiple health issues a screening is done immediately by a case manager. The case managers report that they get good and accurate information from BioMed. This has improved their ability to locate pregnant members and get services in place as early in the pregnancy as possible. If a member cannot be located with multiple efforts, a letter is sent providing the name of the case manager. The case managers report that this often encourages the member to respond. The case managers have found that the member did call back when there was a person's name on the letter.

Assessment and Member Engagement

After receiving a referral, the case manager makes an effort to contact the member, with a goal of making a contact and engaging the member within seven days. When contact is made they complete an assessment. The assessment process initiates a care plan that addresses the needs identified.

The case managers believe that the assessment is a process. It begins with general information and gains more specific information over time. Each case manager seeks to ensure that the member understands what is occurring with the assessment and care planning, but also with the medical services they need. As needs are identified, such as community based services and social supports, the case manager seeks to ensure that the member has access. The case

managers report incorporating information from the member, the PCP, and other sources to complete the assessment. They then devise a plan of care. The case manager helps the member prioritize the care plan or communicates this to the member. The care plan determines in what order services are provided.

Care/Case Coordination

The case managers report working with Cornerstones of Care, who act as the primary case managers in cases where children are in foster care. Medical issues are identified and the MCHP case managers follow the case to ensure that these needs are met. The case managers work directly with specific staff from Cornerstones of Care. If a member changes MCHPs they make every attempt to create a transitional care plan, which will cause the least disruption in services.

Documentation

The case managers report that they document contacts and attempted contacts in their Case Management System. Much of the case management system was created "in house." They believe that their direct input has enhanced the system. They continue to be able to make recommendations for improvement.

The case managers stress the importance of recording progress notes after each contact or attempted contact with a member. Their system allows any case manager to review these notes, so questions can be answered to a member or provider if the assigned case manager is unavailable. They feel this process is very thorough. As the case managers communicate with members; the assessment, goals, and outcomes are updated and incorporated into the case management system. The case managers review claims, doctor's visits, and medications regularly to determine members' history and to ensure that care plans are appropriate.

Case Closure

Case managers report making decisions with members, supervisors, and others to close cases as goals are achieved. Occasionally members refuse further services and the case managers report that as medical issues are resolved members lose interest in the case management process. Discharge education is provided by mail or during telephone contacts whenever possible. A final closing letter is sent to the PCP and the member, indicating that their specific case management case has been closed.

4.3 Observations and Conclusions for All MCHPs

Observations

1. Case management in OB cases often ends right after the baby is born. The case managers report an awareness that the case should remain open for at least sixty (60) days, or until the member loses eligibility. However, they report that the member often loses contact with them. The case manager will make attempted contacts, but the member fails to return calls/changes addresses or phone numbers and the CM no longer has access to the member.
2. Case managers report that they are often unable to create a useful transition plan with the member when it appears the case should be closed. As members' health care needs are met they lose interest in case management and no longer return calls or respond to letters requesting they contact the case manager.
3. Case managers reflect that they have access to a great deal of information in their case management systems but all of this documentation was not shared with the EQRO when case records were produced for review. Reviewers explained they can only look at what they receive, but understand that additional information may exist. This was particularly true regarding care plans.

4. At several MCHPs, reviewers were told that completing the assessment process, in the system, automatically produces a care plan. Even at these MCHPs, reviewers found assessments in the case files while no care plan was included in the record.
5. Complex case management and care coordination is different for each MCHP. It either occurs rarely or is not documented in progress notes. How each MCHP defines and executes complex case management is unclear.
6. It is noted that Missouri Care members receive complex case management and intense care coordination. This is done in an integrated manner and it appears very seamless to the member. Some of the requirements of the Lead Case Managers inhibit a strong case management process. This is a dedicated group of case managers across all the MCHPs. Arbitrarily maintaining open cases, even when the elevated blood lead level is low (below 15dL for example), and requiring the tracking of members through PCP contacts and health department contacts is time consuming and may not be an efficient use of their time.
7. A lack of commitment to members who are difficult to locate or contact was observed. The case managers earnestly provide services to members who are interested and are actively participate in the process. These same case managers exhibit a loss of interest in unresponsive members.
8. The case managers from one MCHP (Harmony) are in a remote location. It should be noted that these case managers do not demonstrate an essential understanding of the members they serve. They discuss members in terms of the "market," rather than individuals in need of guidance or services. Responses to questions do not reflect an intrinsic knowledge of the cultural or geographic idiosyncrasies that exist and are important to adequate member services. These case managers focus on the "St. Louis market" and have little knowledge of the remainder of the Managed Care Eastern Region. These facts create a vacuum in services, referrals, and ancillary resources for MCHP members.

RECOMMENDATIONS

1. Case managers should copy their own records when cases are requested for review.
2. The SMA should provide support to encourage inter-agency cooperation between the Family Support Division and Children's Services staff when dealing with MCHP case management. This would assist case managers as they attempt to communicate the importance of information sharing, both for contact information and for developing on-going case planning.
3. The MCHPs should invest in face-to-face contacts with Family Support Division and Children's Services staff in the counties they serve.
4. The SMA should reevaluate the requirements for lead case management that make this processes overly time consuming, specifically when lead levels have significantly decreased.
5. Each MCHP must commit to finding "hard to locate members", these are often the members who will most benefit from the receipt of case management services.
6. Harmony Health Plan should thoroughly investigate the deficiencies that the EQR reviewers observed with their case management processes. They should pay specific attention to the issues the reviewers attribute to the geographic location of case management staff.

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 EQRO uses 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 during the review process, with an emphasis on areas where individual MCHPs have previously failed to comply or were partially compliant 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 with the progress made in achieving quality, access, and timeliness to services from the previous review year.

The 2009 report was a full compliance review, this year's compliance review is a follow up to that review and will also include a follow up to the 2006 review that included a case review of Grievance and Appeal files. The MHD 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 Grievance and Appeals and Case Management processes. The review included case record reviews and interviews with Grievance and Appeal staff, Case Management staff, and Administrative staff. The results of the Case Management review will be reported in another section of this report as a "Special Project". The interview tools were based on information obtained from each MCHPs' 2010 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 2011 through June 2011 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 2011, 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 Grievance and Appeal files in the first and third quarters of the calendar year (2011). Lists of all Grievance and Appeals for these time frames were obtained from the SMA, as all MCHPs are required to report these actions to the State. These lists were analyzed by the EQR and a random case sample was requested from each MCHP that would be read and reviewed while on-site. These files would determine the questions asked during the Grievance and Appeals Staff interviews, as well as the administrative interviews. This documentation was used as a guide for the 2010 review. The SMA provided updated policy compliance information for this review to support the practice information obtained.

Document Review

Documents chosen for review were those that best demonstrated each 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. 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 2010 Compliance Review. Other information, such as the Annual Quality Improvement Program Evaluation was requested and reviewed to provide insight into each MCHPs' compliance with the requirements of the SMA Quality Improvement Strategy, which is an essential component of the Managed Care contract, and is required by the federal regulations. MCHP Quality Improvement Committee meeting minutes were reviewed. Grievance and Appeal policies and procedures were reviewed and used in assessing both the grievance and appeal records review, and in discussions with MCHP staff. In addition, interviews based on questions from the SMA and specific to each MCHP'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 MCHP. Interview questions were developed for grievance and appeals staff to establish that practice directly with members reflected the MCHPs' 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 MCHPs:

- State contract compliance ratings from 2010 and updated policies accepted through August 2011
- Results, findings, and follow-up information from the 2009 External Quality Review
- 2010 Annual MCHP Evaluation

CONDUCTING INTERVIEWS

After discussions with the SMA, it was decided that the 2010 Compliance Review

would include interviews with Grievance and Appeals staff, Case Management Staff (under the guidelines of the "Special Project") and Administrative Staff. The goal of these interviews was to validate that practices at the MCHPs, 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 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 MCHP's adherence to their policy. Specific questions were also posed, using examples from the grievance and appeals records reviewed.

Previous interviews, generally conducted with administrative and management level MCHP staff, enabled reviewers to obtain a picture of the degree of compliance achieved through policy implementation. Corrective action taken by each MCHP was determined from the previous years' reviews. This process revealed a wealth of information about the approach each MCHP 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 MCHP was developed. 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 MCHP QI/UM staff regarding management information systems; Case Management Special Project; Validating Performance Measures; and Validating Performance Improvement Projects. The review evaluated information from these sources to validate MCHP 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 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 MCHP'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 2011 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, MCHP policy, ancillary documentation, and staff interview summary responses that validate MCHP 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 MCHPs 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 MCHP 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. Across all MCHPs 100% of the regulations were rated as "Met", this is an improvement over the past two year's review when the All MCHP rate of "Met" was 94.87%.

All MCHPs 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 MCHPs are in compliance with other state requirements [438.100(d)].

Three of the MCHPs (CMFHP, BA+, and HCUSA) continue to utilize a Member Advisory Committee that serves to provide insight into the issues faced by members who are attempting to obtain healthcare services. These MCHPs incorporated member suggestions into their operations and marketing materials. These activities were indicators of the MCHPs' commitment to member services and to ensuring that members have quality healthcare.

All MCHPs continued to operate programs for the provision of behavioral health

services. Four of the MCHPs subcontract with Behavioral Health Organizations (BHO) for these services. Two MCHPs (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 MCHP structure. One MCHP (Harmony) utilized a subsidiary of their parent company to provide behavioral health services during 2010.

All MCHPs provided active oversight, if not direct involvement, of their behavioral health subcontractors All of the MCHPs 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. 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.

COMPLIANCE INTERVIEWS – CASE MANAGERS

Interviews were held at each MCHP 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 MCHP'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 MCHP, and focused on issues that might compromise compliance with required case management activities. The specific findings of these interviews are reported in the "Special Project" section of this report and each MCHP's specific questions 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 MCHPs (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 MCHP (Harmony) the case managers are located in Tampa, Florida. Three MCHPs (Molina, MO Care, and HCUSA) serve all three Managed Care regions. Each of these MCHPs locates case management staff in each region.

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 17). Across all MCHPs, 75.49% of the regulations were "Met" which is a **decrease** from the 2009 rate of 86.7% and the 2008 rate of 90.20%. Five of the MCHPs (BA+, CMFHP, HCUSA, Molina, and MO Care) were found to be 76.5% compliant.

- BA+staff reported that there was planned enhancement to their case management system which would improve this, but these enhancements were not scheduled to "go live" until 2011.
- One MCHP (Harmony) is rated at 70.6%. The case records reviewed did not include substantial evidence of complete adherence to policy or complete documentation of the assessment process and services provided. In the case records reviewed many were closed after perfunctory attempts to make contact with a member.

The **decrease** in the Access Standards compliance rate is directly attributable to the findings of the Case Management Special Project (this is discussed in greater detail in Section 4 of this report). However, one MCHP (Harmony) continues to have issues with the adequacy of their provider network; they are unable to acquire hospital services in close proximity to several counties that they serve.

All 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 MCHPs 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; Notice of Adverse Action, and Emergency and Post-Stabilization Services. Throughout this review period, all MCHPs 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 MCHPs excelled.

Table 17 – 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	2	2	2	2	2	6	0	0	100.0%
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	1	1	1	1	0	6	0	0.0%
438.208(c)(1) Care Coordination: Identification	1	1	1	1	1	1	0	6	0	0.0%
438.208(c)(2) Care Coordination: Assessment	1	1	1	1	1	1	0	6	0	0.0%
438.208(c)(3) Care Coordination: Treatment Plans	1	1	1	1	1	1	0	6	0	0.0%
438.208(c)(4) Care Coordination: Direct Access to Specialists	2	2	2	2	2	2	6	0	0	100.0%
438.210(b) Authorization of Services	2	2	2	2	2	2	6	0	0	100.0%
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	2	2	2	2	2	6	0	0	100.0%
438.114 Emergency and Post-Stabilization Services	2	2	2	2	2	2	6	0	0	100.0%
Number Met	13	12	13	13	13	13	77	25	0	75.49%
Number Partially Met	4	5	4	4	4	4				
Number Not Met	0	0	0	0	0	0				
Rate Met	76.5%	70.6%	76.5%	76.5%	76.5%	76.5%				

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 MCHPs (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., 2010 External Quality Review Monitoring MCHPs Protocols.

Evidence existed of efforts to inform members of available providers, urgent care centers, and hospitals through presentations at community events and newsletters. The need to ensure that members received appropriate referrals to PCPs and specialty providers was clearly reflected in the interviews. Required documentation and approved policies did exist in all areas for all MCHPs. All six of the MCHPs had complete policy and practices, and Provider Manual language in the area of emergency and post-stabilization services [438.114]. The MCHPs made efforts to ensure that the problems they experienced did not affect services to members. All MCHPs 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 compared to the prior year's review.

The MCHPs 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 MCHPs reported utilizing out-of-network providers and often paying commercial or **higher** rates to obtain these services. All MCHPs 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.

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, grievance systems, and accountability for activities delegated to subcontractors. Across MCHPs, 100% of these regulations were "Met", which is an ***increase*** over both 2008 and 2009, when 95% and 93.3% of the regulations were "Met", respectively.

The Provider Services departments of all MCHPs exhibited a sound and thorough understanding of the requirements for provider selection, credentialing, nondiscrimination, exclusion, and Managed Care requirements. All six MCHPs were 100% compliant with most of these regulations. This included Provider Selection [438.214(d) and 438.214(e)]; Timeframes [438.56(e)]; and disenrollement. The staff at each MCHP understood the requirements for disenrollment. All of the MCHPs described credentialing and re-credentialing policies that exceeded the requirements of the regulations. All MCHPs have developed policy and procedures that comply with NCQA criteria. Providers were willing to submit to these stricter standards to maintain network qualifications in both the MCHPs and other commercial networks. All of the MCHPs (100.0%) had all required policies and practices in place regarding credentialing.

All MCHPs (100.0%) understood the required oversight of subcontractors. The compliance rate for this regulation [438.230(a,b)] **increased** from the 2009 review (83.3%) and returned to the 2008 review (100.0%) level.

All MCHPs achieved 100.0% compliance and had appropriate grievance systems in place meeting the requirements of this regulation [438.228].

All previous deficiencies for Structure and Operation Standards related to a lack of submitted or approved policies or subcontractor agreements. The MCHPs exhibit a significant understanding and attention to these details and requirements during this review. Interviews revealed that MCHP staff quickly identifies problems if they receive calls related to these issues. All MCHPs 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. A total of 93.9% of the criteria were "Met" by MCHPs, which continues to indicate improvement in meeting federal requirements, over the 2009 rate of 92.4% and the 2008 rate of 89.4%. This number again reflects that one MCHP (Harmony) has policy awaiting SMA approval and continues to have difficulty with the Performance Improvement Project process. Another MCHP (HCUSA) did not submit all Performance Measure data in a format that allowed for required validation. Four MCHPs (MO Care, CMFHP, Molina, and BA+) met all the requirements (100%) in this area.

Table 18 – 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	0	2	2	2	2	5	0	1	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	2	2	2	2	2	6	0	0	100.0%
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	8	10	11	11	11	62	3	1	93.9%
Number Partially Met	0	2	1	0	0	0				
Number Not Met	0	1	0	0	0	0				
Rate Met	100.0%	72.7%	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 MCHPs (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., 2010 External Quality Review Monitoring MCHPs Protocols.

During the 2009 and 2010 on-site reviews it was evident to the reviewers that practice guidelines have become a normal part of each MCHPs' daily operation. Practice guidelines are in place and the MCHPs are monitoring providers to ensure their utilization. All six of the MCHPs (100%) met all the requirements for adopting, disseminating and applying practice guidelines. In the Western Region, staff from the MCHPs 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 MCHPs 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 MCHPs (83.3%) used nationally accredited criteria for utilization management decisions [438.240(b)(3)]. The tools the MCHPs 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 MCHP staff was able to articulate how they utilized these tools and apply them to member healthcare management issues. When requested, members are provided with crieteria or guidelines, thereby ensuring that their children obtained appropriate levels of information.

The MCHPs were actively involved in developing and improving their Quality Assessment and Improvement Programs. Three of the MCHPs (BA+, CMFHP and HCUSA) utilized community based advisory boards and CMFHP's board included

members. These groups assisted the MCHPs in assessing member needs and barriers to services. These MCHPs utilized the recommendations of these groups in their operations, member information, and daily activities. All of the MCHPs 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, specifically in the area of Utilization Management.

All MCHPs' compliance maintained prior year levels or improved in the section of the protocol involving Validating Performance Measures and Health Information Systems. As noted above, issues exist for one MCHP in the area of Validating Performance Improvement Projects. Detailed findings and conclusions for these items are provided in previous sections of this report and within the MCHP summaries.

GRIEVANCE SYSTEMS

The EQR was asked by the SMA to focus more closely on the area of Grievances and Appeals during this follow-up Compliance review. 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.

The EQR developed a methodology whereby, a sample of Grievance and Appeal files were reviewed on-site by the EQR Project Director. A listing of all Grievance and Appeals, as reported by the MCHPs to the SMA, was obtained for 1Q2010 and 3Q2010. A number of these files were then randomly selected for review at the on-site visit. Each MCHP was provided a listing of the files to be reviewed one week prior to the on-site reading day (1/2 day of review).

Once on-site, these files were reviewed for compliance with Subpart F of the regulatory provisions for Medicaid managed care (Grievances and Appeals) and the MCHPs' contract for the provision of MO HealthNet services with the SMA.

Conclusion

All six MCHPs experienced some level of noncompliance with the regulations related to grievances and appeals (see Table 20). Although all plans had policy and procedures that were complete and approved by the SMA, at most of the MCHPs, a review of the files showed a lack of adherence to those policies and procedures. Additionally, it was determined that some of the mandatory language required by the State contract did not rise to meet the requirements of the regulatory provisions outlined in the Federal Protocols. Specifically: 1) the language included in each MCHPs' member handbook, does not delineate the MCHPs' availability to assist members in filing a Grievance and/or Appeal, and 2) the mandatory language included in each MCHPs' member handbook, does not indicate that the MCHP will supply the member with the State or Federal regulations that support any action the MCHP may have taken.

Table 19 – Grievance and Appeals records reviewed by MCHP

MCHP	# of records reviewed	# with issues	% with issues	% Correct
Blue-Advantage Plus	30	7	23.33%	76.67%
CMFHP	42	0	0.00%	100.00%
Harmony	29	19	65.52%	34.48%
HCUSA	35	4	11.43%	88.57%
MO Care	35	5	14.29%	85.71%
Molina	30	6	20.00%	80.00%
Statewide rate	**201**	**41**	**20.40%**	**79.60%**

Opportunities for Improvement

The issues found during the file reviews included: Missing letters of acknowledgement to incorrect addresses of where to mail correspondence provided in Appeals letters; Use of language that does not meet appropriate

grade-level requirements; and Timelines of disposition of grievance or appeal did not meet standards. These issues will be described in each MCHP's individual plan Compliance section of this report.

The MCHP ratings ranged from "Partially Met" to "Not Met" in the category of 438.404 (a) Grievance System: Notice of Action-Language and Format. The All MCHPs rating in this category was 76.2% a **decrease** from prior review years' findings of 100% compliance. This **lower** overall rating is mainly attributable to each MCHP's use of the SMA's approved language in their Notice of Action (NOA) letters. After review of this required language, the EQR believes that the clause pertaining to the "Continuation of Services" is confusing and that the inclusion of a listing of all legal aid offices in the State of Missouri, instead of the one office that services the member's county of residence, adds to the confusing nature of this letter.
Two of the MCHPs (BA+ and Harmony) were rated as "Not Met" with category 438.404(b) Grievance System: Notice of Action - Content as their files showed additional issues with a significant number of the NOA letters examined during the on-site. These issues included: 1) providing members with the Illinois Department of Healthcare and Family Services contact information for requesting a State Fair Hearing; and 2) Providing members with an Explanation of Benefits, when denying a service and not a Notice of Action letter in the format approved by the SMA (these EOB letters did not include the required language informing members of their right to continue benefits during an Appeal or State Fair Hearing).

One MCHP was rated as "Partially Met" with category 438.404 (c) Grievance System: Notice of Action: Timing, as one file reviewed at this MCHP showed a denial of services occurring 70 days prior to the date that a NOA was mailed.

One MCHP was rated as "Partially Met" with category 438.408 (b,c) Resolution

and Notification: Grievances and Appeals- Timeframes and Extensions as the required timeline for disposition of two of the grievances reviewed was not met.

Four MCHPs were rated as "Partially Met" with category 438.408 (d) (e) Resolution and Notification: Grievance and Appeals – Format and Content of Notice. Each MCHPs' deficiencies in this category are detailed in their individual reports.

Two MCHPs were rated as "Partially Met" with category 438.420 Continuation of Benefits while Appeal/Fair Hearing Pending. Both of these MCHPs had numerous files in which the NOA did not include language informing the member that their benefits may continue during the Appeal or State Fair Hearing processes.

Additionally, the member handbooks contain State mandated language that does not include information regarding the MCHPs' availability to assist members in filing grievances or appeals. The handbooks also do not contain information regarding the requirement that members/providers be informed of the regulation that supports the action taken by the MCHP.
The number of member grievances and appeals varied between the MCHPs. However, the numbers were proportional to MCHP 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 all six MCHPs. However, as noted earlier, the EQRO feels that the mandatory language in the "Continuation of Benefits" clause of the NOA letter and the inclusion of all legal aid offices that serve Missouri are unnecessarily confusing.

Interviews were conducted with the specific units or persons who respond to member grievances and appeals and provider complaints, grievances and

appeals during all on-site reviews. Most plans described a system where the number and type of cases or issues are reflected in the notes that Case Management staff record on all member contacts. These processes are resulting in timely processing of the complaints, grievances, and appeals. It appears that all MCHP 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 MCHP 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.

Table 20 – 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	2	2	2	2	2	6	0	0	100.0%
438.402(b)(1) Grievance System: Filing Requirements - Authority	2	2	2	2	2	2	6	0	0	100.0%
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	1	1	1	1	1	1	0	7	0	0.0%
438.404(b) Notice of Action: Content	2	0	2	2	2	0	4	0	2	66.7%
438.404(c) Notice of Action: Timing	2	1	2	1	2	2	4	2	0	66.7%
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	2	2	2	2	1	5	1	0	83.3%
438.408(d)(e) Resolution and Notification: Grievance and Appeals - Format and Content of Notice	1	1	1	2	2	1	2	4	0	33.3%
438.408(f) Resolution and Notification: Grievances and Appeals - Requirements for State Fair Hearings	2	1	2	2	2	1	4	2	0	66.7%
438.410 Expedited Resolution of Appeals	2	2	2	2	2	2	6	0	0	100.0%
438.414 Information about the Grievance System to Providers and Subcontractors	2	1	2	2	2	1	4	2	0	66.7%
438.416 Recordkeeping and Reporting Requirements	2	2	2	2	2	2	6	0	0	100.0%
438.420 Continuation of Benefits while Appeal/Fair Hearing Pend	2	1	2	2	2	1	4	2	0	66.7%
438.424 Effectuation of Reversed Appeal Resolutions	2	2	2	2	2	2	6	0	0	100.0%
Number Met	16	6	16	16	17	11	82	25	2	75.2%
Number Partially Met	2	11	2	2	1	6				
Number Not Met	0	1	0	0	0	1				
Rate Met	88.9%	33.3%	88.9%	88.9%	94.4%	61.1%				

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

Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCHPs) and Prepaid Inpatient MCHPs (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., 2010 External Quality Review Monitoring MCHPs Protocols.

5.3 Conclusions

Across all 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 other individual regulations were rated as "Met" or "Partially Met." All the MCHPs were 100% compliant with the areas of Enrollee Rights and Protections and Structure and Operations Standards. However, unlike prior year reviews, none of the six MCHPs were 100% compliant with all requirements. This is attributable to the in-depth review of the plans' Grievance and Appeals files and Case Management Special Project review. All MCHPs were unable to demonstrate case management information that fully exhibited compliance with the aspects care coordination.

All of the MCHPs 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 MCHPs made it clear that they used the results of the prior EQR to complete and guide required changes. One MCHP (BA+) 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. The following summarizes the strengths in the areas of Access to Care, Quality of Care and Timeliness of Care.

QUALITY OF CARE

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

All of the 10 regulations for Structure and Operations Standards were 100% "Met." These included provider selection, and network maintenance, subcontract relationships, and delegation. The MCHPs had active mechanisms for oversight of all subcontractors in place. All MCHPs 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 Managed Care members.

ACCESS TO CARE

All six MCHPs' compliance with the 17 federal regulations concerning Access Standards **decreased significantly** during this year's review. Five MCHPs were 76.5% compliant and one was found to be 70.6% compliant. Although the EQRO observed that most of the MCHPs monitored high risk Managed Care members and had active case management services in place, the records requested did not always contain information to substantiate these observations. Each MCHP

described measures they used to identify and provide services to MO HealthNet Managed Care Members who have special healthcare needs. Five of the MCHPs 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 MCHPs 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 MCHPs had all required policy in place, all the MCHPs were unable to demonstrate through chart review that they had fully compliant care coordination processes in place.

TIMELINESS OF CARE

Seven of the 12 regulations for Measurement and Improvement were 100% "Met." Four of the six MO HealthNet MCHPs met all of the regulatory requirements. All six MCHPs adopted, disseminated and applied practice guidelines to ensure sound and timely healthcare services for members. The MCHPs used their health information systems to examine the appropriate utilization of care using national standard guidelines for utilization management. One of the MCHPs (MO Care) has become very adept at utilizing the data and demographics in their systems to track and trend information on members to assist in determinations of risk and prevention initiatives. Several MCHPs continue to use member and community based quality improvement groups to assist in determining barriers to services and methods to improve service delivery. The Case Management departments reported integral working relationships with the Provider Services and Relations Departments of the MCHPs, this was not always evident in the documentation reviewed. 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 MCHPs all provided examples of how these relationships served to ensure that members received timely and effective healthcare. The MCHP staff would contact providers directly to make appointments whenever members expressed difficulty in obtaining timely services.

Only four of the 18 regulations for Grievance Systems were 100% "Met" for all of the MCHPs. These four regulations all pertained to the written policy and procedure of the MCHPs, it was evident that the practice at five of the six MCHPs was severely deficient compared to that written policy. All six MCHPs did receive the rating of "Partially Met" in the area of Notice of Action Letter – Language and Format; this rating is actually a result of the EQRO's finding that the State's required Mandatory Language is confusing and is not necessarily entirely attributable to the individual plans. Issues with NOA letter content and timeframes were prevailing in this area of review. Additionally, the member handbooks contain State mandated language that does not include information regarding the MCHPs' availability to assist members in filing grievances or appeals. The handbooks also do not contain information regarding the requirement that members/providers be informed of the regulation that supports the action taken by the MCHP.

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 MCHPs observed that these efforts combined to create a system that allowed members timely access to quality healthcare.

RECOMMENDATIONS

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

2. MCHPs identified the need for continuing to monitor provider availability in their own networks. Although most MCHPs 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 MCHPs. The MCHPs admit to struggling with recruitment of certain specialty physicians so availability in this area must be a focus of continued improvement.

3. 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 MCHPs are operating a case management program. Attention to the depth and quality of case management services is a priority of the SMA. The MCHPs 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.

Additionally, attention must be applied to ensure the EQRO receives documentation as requested to validate that these services are occurring.

5. The Grievance Systems must be closely monitored at all the MCHPs to ensure compliance with the Federal regulations and the State contract. Content of letters and member handbooks must be understandable to the Managed Care members and meet the Federal and State requirements.

6. The Mandatory Language contained in all MCHPs' member handbooks should be reviewed. The EQRO was unable to find language detailing the MCHPs' availability to assist members when filing appeals and/or grievances (other than language assistance). The EQRO was also unable to locate in the handbook any assurance that the member had the right to be supplied with the regulations that support any action taken by the MCHP(s).

6.0 Blue-Advantage Plus

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6.1 Performance Improvement Projects

METHODS

DOCUMENT REVIEW

Blue Advantage Plus supplied the following documentation for review:

- Little Stars Program for Teenagers
- Statewide Performance Improvement Project – Improving Oral Health

INTERVIEWS

Interviews were conducted with the project leaders for each Performance Improvement Project (PIP) by the EQRO team on July 8, 2011 during the on-site review. Interviews included the following:

- Judy Brennan – Director State Programs BA+, Plan Administrator
- Tee-Ka Johnson – Special Programs Coordinator
- Shelly Bowen – Assistant Vice President Quality Management

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 to address questions asked by the MCHP.

FINDINGS

Clinical PIP – Little Stars Program for Teenagers

Study Topic

The first PIP evaluated was the Little Stars Program for Teenagers. This project was submitted for the first time as a clinical performance improvement project. This clinical project focused on the importance of prenatal and postnatal care, particularly for teen parents. The goal was to explore how enhanced medical services create positive health outcomes for the mother and baby. The MCHP selected this topic based on the increased number of teenage mothers referred to the Little Stars Program, reflecting a rising trend in teen pregnancies. The narrative information provided by the MCHP detailed a strong argument for increasing the participation of teenage pregnant members in the Little Stars Program. This decision was based on The MCHP's literature review supported the observation that both national and regional reports indicated an increase in teenage pregnancy. This research also supported the theory that teenage pregnancies pose an increased risk to the health of the mother and her unborn child. The information supporting the rationale for the study is fully integrated into the study topic discussion on local issues and needs.

The study topic 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 of how improving services to pregnant teens will positively impact a key aspect of member care. The narrative related this choice to improving available services at a critical time for this population of BA+ pregnant and under the age of eighteen (18) are included in this study. No members were excluded based on the need for special health care services.

Study Question

The study question submitted is, "Will education and interventions geared toward

teenage pregnant members under the age of 18, and the parents/guardians of pregnant teenagers increase the initial participation rate and the completion rate for the Little Stars Program by 10%?" The concept of engaging this population and their caregivers in enhanced prenatal and postnatal care is included in the explanation supporting the study question.

Study Indicators

The study indicators presented are clear, measurable, and understandable. Two study indicators were presented:

- The first indicator presented measures the initial number of pregnant teens who agree to engage in the program.
- The second indicator measures the pregnant teens that complete the assessment process, actively engage in the program, and complete the second assessment.

Information provided defined the numerators and denominators that would be used to calculate success. Detailed demographic characteristics were presented in the narrative. The indicators measured the outcomes that would best indicate program engagement and completion.

Study Population

The focus of this study includes BA+ members only. The population included in the study are all pregnant members under the age of eighteen (18) meeting the specifications to participate in the Little Stars Program: 1) eligible for the maternity benefit; and 2) less than thirty (30) weeks gestation at the time of initial referral to the program. The methods for referral to the program are clearly delineated and are inclusive in nature.

Sampling

No sampling was used to determine who would be included.

Study Design and Data Collection Procedures

Limitations and barriers, such as member tenure are discussed as they relate to the success of this project. A commitment to improving outcomes in this population is clearly expressed. The data will be collected monthly. A month-to-month comparison will be conducted to look for trends. Final measurements and a final assessment will be based on the annual calendar year data. These measurements will provide insight into project progress and meet protocol standards.

The study design delineated the data sources to be utilized, how it will be collected, and the methodology to be used to analyze this data. Additional information supplied after the time of the on-site review explained the methodology for data collection. The sources of data include the statistics kept for the Little Stars Program. This data is easily obtained in the BA+ FACETS system, and will be placed in an Access System File for analysis and evaluation. Monthly data runs will occur. This data will provide updates to enable the MCHP to track and trend PIP progress. The details of these sources were provided with adequate detail to produce confidence in their reliability and validity. The methodology for data collection remained constant across all time periods studied. The baseline year was defined as 2009. The three yearly analysis cycles included 2010, 2011, and 2012. The review for 2010 included a quantitative and qualitative analysis. The data included information exclusive to MHD members.

The study design included a detailed definition regarding how methods were established creating internal monitoring of the members included in this program. This explanation includes a narrative explanation of how the qualitative and quantitative analysis will occur. An in-depth prospective data analysis plan was presented in the documentation. Additional planning prescribing barrier impact is presented. This plan provided information on how results would be presented and compared.

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

Improvement Strategies

The interventions for the baseline year (2009) and first measurement year (2010) were described in detail. Interventions, barriers, and opportunities for improvement were included. Each year included multiple interventions, all

interventions were to remain ongoing from one measurement year to the next. The narrative discussed the challenges of engaging teens in a health improvement program. The MCHP provided an argument for multiple interventions based on the need to maintain the teens' interest and commitment to this process. A discussion of methods or plans to improve or enhance these interventions to obtain a more successful outcome is included. The information included was of sufficient detail to provided confidence that this project can have a positive impact on member's behavior, with the goal of continued engagement in the Little Stars Program. The MCHP realizes that this approach makes it impossible to measure the effectiveness of any single intervention, but they were able to supply a reasonable argument for trying an approach relying on multiple interventions.

Data Analysis and Interpretation of Results

The interventions and data analysis were discussed in relation to the outcomes achieved. This information was presented according to the data analysis plan.

- For the first indicator, the 2010 measure is an improvement over the baseline. The rate at which pregnant teens were enrolled went from 26.97% to 40.81%. This is not statistically significant, but exceeds the stated goal of 38.5%. Providing interventions focused on teenage members was considered successful and the MCHP believes it is an important approach.

- The second indicator, which focused on teenagers who completed the program, increased from 20.85% to 65.00%, a statistically significant improvement. It far exceeded the stated goal of 30.85%. Providing interventions that focused on outreach to both parents and teens, including a personal interaction with a nurse /case manager, proved to have the desired impact.

Influences on member behavior, as well as the resulting data are included. The data indicates positive initial and on-going trends, even though only one remeasurement year is available. The analysis information included planned improvements and a commitment to maintaining current efforts that have thus far created a positive impact.

Assessment of Improvement Process

A well-constructed interpretation of success and the planned follow-up activities are described. The plans for new and innovative interventions geared toward pregnant teenagers are included. A plan for sustaining and continuing this improvement is presented with an argument that this "real" improvement can be matched. Although there is only one baseline year and one remeasurement year available, the MCHP is aware that they are required to show sustained improvement.

Conclusion

This PIP leads the reviewers to expect, with a high level of confidence, future credible results. The MCHP's 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 demonstrating that the use of creative interventions had the positive impact that the study was designed to produce. The MCHP provided assurances that the interventions will be continued and enhanced.

Non-Clinical PIP – Improving Oral Health

Study Topic

The second PIP evaluated was the BA+ individualized approach to the Statewide PIP "Improving Oral Health." This is a non-clinical project. The rational presented included information related to the statewide PIP study topic decision and included the required argument for addressing the BA+ population individually. The BA+ project, based on interventions pertinent to its members, was supported with MCHP specific data. The narrative information effectively showed that this non-clinical approach was focused on improving the key aspects of member services. The BA+ narrative related to their members, was well researched, and supported by the information presented.

Study Question

The study question for this project is, "Will provider education and implementation of member-focused outreach to the BA+ population (2-20) on the importance of dental visits increase the ADV HEDIS rate by 3%?" The study question is focused, includes a specific goal, and informs the reader of the intention of the MCHP's interventions. The design of the PIP does lead to the conclusion that the impact of both interventions can be measured.

Study Indicators

The indicator for this PIP is an improvement in the Annual Dental Visit HEDIS measure. This measure and its technical specifications were provided. It is strongly associated with an improved process of care. The MCHP notes that a member's average length of time on their MCHP is seven and one half (7 ½)

months. HEDIS criteria require that members who are not continuously enrolled during the measurement year be excluded. This is an identified barrier to improvement for the MCHP. The BA+ specific information included their most recent HEDIS rate, 31.7%, and their goal for improvement of 3%. The indicator was focused on improving the process of care and associating this with improved health care outcomes for members ages 2 through 20.

Study Population

The study population includes all BA+ members ages 2-20 meeting the HEDIS technical specifications for the Annual Dental Visit measure. The specifications were explained in detail.

Sampling

No true sampling was employed in this PIP.

Study Design and Data Collection Procedures

The study design clearly articulates the purpose of the study. Administrative data will be collected and utilized to calculate annual dental visit rates. The manner in which this data is collected, and how it will be managed by the project director is provided. The MCHP will calculate their HEDIS rate using their NCQA software (ViPS). The PIP narrative ensured that all data in this system was valid and reliable, itidentified all data to be submitted, and detailed how all relevant claims and encounters will be used in the appropriate calculations. The narrative states that all members ages 2-20 with a claim or encounter with a dental practitioner, with specific CPT/ICD-9, codes are included. An analysis of this data, conducted by the Special Programs Coordinator, will occur annually. It is evident that systems are in place to produce accurate data for all time periods studied. All necessary elements are referenced in the documentation included.

A comprehensive prospective data analysis plan is woven throughout the

narrative on data collection and management. As data becomes available throughout the study year it will be analyzed by the Project Director, with a comprehensive evaluation in June of each year. Plans for annual reviews and comparisons are described. This includes planning for a quantitative and qualitative analysis each July. Results are shared with the Quality Council and the BA+ Oversight Committee each fall. All team members involved, including the project leader, their roles, and qualifications were all provided in detail.

Improvement Strategies

Interventions described for 2009 included:

- WellAware Articles educating members on oral health issues (Member Newsletter), which is ongoing; and
- BA+ Customer Service (ongoing) – MCHP or subcontractor assistance in finding a dental provider within the network, as well as assistance with making appointments is available.

Interventions described for 2010 included:

- Reminder letters to any member who has not seen a dentist for preventive services in the last six months;
- Dental Webpage – A new section was developed on the member website providing articles on the importance of good oral health and information on how to find a dentist.
- WellAware Articles;
- Cooperation in the Health Start Dental Home Initiative;
- New Member Packets including a flyer "Improving You Oral Health";
- Improvements in information available in the member handbook;
- An article reminding Providers to ask parents to get a check-up for all children;
- Outreach to members and their families when going to their annual well child visit; and
- Development and distribution of a provided toolkit.

This is an overwhelming list of interventions. Although the interventions undertaken acknowledge a comprehensive commitment to improving oral health, they dilute the ability to assess what is working and what is not. The MCHP was informed that it will be difficult to evaluate what is most effective. This comprehensive strategy may prove to be beneficial. Barriers are identified. The

MCHP does point out that these interventions are focused on efforts to overcome these barriers.

Data Analysis and Interpretation of Results

Data analysis, including the baseline rate, and the re-measurement rates, are included. A description of the barriers to success was provided. The findings for the baseline year and the follow-up year are provided. This was produced as discussed in the prospective data analysis plan. A detailed quantitative and qualitative analysis was provided in the narrative. The tables and charts included were informative and produced in a manner that provided clarification to the reviewer and were supported by the narrative.

The HEDIS Annual Dental Visit rate for the MCHP improved from 31.7% to 40.92%, which exceeds their stated 3% goal. The MCHP recognized that prior to the PIP, they did not have any strong interventions in place that promoted good oral health care. They assert that changing the interventions from two to eleven proved to be a favorable experience for BA+ members.

Assessment of Improvement Process

This study produced evidence of credible findings. The re-measurement period included in the presentation contained a detailed analysis of the impact of the interventions on member and provider behavior. A detailed ongoing barrier analysis was presented. A cogent evaluation of the data presented was provided. The discussion presented described the effectiveness of the interventions and how all available resources were utilized by members, creating an overall positive outcome.

This PIP provided quantitative improvement in the process of care. The MCHP directly related the improvements in the HEDIS rate to the interventions employed with members and providers. Statistical significance testing was employed to support the findings. The analysis included a commitment to

continue efforts to improve the rate of Annual Dental Visits and methods to achieve this goal. New interventions planned for this ongoing project will address the current barriers presented. Planned improvements were included.

Conclusion

BA+ provided convincing evidence that their comprehensive approach to making the needed improvements had merit. They clearly exceeded the 3% goal set for this statewide initiative. They plan to continue to implement new and creative interventions for improvement and to monitor these for their rate of success. This supports the MCHP's assertion that this year's improvement was real improvement.

The MCHP has a sound plan for continued improvement. They realize that with only one re-measurement period they cannot claim that their approach will have sustained improvement. However, their approach produces high confidence that this PIP will continue to be successful when future interventions are implemented.

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 engaging members, educating members, maintaining member participation, and engaging providers was evident throughout the documentation provided for both PIPs. Including an active member engagement process to assist pregnant teenagers into participating in their own pre and postnatal care proved to be an approach that enhanced the quality of life for the members served by the clinical PIP. Continued allocation of resources and process improvement were evident throughout the non-clinical PIP. In both projects the MCHP sought to improve the quality of services, which has resulted in improved member care.

ACCESS TO CARE

Both Performance Improvement Projects submitted by the MCHP had a focus that addressed improved access to health care services. The first PIP, regarding improved compliance with obtaining prenatal and postnatal care, exhibited a clear understanding that member engagement and retention is essential to ensuring that members take responsibility for their health outcomes. Efforts were made to ensure that members were aware of the necessity of regular dental care and how to obtain this care. These values were evident in the efforts made in the non-clinical project, as well. The attention to reminding members of available resources, such as transportation, enhanced member access and directly impacted a positive outcome. The MCHP made a concerted effort to improve access for members and availability of good healthcare in both projects.

TIMELINESS TO CARE

Both projects had a distinct focus on timely and adequate care. In the first PIP, regarding timely and appropriate prenatal and postnatal care for a typically at-risk population, positive health outcomes were noted for mothers and babies. In the second PIP, regarding improving the rate of annual dental visits, there was attention to timely notification and encouragement of the use of benefits to assure that the services needed by the member were delivered. 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. Both of these PIPs were well-written and complete. Continue developing projects with this level of commitment to improving member services and healthcare outcomes.

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 February 16, 2011. The EQRO reviewed documentation between February 16, 2011 and June 30, 2011. 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 2010 Compliance Audit Report
- Letters of communication between the EQRO and BA+
- BA+ policies pertaining to HEDIS 2010 rate calculation and reporting
- BA+ Information Services (IS) policies on disaster recovery
- BA+'s HEDIS implementation work plan and HEDIS committee agendas for 2010
- 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 Denominator.txt
- ADV Enrollment.txt
- AWC Denominator.txt
- AWC Enrollment.txt
- FUH Denominator.txt
- FUH Enrollment.txt

INTERVIEWS

The EQRO conducted on-site interviews with Tee-Ka Johnson – Special Programs Coordinator at BA+ in Kansas City, MO on Wednesday, July 6, 2011. A follow-up conference call was scheduled with Michelle Williams, HEDIS Coordinator, as she was unavailable during the on-site. Ms. Williams 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 2010 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 2010 Adolescent Well-Care Visits, Follow-Up After Hospitalization for Mental Illness, and Annual Dental Visits measures. MCHP to 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 2010 combined rate for Annual Dental Visits reported by BA+ was 31.69%, comparable to the statewide rate for MCHPs (39.03%, z = -0.66; 95% CI: 26.32%, 37.06%; n.s.). This reported rate is **lower** than the rates reported by this MCHP in the 2007, 2008, and 2009 EQR reports (33.72%, 32.54%, and 32.73% respectively; see Table 21 and Figure 29).

The reported rate for BA+ for the HEDIS 2010 Adolescent Well-Care Visits measure was 36.31%, which is **significantly lower** than the statewide rate for MCHPs (41.31%; z = -0.82, 95% CI: 32.65%, 39.97%; $p < .95$). However, the rate for this measure has continued to **increase** over time, from 31.54% in 2007 to 34.79% in 2008 to 35.32% in 2009 and 36.31% in 2010 (see Table 21 and Figure 29).

The 7-day reported rate for BA+ for the HEDIS 2009 Follow-Up After Hospitalization for Mental Illness measure was 50.35%, comparable to the statewide rate for all MCHPs (45.47%; z = 0.89, 95% CI: 42.75%, 57.94%; n.s.). This rate is a **decrease** from the rates reported in 2007
(58.67%) and 2009 (52.03%), but is a slight **increase** from the rate (50.17%) reported in 2006 (see Table 21 and Figure 29).

The HEDIS 2009 30-day rate for Follow-Up After Hospitalization for Mental Illness reported by BA+ was 73.96%, **significantly higher** than the statewide rate for

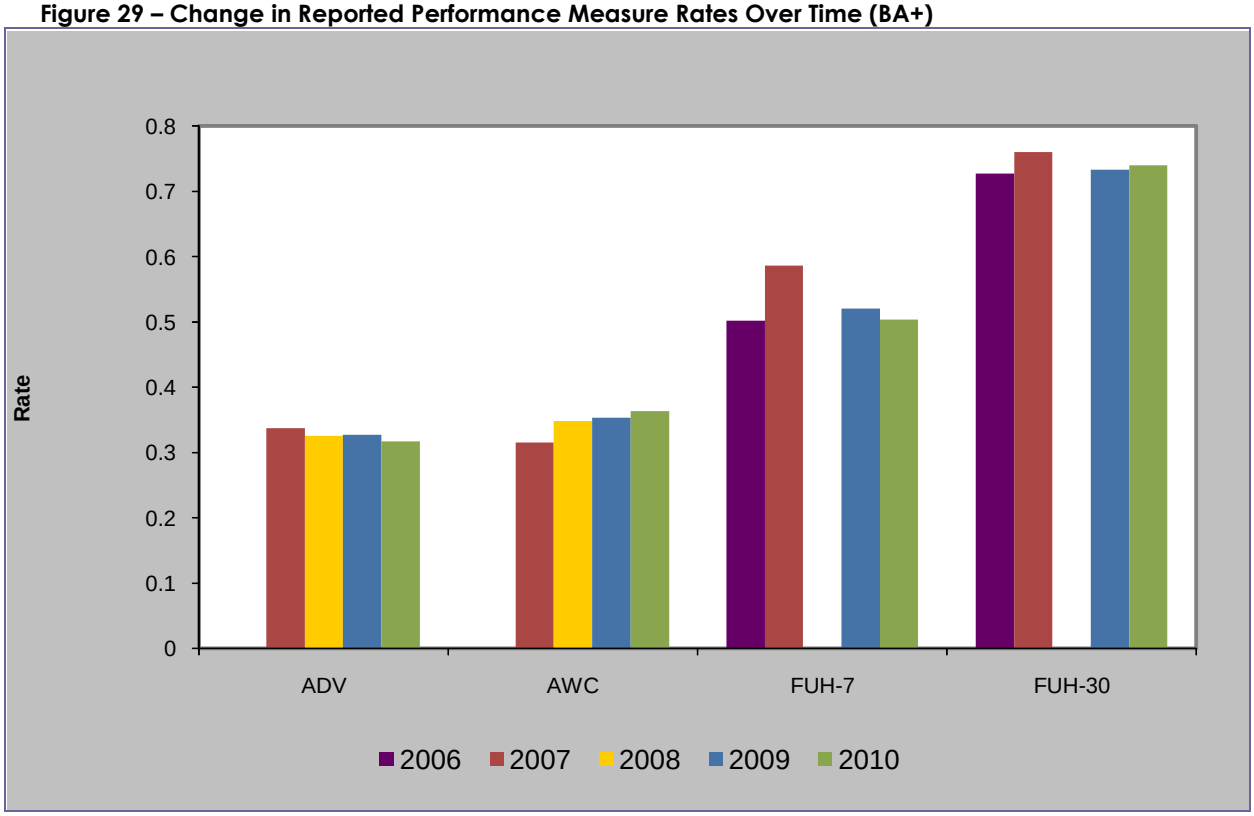
MCHPs (69.50%, z = 3.37; 95% CI: 66.36%, 81.55%; p > .95). This reported rate is a slight **increase** over the rates reported by this MCHP in the 2006 and 2009 EQR reports (72.76% and 73.31% respectively), but is still below the rate (76.00%) reported in the 2007 EQR findings (see Table 21 and Figure 29).

Table 21 – Reported Performance Measures Rates Across Audit Years (BA+)

Measure	HEDIS 2006 Rate	HEDIS 2007 Rate	HEDIS 2008 Rate	HEDIS 2009 Rate	HEDIS 2010 Rate
Annual Dental Visit (ADV)	NA	33.72%	32.54%	32.73%	31.69%
Adolescent Well-Care Visits (AWC)	NA	31.54%	34.79%	35.32%	36.31%
Follow-Up After Hospitalization for Mental Illness – 7-day (FUH7)	50.17%	58.67%	NA	52.03%	50.35%
Follow-Up After Hospitalization for Mental Illness – 30-day (FUH30)	72.76%	76.00%	NA	73.31%	73.96%

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

Figure 29 – Change in Reported Performance Measure Rates Over Time (BA+)



Sources: BHC, Inc. 2006-2010 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 main report for activities, ratings, and comments related to the Validating Performance Measures Protocol Attachments.

Data Integration and Control

BA+ used a NCQA-certified vendor application for calculation of rates for the HEDIS 2010 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. 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. BA+ met all criteria that applied for the three measures validated. BA+ did utilize statistical testing.

Processes Used to Produce Denominators

BA+ met all criteria for the processes employed to produce the denominators of the performance measures validated. 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 14,284 eligible members reported and validated for the denominator of the Annual Dental Visit measure.

A total of 4,811 eligible members were reported and validated for the Adolescent Well-Care Visits measure.

A total of 288 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 2010 Technical. No medical record reviews were conducted or validated.

BA+ reported a total of 4,527 administrative hits for the HEDIS 2010 Annual Dental Visit measure; 4,524 of these hits were validated by the EQRO. This resulted in a reported rate of 31.69% and a validated rate of 31.67%, an overestimate of 0.02%.

For the HEDIS 2010 Adolescent Well-Care Visits measure, there were a total of 1,747 administrative hits reported and 1,730 hits found. This resulted in a validated rate of 35.96%; with a reported rate of 36.31%, this is an overestimate of 0.35%.

The number of administrative hits reported for the 7-day rate for the HEDIS 2010 Follow-Up After Hospitalization for Mental Illness measure was 145; the EQRO found all 145. This resulted in reported and validated rates of 50.35%, yielding no bias for this measure.

The HEDIS 2010 Follow-Up After Hospitalization for Mental Illness measure 30-day rate showed 213 administrative hits; the EQRO found 209. This resulted in a reported rate of 73.96% and a validated rate of 72.57%. This represents a bias

(overestimate) of 1.39% 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 Data Submission Tool (DST) for all three measures validated. The DSTs were submitted 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 2010 measures evaluated. All three measures were slightly overestimated. However, the bias observed was minimal (less than or near 1% in each case). The rate validated for each measure fell within the 95% confidence interval reported by the MCHP for that measure.

Table 22 - Estimate of Bias in Reporting of BA+ HEDIS 2010 Measures

Measure	Estimate of Bias	Direction of Estimate
Annual Dental Visit	0.02%	Overestimate
Adolescent Well-Care Visits	0.35%	Overestimate
Follow-Up After Hospitalization for Mental Illness (7-day)	No Bias	N/A
Follow-Up After Hospitalization for Mental Illness (30-day)	1.39%	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 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 also overestimated. However, all fell within the confidence intervals reported by the MCHP.

Table 23 - 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 MCHP. 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 Managed Care Members qualified for the measure.

Conclusions

BA+'s Annual Dental performance measure reported rate was consistent with the average for all MCHPs. The Adolescent Well Care rate was **significantly lower** than the average, and the Follow-Up After Hospitalization rate was **higher** than the average.

Quality of Care

BA+'s calculation of the HEDIS 2010 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 comparable to or **significantly higher** than the average for all MCHPs. The MCHP's members are receiving the quality of care for this measure equal to or greater than the care delivered to all other 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 MCHP'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 remain **lower** than the rates reported by the MCHP during the audit of the HEDIS 2007 measurement year, although the 30-day rate did represent a slight **increase** over the HEDIS 2009 reported rate. This would indicate an apparent quality of services to members that has not yet returned to the level seen previously from this MCHP.

ACCESS TO CARE

The Annual Dental Visit measure was substantially complaint with specifications; this measure is categorized as an Access/Availability 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 MCHPs.

This rate has fluctuated slightly, but has **decreased** overall from the rates reported in each of the previous three HEDIS reporting years (2007, 2008, and 2009), indicating an apparent **decrease** in access to care for MCHPs members. BA+'s members are receiving the quality of care for this measure consistent with the level of care delivered to all other Managed Care members. This rate was however below the National Medicaid Average for this measure. This indicates

that the MCHP's members are receiving **lower** access to dental care than the average National Medicaid member.

TIMELINESS OF CARE

The MCHP's calculation of the HEDIS 2010 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 MCHP's reported rate for this measure was **significantly lower** than the average for all MCHPs.

This rate has continued to rise from the rates reported by the MCHP in each of the last three HEDIS reporting years (2007, 2008, and 2009), thereby showing that BA+ members are receiving more adolescent well-care visits than during previous reporting years. The MCHP's dedication to improving this rate is evident in the continually increasing averages.

The timeliness of care received by BA+ members for this measure is **lower** than the care delivered to all other Managed Care members. Despite the **increases** over prior reviews, this rate was **lower** than both the National Medicaid and National Commercial averages for this measure. Thereby, the timeliness of care received by this MCHP's members is **lower** than the average Medicaid or Commercial member across the nation.

RECOMMENDATIONS

1. BA+ should utilize hybrid methods where HEDIS specifications recommend using the hybrid approach.
2. Continue work to conduct and document statistical comparisons on rates from year to year.

3. The Follow-Up After Hospitalization for Mental Illness Rate showed a continued **decrease** over the previous audit years' (2007 and 2009) rates. The EQRO recommends that the MCHP monitor this **decrease** and attempt to determine the possible reasons for this decline.
4. The EQRO recommends that the MCHP 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** (FUH7, ADV) or only **increase** slightly (FUH30).
5. BA+ should review the strategies/initiatives in place currently that are effectively raising the AWC rate to determine if similar strategies could be implemented to reverse the decline being seen in the FUH and ADV rates.

6.3 MCHP Compliance with Managed Care Regulations

METHODS

Prior to the site visit, documentation was received and reviewed regarding the 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 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 MCHP. Interviews occurred with Case Management Staff, Grievance and Appeals 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 and Grievance and Appeals 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 and Grievance/Appeals staff were generated by the cases reviewed as well as the review of MCHP policy. Interviews queried staff in an effort to ensure that all pertinent elements

of the federal regulations were addressed in the MCHP 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 using 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
- 2010 Marketing Plan and Marketing Materials
- 2010 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
- Program Quality Initiative Information

FINDINGS

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.
- 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.

The staff was asked about utilizing the report from the SMA regarding members with special health care needs. The MCHP 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. Case Managers 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.

Regular reports from the emergency rooms and from hospitals are received by Staff. 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.

The rating for Enrollee Rights and Protections (100.0%), see Table 24reflects 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 MCHP provided evidence of their practice throughout the on-site review process. It appears that the MCHP is in compliance with all Managed Care contract regulations and federal requirements.

Table 24 – Subpart C: Enrollee Rights and Protections Yearly Comparison (Blue-Advantage Plus)

Federal Regulation	BA+		
	2008	2009	2010
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 MCHPs (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.

The Behavioral Health Organization 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 Managed Care members. However, these are mailed

to members any time they are requested.

Access Standards

Blue Advantage Plus continues to have an adequate provider network available. Provider Relations staff continues active recruitment efforts for specialty medical providers. The MCHP reported that they continue to improve their relationships with providers. They are always anxious to recruit new providers. The MCHP 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 MCHP does monitor to assure that PCPs have open panels.

The rating regarding Access Standards regulations is (76.5%), see Table 25. 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.

During the on-site review the commitment to good case management practice was observed by the staff involved. The MCHP exhibits a strong commitment to compliance with the Managed Care contract requirements and all federal regulations.

Table 25 – Subpart D: Quality Assessment and Performance Improvement: Access Standards Yearly Comparison (Blue-Advantage Plus)

Federal Regulation	BA+		
	2008	2009	2010
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	1	1
438.208(c)(2) Care Coordination: Assessment	2	1	1
438.208(c)(3) Care Coordination: Treatment Plans	2	1	1
438.208(c)(4) Care Coordination: Direct Access to Specialists	2	2	1
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	14	13
Number Partially Met	0	3	4
Number Not Met	0	0	0
Rate Met	100.0%	82.35%	76.5%

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 MCHPs (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 MCHP

meets with New Directions Behavioral Health, Doral Dental and MTM at regular Delegated Oversight Quality Meetings.

Blue Advantage Plus continued the use of Milliman Criteria, this approach 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 MCHP 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 MCHP to assure that re-credentialing is completed as required.

Ratings for compliance with Structure and Operation Standards regulations (100%), see Table 26, 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 MCHP has made every effort to be compliant with both the Managed Care contract requirements and federal regulations.

Table 26 – Subpart D: Quality Assessment and Performance Improvement: Structure and Operation Standards Yearly Comparison (Blue-Advantage Plus)

Federal Regulation	BA+		
	2008	2009	2010
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 MCHPs (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

Blue Advantage Plus continues its efforts to recognize and deal with the issue of Fraud and Abuse. The move of their Special Investigation Unit into Audit Services has helped to facilitate the process of identifying and rectifying fraud and abuse. When fraud and abuse is suspected, the MCHP does not renew provider contracts at their next renewal date. Other actions involve education of providers regarding problem areas identified. The special investigation unit continues to assist when a suspected problem of fraud or abuse arises.

The MCHP 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 MCHP 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 MCHP'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 MCHP 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. Performance Improvement Projects and Performance Measures were validated and in Compliance with all State and Federal requirements. 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%), see Table 27, for the sixth consecutive year, which reflects that all required policy and practice meets the requirements of the Managed Care contract and the federal regulations.

Table 27 – Subpart D: Quality Assessment and Performance Improvement: Measurement and Improvement Yearly Comparison (Blue-Advantage Plus)

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 MC+ Managed Care Program. This percent is calculated for the regulations that are applicable to the MC+ Managed Care Program. 0 = Not Met; 1= Partially Met; 2 = Met
Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient MCHPs (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

BA+'s grievance and appeal processes have changed from manual folders to uploading all information into the MCHP'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.

Review of Grievance and Appeals Files

The EQRO reviewed grievance and appeals files while on-site at Blue-Advantage Plus of Kansas City on Wednesday, July 6, 2011. The EQRO Project Director, Amy McCurry Schwartz, read 30 files and completed an analysis tool for each file reviewed. These files were reviewed for compliance with Federal Regulations and the MCHP's State Contract. The table below summarizes the findings of this file review.

Table 28 – Compliance File Review, BA+

MCHP	# of records reviewed	# with issue	% with issues	% Correct
BA+	30	7	23.33%	76.67%

The specific issues identified by the Project Director in BA+'s files included the following:

- Timeline for mailing of Notice of Action letter not upheld (1 file)
- The use of Explanation of Benefits letters in lieu of Notice of Action letters (the EOB did not contain the required language informing members of their right to continued benefits if they chose to appeal the MCHP's decision) (6 files)

Although not specifically attributable to this MCHP, it is noted that the mandatory language required by the State of Missouri in all Notice of Action letters is considered confusing by the EQRO. The language contained in the clause related to the member's right to "Continuation of Services" and the requirement to list all legal aid offices in the State of Missouri and not the one specific to the member's address both serve to make the letter confusing.

Due to the findings of the grievance and appeals files, the rating for compliance with Grievance System regulations (61.1%), was **significantly lower** than the prior two year's reviews. (See Table 29).

Table 29 – Subpart F: Grievance Systems Yearly Comparison (Blue-Advantage Plus)

Federal Regulation	BA+		
	2008	2009	2010
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	1
438.404(b) Notice of Action: Content	2	2	0
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	1
438.408(d)(e) Resolution and Notification: Grievance and Appeals - Format and Content of Notice	2	2	1
438.408(f) Resolution and Notification: Grievances and Appeals - Requirements for State Fair Hearings	2	2	1
438.410 Expedited Resolution of Appeals	2	2	2
438.414 Information about the Grievance System to Providers and Subcontractors	2	2	1
438.416 Recordkeeping and Reporting Requirements	2	2	2
438.420 Continuation of Benefits while Appeal/Fair Hearing Pends	2	2	1
438.424 Effectuation of Reversed Appeal Resolutions	2	2	2
Number Met	18	18	11
Number Partially Met	0	0	6
Number Not Met	0	0	1
Rate Met	100.0%	100.0%	61.1%

Note: 0 = Not Met; 1= Partially Met; 2 = Met
Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient MCHPs (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

BA+ continues to met 100% of the written policy and procedural requirements of compliance with both the Managed Care contract and the federal regulations. The MCHP struggled this review year with Quality Assessment and Performance Improvement: Access Standards as a result of the Case Management Record Review (see Section 4.0 of this report). The MCHP also struggled with Grievance System compliance as 23.33% of the files reviewed during the on-site review contained non-compliance issues.

It is evident to the reviewers that BA+ is focused on meeting member needs and that they sometimes go beyond the requirements of their contract in order to meet those needs. The MCHP believes that 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 BA+ as evident through Care Coordination (see Table 25) has declined over the past two years of review. The EQR was unable to validate the MCHP's stated commitment to continuing quality improvement. The health plan supplied case management files contained numerous deficiencies in the areas of Care Coordination. These deficiencies included: 1) missing assessments; 2) no evidence of completed treatment plans; and 3) a lack of identification of members who required case management. Although the MCHP utilizes advisory groups that include community members and physicians, the EQRO did not find evidence that the perspective derived from these groups was utilized in the case management process.

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 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 state that they are aware of the need to assist members in obtaining timely health care and make every effort to intervene if they can assist. No evidence was presented to the EQRO detailing the numbers of persons introduced to case management from these initiatives.

RECOMMENDATIONS

1. Continue development and use of products for predictive modeling and supporting empowerment of members to seek appropriate health interventions.
2. Continue efforts to improve behavioral health services and behavioral health case management practices, to ensure a coordinated approach to member care.
3. Ensure that case management records are inclusive of all pertinent information, particularly assessments and notes regarding follow-up and outcomes of care.
4. Track the number of members who enter case management through BA+ interventions/programs and the number who enter case management due to placement on a listing obtained from the SMA. This information would go a long way to show the success of the many quality initiatives that BA+ supports.
5. The EQRO recommends that the SMA examine the "Mandatory Language" required in each MCHP's member handbook for compliance with all Federal Regulations.
6. The EQRO recommends that the SMA examine the "Mandatory Language" contained in each Notice of Action letter (specifically the "Continuation of Benefits" clause and Legal Aid office listings) and make

changes as to ensure less confusion.

7.0 Children's Mercy Family Health Partners

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7.1 Performance Improvement Projects

METHODS

DOCUMENT REVIEW

Children's Mercy Family Health Partners supplied the following documentation for review:

- Improving Childhood Immunization Rates
- Statewide Performance Improvement Project – Improving Oral Health

The MCHP supplied data at the time of the on-site review, this data contained additional information and data analysis that was not included in their first submission. 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 7, 2011, during the on-site review, and included the following:

- Ma'ata Touslee – Chief Clinical Officer
- Jenny Hainey – Manager, Quality Management
- Susan Wood – Health Improvement Project 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 at the request of the MCHP.

FINDINGS

Clinical PIP – Improving Childhood Immunization Rates

Study Topic

The first PIP evaluated was "Improving Childhood Immunization Rates." The study topic was in the initial stages of development. New information obtained at the time of the on-site review provided updated and enhanced information regarding this PIP. The documentation provided a strong argument for choosing Improving Childhood Immunization Rates as a topic. The topic justification includes comparisons of national, state, and local data. The importance of the goal of improving immunization rates as a gateway to improved preventive care is clearly presented and explained. The MCHP explained that more information is needed to understand all the factors that influence the decisions of parents regarding immunizing their children. They did provide their HEDIS rates for 2008 – 2011, which ranged from 68.6% in 2008 to a low of 60.1% in 2011. The rates for the first three years exceeded the Missouri State average, but in 2011 only ranked in the 25th percentile nationally (according to NCQA data). The statistics and information presented regarding changes looked at the HEDIS measure: Childhood Immunization Status for Combo 2. The MCHP's stated goal is to improve this rate to 90%.

The topic choice and rationale were well supported by the review of local issues and comparisons to state and national trends. The MCHP does include proposals for interventions that they hope will positively impact these statistics. The hypothesis presented focuses on targeting non-adherent members for specific educational outreach.

Study Question

The study is designed to answer two questions.

1. "Will increasing educational outreach by means of mailings, automated calling, and topic specific articles in newsletters to parents/guardians of members identified as non-adherent to the recommended immunization schedule increase access to preventative care services as demonstrated by an increase in the immunization rates for the intervention population by three

percent?"

2. "Will increasing education outreach by means of mailings, automated calls, and topic specific articles in newsletters to parents/guardians of all targeted eligible members result in an increase in access to preventative care services as demonstrated by an increase in the HEDIS CIS Combo 2 sub-measure rate to 63%, which is the 25th percentile (without NCQA rate adjustment) for this specific sub-measure?"

Although these questions are complex they do focus on the adherent and non-adherent populations, with the goal for both of increasing the number of children obtaining immunizations and more comprehensive preventive healthcare.

Study Indicators

The study has objective, clearly defined and measurable indicators. The indicators are:

- Intervention Population Indicator; and
- The HEDIS Indicator.

These indicators are designed to present information that will determine if the additional immunization educational outreach (mailings, IVRS, and newsletters) to the targeted eligible population is effective. These indicators look at a change in health status and are focused on the issue of improving preventive care. Numerators and denominators for each measure are presented and clearly defined.

Study Population

The members involved in this study were from thirteen (13) Missouri counties in the Managed Care Western region. The Intervention Study Population includes all children 2 years of age, as of the last day of the measurement period (12/31 of the measurement year). They are not required to be continuously eligible.

The HEDIS Measure study population includes all children age 2 on the last day of the measurement period, who were continuously enrolled, without a gap of up to 45 days during the 12 months prior to the child's second birthday. These are clear and understandable. The measures include all pertinent children, and do not exclude any part of the appropriate population.

Study Design and Data Collection Procedures

The study design is presented. It includes the data to be used, eligibility files and administrative claims, from the preceding calendar year. This data will be collected from the CMFHP MC400 claims system. The study data will indicate members who did not receive or are due to receive recommended immunizations, which in turn presents the targeted population for each study

question. The study design does identify the type of data to be used and its sources. The data fields and what they provide was described. Quarterly additions to the base files will occur. The CMFHP iBenefits claims system will be queried to identify members that meet the intervention population denominator criteria. The criteria that will apply to the numerator are

described and the data to be extracted pertaining to this population was explained. The claims data system is to be queried quarterly to measure activities throughout the year.

HEDIS data for 2011, Childhood Immunization Rates for sub-measure Combo 2 will be the baseline for Indicator #2. HEDIS 2011 will be utilized to assess a mid-year baseline. HEDIS 2012 will provide for the first year's remeasurement period.

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. The instrument to be included, in addition to the MCHP's claims system, are the development of a spread sheet from the eligibility files. A prospective data analysis plan was presented in detail. The approach exhibited in the study design provides evidence of the MCHP's commitment to improve access to preventive care for its members. The information submitted did include the project manager, other study staff, their roles, and their qualifications.

Improvement Strategies

Proposed interventions, focused on members, were described in sufficient detail. However, a fourth intervention stated "Communication directed toward providers is being considered." Although this may be developed later, and may be a useful intervention, at this point this statement leads to a number of questions about the commitment to this intervention and its measurability. Ongoing improvement activities that may have a positive effect of the CIS HEDIS measure are delineated. This is helpful in the sense that it does provide verification that the MCHP does not consider this a one dimensional problem.

Data Analysis and Interpretation of Results

Assessment of Improvement Process

Data analysis and the effects of these interventions are not yet available.

Conclusion

This project does have promise and is constructed in a complete and measureable manner.

Non-Clinical PIP – Improving Oral Health

Study Topic

The second PIP evaluated was the CMFHP individualized approach to the Statewide PIP "Improving Oral Health." 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 study topic information presented includes information specific to the project that CMFHP began in 2008, prior to this becoming a statewide PIP. The MCHP incorporated information that was included in the statewide documentation. The rationale included specific information about the impact that good oral health has on general health. The connection between good and regular dental care and a member's overall physical health was explained. The MCHP provided the potential barriers to members obtaining the necessary dental care. Access to dental care is a primary ongoing challenge in the state and on a national level.

Study Question

The study question is "Will providing educational information about dental care and dental service through mailings, IVRS, and newsletters to CMFHP members from the ages of 2 – 20 increase the number of children accessing dental services and who receive an annual dental visit by 3% measured by HEDIS 2011 ADV rates (data from calendar year 2010) compared to HEDIS 2010 ADV rate (data from calendar year 2009)?"

The MCHP included a complex but thorough study question. It includes the study

population, the goals of the project, and the outcome measures. This is an adequate study question.

Study Indicators

The study indicators are presented in a clear concise manner based on the HEDIS technical specifications. This is an administrative measure, the criteria for the HEDIS measure will be applied, including the continuous eligibility requirement.

The numerator and denominator are included, with a stated goal of a 3% of improvement in the first re-measurement year. The narrative supports the belief that improvement in the

measurement will reflect improvement in the process of care – the receipt of an annual dental examination.

Study Population

The study population definition explains that it will consist of all eligible members from the ages of 2 – 20 in the measurement year, these are the defined at-risk members based on the study topic. Pregnant members were also specifically mentioned as included, it is unclear where they fit into this plan. In the description of the HEDIS technical specifications the only population mentioned is 2 – 20 year olds.

Study Design and Data Collection Procedures

The study design delineated the data to be collected, including all of the HEDIS data from 2010 and 2011. The sources and methods of calculation are provided in detail. The MCHP will use all claims encounter data available. In addition, they will extract and load membership, practitioner, and vendor data into the CRMS warehouse (MCHP data warehouse). Once this data is loaded it will be formatted and exported to all necessary files for evaluation. The Annual Dental Visit measure utilizes data from the dental subcontractor, Bridgeport Dental. Data is downloaded using an automated process which loads these figures into a data warehouse where they can be processed and measured. The study design was complete and addressed all necessary elements of data assessment.

The study design did include a prospective data analysis plan. The 2010 HEDIS data will be the baseline measurement year. The 2011 data and beyond will provide the remeasurement data. Claims and eligibility data for the study population will be queried quarterly by the CMFHP information technology department. The data will be utilized to evaluate the effectiveness of the outreach interventions. Changes will occur based on the analysis of year-end documentation.

CMFHP includes experienced and qualified staff in the data collection and analysis process for this project. Their names and qualifications were listed in an appendix to the documentation.

Improvement Strategies

The MCHP utilized a number interventions during 2010. These included:

- Adding dental information to the website, including dental pod cast
- Adding dental information on social network site, Facebook
- Including dental information in the member, provider and teen newsletters
- Collaborating to get dental posters and educational materials in provider offices, Women Infant and Children (WIC) offices, YMCA sites, and Head Start Schools
- Collaborating with Customer Relations to teach proper dental hygiene in the community
- Collaborating with Bridgeport (Dental vendor) to share materials and information with dental providers via e-mail
- Collaborating with Head Start by participating in the Oral Health Roundtable meetings

The MCHP partnered with their subcontractor, Bridgeport, to implement interventions at provider offices. These mirror the above with a provider focus. Interventions were implemented throughout the study period, beginning in the first quarter of 2010.

Use of multiple interventions does eliminate the ability to assess the success or failure of any specific effort. The MCHP believes that this approach will reach all parts of the population and has a greater chance of creating success.

Data Analysis and Interpretation of Results

There was a complete analysis of the data, containing a comparison between the baseline and remeasurement year. Statistical significance testing was applied, and the improvement did indicate a positive increase using the chi-squared method. All tables and graphs were clear and understandable. The 2011 HEDIS rate of 47.73% exceeded the goal of 46.66%. This is a definite improvement over the 2010 rate of 45.30%. In completing the analysis the MCHP was able to determine that member access to dental services did increase over the stated goal. The MCHP included information on next steps to continue monitoring the HEDIS measure through interim rates, and to continue member education efforts through established interventions.

Assessment of Improvement Process

The MCHP believes that the interventions implemented to date have demonstrated a significant improvement in member access to dental care and member willingness to utilize this resource. The MCHP will continue reminding members to utilize available care through communications in their newsletter, on their website, and other improvement activities. Targeted work with the dental subcontractor, Bridgeport Dental, will also continue. The MCHP did include information stating that future activities that are more provider focused will be their next step in sustaining the achieved improvement.

Conclusion

CMFHP individualized their approach and analysis to comply with the direction of the Statewide Performance Improvement Project. It did so in a manner that highlighted their approach to impacting the problem of under-utilization of this healthcare resource. As a result of the positive impact these interventions have had on this issues, the MCHP will continue to intervene with the newsletters and website information. It appears that this is a viable project with a high degree of confidence in the approach.

CONCLUSIONS

QUALITY OF CARE

Quality services are provided in the most appropriate environment, and in a preventive manner, whenever possible. The two projects reported here embodied these values and sought to enhance the services available to Managed Care members. Quality health care is evident in the types of interventions used in these projects. The strong reliance on member education, utilization of community resources to inform members about the services

available to them, particularly with a focus on preventive care, is evidence of the MCHP's commitment to delivering quality services to members. The MCHP used multiple improvement strategies in the Improving Oral Health PIP and achieved the results sought. Their HEDIS rate improved over the stated goal, which supports the use of these strategies in creating an enhanced quality of care for members.

ACCESS TO CARE

The focus of both Performance Improvement Projects developed by the MCHP indicated a strong commitment to improving access to and knowledge about the preventive health care services available to members. In the first PIP, the MCHP provided information and training about the importance of accessing childhood immunizations. Although this is a very new PIP, it is focused on an essential target in adequate childhood health services. In the second project the MCHP provided member education regarding the availability of dental care. Both projects enhanced members' knowledge about the availability of services and enhanced their access to these services. The success the MCHP had in this non-clinical project is evident. The education about accessing this important aspect of care, regular dental health, was effective in changing member behavior.

TIMELINESS OF CARE

The PIP regarding Annual Dental visits concentrated on timely preventive care for children. The educational approach taken by this PIP empowers families to make sound decisions that leads to continued efforts to obtain timely preventive healthcare services on an ongoing basis. The PIP that focused on improving childhood immunizations will directly impact members' knowledge about the availability of timely healthcare. Although this PIP is in an early stage of implementation, it seeks to implant innovative methods of achieving its goal. The results witnessed in the Improving Oral Health PIP indicate that the educational

and information sharing approach, as well as collaborating with other community-based agencies, can have a profound impact on member behavior.

RECOMMENDATIONS

1. Continue the work the MCHP 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.

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 February 16, 2011. The EQRO reviewed documentation between February 16, 2011 and June 30, 2011. 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 2010 rate calculation
- The NCQA RoadMap submitted by Children's Mercy Family Health Partners for the HEDIS 2010 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 2010
- Children's Mercy Family Health Partners' HEDIS 2010 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:

- 2010_EQRO_ADV_Enrollment.txt
- 2010_EQRO_ADV_NUM_DENOM.txt
- 2010_EQRO_AWC_Enrollment_Hybrid.txt
- 2010_EQRO_AWC_MR.txt

- 2010_EQRO_AWC_NUM_DENOM.txt
- 2010_EQRO_FUH_Enrollment.txt
- 2010_EQRO_FUH_NUM_DENOM.txt

INTERVIEWS

The EQRO conducted on-site interviews Tish Fisher-Krings, IT Analyst; 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 6,2011. 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 2010 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. 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 2010 combined rate for Annual Dental Visits reported by CMFHP was 45.30%, which is **significantly higher** than the statewide rate for MCHPs (39.03%, $z = 1.36$; 95% CI: 39.93%, 50.67%; $p > .95$). This reported rate is **higher** than the rates reported in 2007 (37.49%), 2008 (38.59%) and 2009 (38.99%; see Table 30 and Figure 30).

The rate for the HEDIS 2010 Adolescent Well-Care Visit reported to the SMA and the State Public Health Agency (SPHA) by CMFHP was 45.50%. This was **significantly higher** than the statewide rate for MCHPs (41.31%; z = 1.19, 95% CI: 41.84%, 49.16%; p > .95). This rate is substantially **higher** than the rates reported in the each of the previous three EQR reviews: 42.82% in 2007, 41.61% in 2008, and 39.42% in 2009 (see Table 30 and Figure 30).

The 7-day reported rate for CMFHP for the 2010 HEDIS Follow-Up After Hospitalization for Mental Illness measure was 51.82 %. This rate was **significantly higher** than the statewide rate for MCHPs (45.47%; z = 1.04, 95% CI: 44.23%, 59.42%; p > .95). This rate has **increased** across HEDIS EQR review years over the rates of 45.15% reported in 2006, 48.50% reported in 2007, and 40.20% reported in 2009 (see Table 30 and Figure 30).

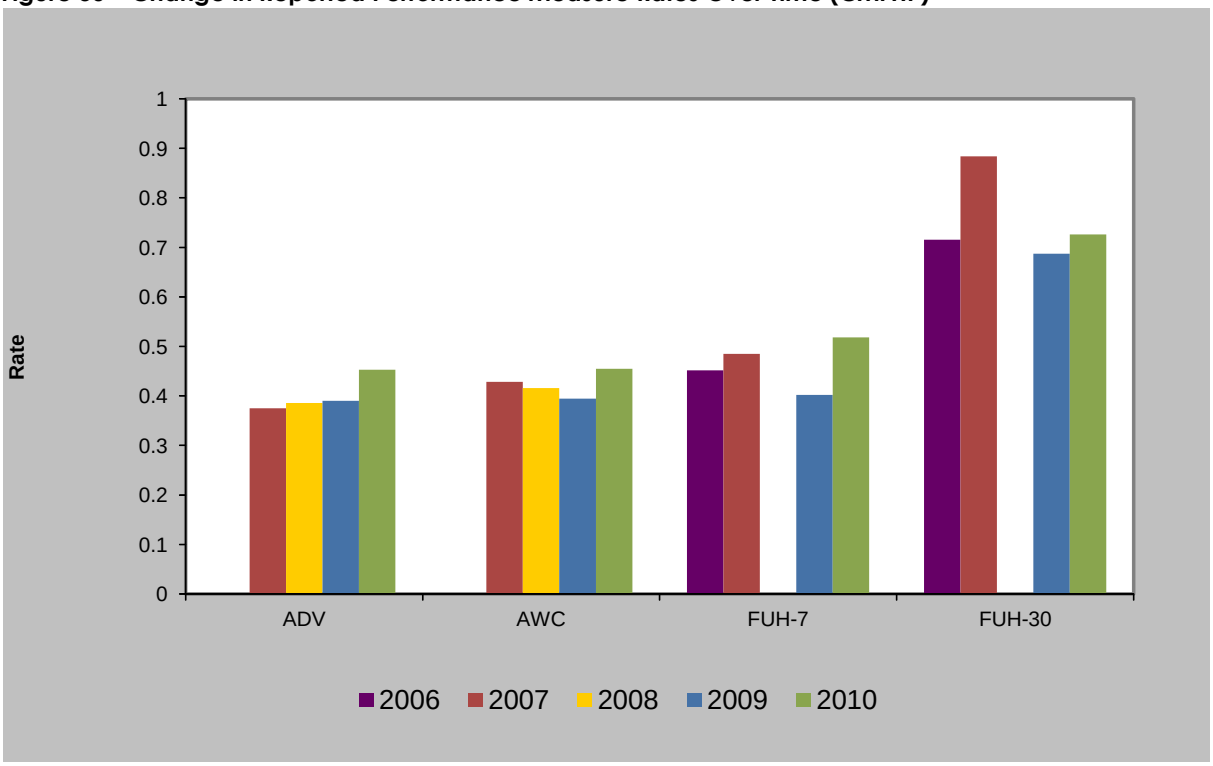
The 2010 HEDIS Follow-Up After Hospitalization for Mental Illness measure, 30-day rate reported for CMFHP was 72.63%. This rate was comparable to the statewide rate for MCHPs (69.50%; z = 3.23, 95% CI: 65.03%, 80.22%; n.s). This rate was **higher** than the rates reported in both the 2006 and 2009 EQR audits (71.52% and 68.70%, respectively) but is **lower** than the level seen in the 2007 EQR audit (88.40%; see Table 30 and Figure 30).

Table 30 – Reported Performance Measures Rates Across Audit Years (CMFHP)

Measure	HEDIS 2006 Rate	HEDIS 2007 Rate	HEDIS 2008 Rate	HEDIS 2009 Rate	HEDIS 2010 Rate
Annual Dental Visit (ADV)	NA	37.49%	38.59%	38.99%	45.30%
Adolescent Well-Care Visits (AWC)	NA	42.82%	41.61%	39.42%	45.50%
Follow-Up After Hospitalization for Mental Illness – 7-day (FUH7)	45.15%	48.50%	NA	40.20%	51.82%
Follow-Up After Hospitalization for Mental Illness – 30-day (FUH30)	71.52%	88.40%	NA	68.70%	72.63%

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

Figure 30 – Change in Reported Performance Measure Rates Over Time (CMFHP)



Sources: BHC, Inc. 2006-2010 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 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. There were no biases or errors found in the manner in which they transferred data into the repository used for calculating the HEDIS 2010 measures.

Documentation of Data and Processes

Data and processes used for the calculation of measures were adequate. 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. This involved the selection of eligible members for the services being measured. The Annual Dental Visit denominator included 29,033 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 548 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 2010 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 2010 criteria.

Review of the administrative hits for the combined rate of the Annual Dental Visit measure validated 13,130 of the 13,151 hits found by the MCHP. The rate reported by the MCHP was 45.30%; the rate validated by the EQRO was 45.22%. The total estimated bias for the Annual Dental Visit measure was a 0.07% overestimate of the rate by the MCHP.

CMFHP used the Hybrid Method to calculate HEDIS 2010 Adolescent Well-Care Visits measure. All 15 of the medical records requested were received, and all 15 were able to be validated by the EQRO. As a result, the medical record review validated 15 of the 15 hybrid hits reported. The MCHP reported 172 administrative hits; of these, the EQRO was able to validate all 172. Based on the number of hits validated by the EQRO, the rate calculated was 45.50%, as was the reported rate. There was no observed bias in the rate reported by the MCHP.

For the HEDIS 2010 Follow-Up After Hospitalization for Mental Illness measure, the MCHP reported 284 administrative hits for the 7-day follow up rate. The EQRO found 279 hits. The rate reported by the MCHP was 51.82% and the rate calculated by the EQRO was 50.91%, with a bias of 0.91%: an overestimate by the MCHP in the reporting of the measure.

CMFHP reported 398 hits for the Follow-Up After Hospitalization for Mental Illness measure 30-day rate. The EQRO was able to validate 394 hits. This resulted in a reported rate of 72.63% and a validated rate of 71.90%. This shows a bias of 0.73% overestimate by the MCHP.

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 Data Submission Tool (DST) for each of the three measures validated. These DSTs were submitted 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 31 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 31 - Estimate of Bias in Reporting of CMFHP HEDIS 2010 Measures

Measure	Estimate of Bias	Direction of Estimate
Annual Dental Visit	0.07%	Overestimate
Adolescent Well-Care Visits	No Bias	N/A
Follow-Up After Hospitalization for Mental Illness (7-day)	0.91%	Overestimate
Follow-Up After Hospitalization for Mental Illness (30-day)	0.73%	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 32 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 32 - 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 MCHP. 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 Managed Care Members qualified for the measure.

Conclusions

Three rates were validated for the MCHP. CMFHP's Adolescent Well Care rate was consistent with the average for all MCHPs. The other two rates (Follow-Up After Hospitalization for Mental Illness and Annual Dental Visit) were **significantly higher** than the average for all MCHPs.

Quality of Care

Children's Mercy Family Health Partner's calculation of the HEDIS 2010 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 MCHP's reported rates were consistent with or **higher** than the overall MCHPs calculated rates. Therefore, CMFHPs' members are receiving a quality of care for this measure equal to or better than the care delivered to the average MO Health Net Managed Care member in the 7-day and 30-day timeframes.

The reported 7-day and 30-day rates were both **higher** than the National Medicaid Rates but **lower** than the National Commercial Rates. Therefore, CMFHP is delivering a slightly **higher** level of quality than that received by the

average Medicaid member, but slightly **lower** than that received by the average Commercial member across the nation.

Both the 7-day and 30-day rates reported in the HEDIS 2010 measurement year were **higher** than the last time this measure was validated (HEDIS 2009) which shows an **increase** in the quality of services provided to members over the past year.

ACCESS TO CARE

The calculated rate by CMFHP for the HEDIS 2010 Annual Dental Visit rate was substantially complaint with specifications; this measure is categorized as an Access/Availability 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 MCHP's reported rate for this measure was **significantly higher** than the average for all MCHPs; the rate has continued to rise over the rates reported by the MCHP in 2007, 2008, and 2009. CMFHP members are receiving a quality of care that is **higher** than the level of care delivered to the average Managed Care member.

The rate reported was only slightly **lower** than the National Medicaid Average rate for this measure, showing that CMFHP members have closer to the same level of access to dental care as the average Medicaid member across the nation.

TIMELINESS OF CARE

The MCHP's calculation of the HEDIS 2010 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 MCHP's reported rate for this measure was **significantly higher** than the

overall MCHPs calculated rate. This rate also showed a substantial **increase** over the rates reported in each of the last three HEDIS audit years, indicating a positive improvement in the timeliness of care for this measure for members. CMHP members are receiving a timeliness of care greaert than the care delivered to all other Managed Care members.

This rate was **higher** than the National Commercial Rate but **lower** than the National Medicaid Rate, indicating that the timeliness of care received by CMFHPs' members for this measure is **higher** than the average Commercial member, but **lower** than the average Medicaid member across the nation.

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 MCHP experienced a substantial **increase** in the Adolescent Well-Care Visit rate over those rates reported in the last three years. CMFHP should continue to support the strategies that have been implemented to improve this rate, as the positive results are evident.
4. The Follow-Up After Hospitalization for Mental Illness Rate showed an **increase** over the previously audited rate in 2009 for both the 7-day and 30-day rates. However, the 30-day rate has not yet risen to the levels seen previously in 2007. The EQRO recommends that the MCHP continue to monitor these trends and attempt to identify any further steps that can be taken to **increase** the 30-day rate.

7.3 MCHP Compliance with Managed Care Regulations

METHODS

Prior to the site visit, documentation was received and reviewed regarding the Managed Care 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 MCHP's documentation is developed 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 MCHP. Interviews occurred with Case Management Staff, Grievance and Appeals 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 and Grievance and Appeals 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 and Grievance/Appeals staff were generated by the cases reviewed as well as the review of MCHP policy. Interviews queried staff in an effort to ensure that all pertinent elements of the federal regulations were addressed in the MCHP 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 2010

The following documents were requested for on-site review:

- Member Handbook
- Provider Handbook
- 2010 Marketing Materials
- Case Manager Program Policy
- Grievance and Appeals Policies
- Quality Management Committee Minutes -- 2010

Additional documentation made available by Children's Mercy Family Health Partners included:

- 2010 Marketing Plan
- Children's Mercy Family Health Partners' Organizational Chart
- Connection – Member Newsletter

FINDINGS

The case managers explained that they obtain new referrals from a variety of sources, including the utilization of 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, obtaining correct contact information, and all services that are currently being utilized by the family. The case managers report that they 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 MCHP contracts directly with the Jackson County Health Department for case management services for members with identified elevated lead levels, members in all other geographical areas of the MCHPs service area are case managed by CMFHP's staff . The CMFHP's lead 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 MCHP 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 MCHP and the behavioral health provider coordinate their services, share their database information and communicate

regularly.

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 MCHP 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 MCHP. In some cases this does lead to successfully engaging members in the case management process.
The case managers report that they average about 40-50 open cases. They also report that their cases are audited regularly by their supervisor.

Enrollee Rights and Protections

The staff at Children's Mercy Family Health Partners (CMFHP) continues to exhibit a strong commitment to ensuring that member rights are protected, and to solving member's health care problems. The MCHP 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 MCHP provides alternatives to members who may have reading, vision, or hearing problems that enabled them to obtain required information about the MCHP 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 MCHP conducts a "post call survey" for members and a random customer call-back program. The MCHP continues to document member needs, to conduct quality reviews and to seek measures to improve service.

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 do receive an assessment when located.

The MCHP 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 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.

Children's Mercy Family Health Partners 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.

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 MCHP is fully compliant in this area.

Table 33 – Subpart C: Enrollee Rights and Protections Yearly Comparison (CMFHP)

Federal Regulation	CMFHP		
	2008	2009	2010
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 MCHPs (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 Behavioral Heatlh Organization (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

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.

Access Standards

CMFHP continued to have a strong provider network throughout the Managed Care Region. The MCHP has worked one-on-one with providers, including specialists who agreed to become panel members. The MCHP 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 MCHP 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 MCHP continues to use member satisfaction 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.

They assist member in obtaining copies of their medical records.

The rating regarding Compliance with Access Standards regulations is (76.5%), see Table 34. Children's Mercy Family Health Partners 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 was not available. These findings are detailed more specifically in the Special Project, Section 4 of this report. During the on-site review the commitment to good case management practice was evident during case management interviews. The MCHP exhibits a strong commitment to compliance with the Managed Care contract requirements and all federal regulations.

Table 34 – Subpart D: Quality Assessment and Performance Improvement: Access Standards Yearly Comparison (CMFHP)

Federal Regulation	CMFHP		
	2008	2008	2010
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	1
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	13
Number Partially Met	0	0	4
Number Not Met	0	0	0
Rate Met	100.0%	100.0%	76.5%

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 MCHPs (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 MCHP'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 MCHP 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 MCHP 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 MCHP oversight committee, and were approved by the SMA.

The ratings for compliance with Structure and Operation Standards (100%) reflected complete policy and procedural requirements for the fifth year. The MCHP appears to be compliant with all policy and practice in this area that meets SMA contract compliance and federal regulations.

Table 35 – Subpart D: Quality Assessment and Performance Improvement: Structure and Operation Standards Yearly Comparison (CMFHP)

Federal Regulation	CMFHP		
	2008	2009	2010
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 MCHPs

(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. All clinical guidelines used are reviewed through the Clinical Criteria Committee prior to implementation. The MCHP 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 MCHP.

CMFHP did submit two Performance Improvement Projects (PIPs) for validation. It was noted that the MCHP utilized projects that had been started, and perfected these projects in an effort to improve services to members during the measurement year. These PIPs were well-constructed and provided adequate information for validation.

The MCHP 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.

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 Managed Care contract and the federal regulations for the fifth consecutive year.

Table 36 – Subpart D: Quality Assessment and Performance Improvement: Measurement and Improvement Yearly Comparison (CMFHP)

Federal Regulation	CMFHP		
	2008	2009	2010
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 MCHP 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 MC+ Managed Care Program. This percent is calculated for the regulations that are applicable to the MC+ Managed Care Program.
0 = Not Met; 1= Partially Met; 2 = Met
Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient MCHPs (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 (94.4%) indicate that the MCHP completed most of the requirements regarding policy and practice. This is the first in six years that the MCHP is not fully compliant in this section of the review.

The EQRO reviewed grievance and appeals files while on-site at Children's Family Health Partners, in Kansas City, MO on Wednesday, July 6, 2011. The EQRO Project Director, Amy McCurry Schwartz, read 42 files and completed an analysis tool for each file reviewed. These files were reviewed for compliance with Federal Regulations and the MCHP's State Contract. The table below summarizes the findings of this file review.

Table 37 – Compliance File Review, CMFHP

MCHP	# of records reviewed	# with issue	% with issues	% Correct
CMFHP	42	0	0.00%	100.0%

Although not specifically attributable to this MCHP, it is noted that the mandatory language required by the State of Missouri in all Notice of Action letters is considered confusing by the EQRO. The language contained in the clause related to the member's right to "Continuation of Services" and the requirement to list all legal aid offices in the State of Missouri and not the one specific to the member's address both serve to make the letter confusing.

Case Management and Administrative 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 member services staff tries to assist them so the member is aware of 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, i.e. a provider complaint, the staff advises them

of the importance of filing a grievance.

Table 38 – Subpart F: Grievance Systems Yearly Comparison (CMFHP)

Federal Regulation	MCP		
	2008	2009	2010
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	1
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	17
Number Partially Met	0	0	1
Number Not Met	10	0	0
Rate Met	100%	100%	94.4%

Note: 0 = Not Met; 1= Partially Met; 2 = Met
Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient MCHPs (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

Children's Mercy Family Health Partners continues their strong commitment to meeting all policy, procedure, and practice areas of compliance with both the Managed Care contract requirements and the federal regulations. The MCHP 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.

Interviews with CMFHP staff reinforce their commitment to excellence in serving Managed Care members. They demonstrated respect and dignity toward members, while meeting their healthcare service needs efficiently and effectively. However, much of the documentation received in the area of Case Management record reviews did not entirely support this commitment. CMFHP must ensure that the EQRO's auditors receive all requested information in order to report completely on what is occurring at the MCHP on a daily basis.

QUALITY OF CARE

CMFHP continues to receive high ratings in the areas of Quality Assessment and Improvement. However, the EQRO was unable to validate many of the areas involving Care Coordination as the Case Management files received from the MCHP did not reflect Care Coordination. Although the EQRO was impressed with the commitment to quality conveyed during the on-site interviews, this was not substantiated by the medical record review.

ACCESS TO CARE

Children's Mercy Family Health Partners demonstrates its commitment to ensuring access to care for members throughout their organization. The member services staff report:

- 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.
- They assist member in obtaining copies of their medical records.

The MCHP 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 MCHP has ensured that the treatment of members and providers during the grievance and appeal process is of primary importance. During the file review of grievance and appeals, CMFHP was the only MCHP that did not have any findings regarding "timeliness" issues. CMFHP continues to utilize member satisfaction surveys to guide their approach to delivering timely services and the MCHP is quick to set a corrective action if necessary to correct these issues.

RECOMMENDATIONS

1. Make every effort to supply the EQRO with all relevant information for every case file, grievance file, policy or procedure requested. The lack of information, that was verbally communicated to the reviewers explains many of CMFHP's **lower** rates for this year's review.
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 MCHP resources,

particularly for high-risk populations.

4. Case Management and Care Coordination were issues for this year's review, evidence of treatment planning and assessments were not present in all requested case files, make every effort to assure these are occurring and supply complete files for review.
5. Work with NDBH to improve communication with PCPs.
6. The EQRO recommends that the SMA examine the "Mandatory Language" required in each MCHP's member handbook for compliance with all Federal Regulations.
7. The EQRO recommends that the SMA examine the "Mandatory Language" contained in each Notice of Action letter (specifically the "Continuation of Benefits" clause and Legal Aid office listings) and make changes as to ensure less confusion.

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8.0 Harmony Health Plan of Missouri

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8.1 Performance Improvement Projects

METHODS

DOCUMENT REVIEW

Harmony Health Plan supplied the following documentation for review:

- Improving Asthma Management
- Statewide Performance Improvement Project – Improving Oral Health

INTERVIEWS

Interviews were conducted with the project leaders for each Performance Improvement Project (PIP) by the EQRO team on June 30, 2011, during the on-site review, and included the following:

- Dr. Olusegun Ishmael – Medical Director
- Ramona Kaplenk – Manager, Quality Improvement
- Esther Morales – Vice President, Quality and Field Operations

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 at the request of the MCHP.

The PIPs submitted for validation included some information. At the time of the on-site review the MCHP was provided information about the need to structure the Performance Improvement Projects in the format suggested in the federal protocols. The MCHP was informed that for the evaluation process to provide a fair interpretation of the work done, they need to provide both the study design and the outcomes in a format that presented their rationale and data in a study format. The MCHP was instructed that they could submit additional information that included enhanced outcomes of the intervention and supporting data.

Additional clarifying written information was received after the on-site review.

FINDINGS

Clinical PIP – Improving Asthma Management

Study Topic

The first PIP evaluated was titled "Improving Asthma Management." This study was considered clinical and focused on improving the screening and treatment compliance with the Clinical Practice Guidelines for Management of Asthma. The stated goal is to foster wellness, prevention, and personal responsibility for member healthcare. The foundation and supporting documentation for this topic choice was well presented. The decision to choose this subject is based on lack of adherence to the appropriate controller medications. However, this is not explained or compared.

The MCHP did present a barrier analysis in the study topic section, which they stated will provide a "baseline" for measurement. However, the issues cited in this analysis are issues that are clearly contract requirements of the MCHP. If the barriers identified are truly problems for members, the MCHP is not providing services and healthcare as required by their contract. The approach or goal of this study is stated but never clearly explained in the study topic presentation.

Study Question

The study question presented was "Will targeted health plan interventions increase the appropriate use of prescribed medications to treat members with persistent asthma up to the 50th percentile for HEDIS 2012 (or approximately 4 percentage points year over year)?" The question framed the content and intention of this study. The question includes a stated goal. The additional information presented did clarify the interventions or focus of the study.

Study Indicators

The study indicator presented is:

- The rate of eligible members 5 through 64 years of age who have been identified as having persistent asthma who met a least one of the following

criteria during both the measurement year and the year prior to the measurement year who have had use of appropriate medication during the calendar year. Eligible members are those who were continuously enrolled with no more than one 45-day gap in enrollment during the year.

The numerator and denominator provided and the additional information included appear to be only minimally related. It is difficult, at best, to even assume that there is a strong relationship between the proposed data elements. There is little clarity, based on the information presented, about who is to be studied and how this will occur.

Study Population

The study population appears to be members ages 5 – 64 who are diagnosed with persistent asthma. This is not delineated in a section about the chosen population. However, based on a discussion of the 2012 HEDIS technical specifications this might be assumed. There is no discussion about how these members will be captured.

Sampling

The documentation provided indicated that there was sampling for measurement related to their provider intervention. The MCHP reviewed, or plans to review, thirty (30) medical records from "pediatricians or family practitioners who have at least one non-compliant HEDIS eligible member in the last quarter of 2011 in the HEDIS asthma measure." A numerator and denominator are defined. Then the explanation adds: "Review all their records of all their HEDIS eligible members in the HEDIS measure." This makes it impossible to determine what records or what number of records will be reviewed. In none of the documentation do we learn if a valid sampling technique will be employed. The protocols clearly explain the types of sampling allowable. It is not possible to determine if valid sampling occurred based on the statement that 30 records would be reviewed. The number of providers and how these records are chosen is unclear. To substantiate that this methodology is valid, more information is required. The narrative does not discuss how medical record reviews will occur, or the expected improvement that might occur employing this process.

Study Design and Data Collection Procedures

The documentation does present some information that appears to be the beginning of a study design. The MCHP intends to use data obtained through the HEDIS methodology for an administrative measure – Use of Appropriate Medications for Asthma. This data will come from claims and encounter data. The encounters that are likely to produce a diagnosis of asthma, including the CPT and diagnosis codes are presented. The systematic method is implied by the use of the HEDIS requirements. 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. A prospective data analysis plan is alluded to, but not actually included.

The MCHP personnel involved in the PIP, including the team leader, and support team, are all identified. Their roles and qualifications are included.

Improvement Strategies

A description of the planned intervention for members includes sending any member diagnosed with asthma a booklet entitled "Asthma Handbook." It includes information on triggers, the development of an Asthma Action Plan, and appropriate medications. It is similar to a booklet sent to members in "active case management." "This intervention will be the issuance of these booklets at the first sign of persistent asthma, hopefully increasing the appropriate use of medications." Distribution is to begin after DMH approval, so implementation of this intervention will only occur late in 2011, at the earliest.

A second intervention, focused on providers is described as the review of medical records previously described, and the provision of education to providers and their staff on their results. The provider intervention includes:

- Medical record review
- Review of the results of the medical record review
- Distribution of the Clinical Practice Guidelines
- Additional member education resources to provider practices for asthma

Data Analysis and Interpretation of Results

The desired outcomes other than improved HEDIS measures were not discussed. Since this PIP has not yet been implemented no analysis or other results were available.

Non-Clinical PIP – Improving Oral Health

Study Topic

The second PIP evaluated was the MCHP's individualized approach to the Statewide PIP "Improving Oral Health." 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 the information pertinent to the decision to address this topic as a statewide initiative. In the study topic narrative the MCHP did make an effort to relate the need to improve oral health to its members. Any relevant sources were not annotated. The MCHP did state that they changed dental subcontractors at the beginning of the year (January 1, 2011), so they were unable to implement any initiatives for change prior to August 1, 2011.

The PIP narrative does recognize that improving oral health through a greater number of annual dental visits has a positive impact on member health, and also improves this HEDIS measure. The MCHP was able to identify that this topic is important to their members. They did not provide evidence of how these conclusions were reached.

Study Question

The study questions presented are:

- "Will targeted health plan interventions for eligible members increase the number of children who receive an annual dental visit by 5 percentage points?"; and
- "Will targeted health plan interventions for providers increase screening and/or referral as part of the EPSDT process by 15%?"

The study questions are uncomplicated and measureable. They do not allude to the type of interventions to be employed.

Study Indicators

Two study indicators are presented as follows:

- The first indicator is the rate of eligible members ages 2 – 21 who have at least one dental exam as measured by the HEDIS Annual Dental Visit rate using the administrative method of measurement. (The actual HEDIS measure relates to individuals ages 2-20.) A numerator and denominator are presented and appear to be the standard HEDIS measures. The narrative goes on to explain that the MCHP is arbitrarily changing its baseline year because they changed dental subcontractors. The narrative states that this will give the MCHP "an opportunity to compare rates based on no initiatives in 2010 with our old dental vendor to a member intervention with our new dental vendor". Since the directive for this Statewide PIP was to use 2009 HEDIS data as a baseline year, and HEDIS 2010 as the first remeasurement year, based on interventions in place during that calendar year, it is disturbing to see that this MCHP failed to implement any improvement strategies during that time. The MCHP proposes to improve their HEDIS rates by 5% annually. This is not an unreasonable goal, but it does exceed that of the statewide plan, which is 3% in the first remeasurement year.

- The second study indicator is stated to be the percentage of EPSDT medical records with documentation of PCP discussion about oral health…"either conducting dental screenings or referrals or encouraging members to schedule an annual dental exam." The stated denominator is "75 medical records from members 2 – 20 who had EPSDT visits in the last quarter of 2011." The numerator is the "number of medical records reviewed who had documentation of PCP discussion about annual dental visits."
    - In this case the description of the study indicator and the numerator/denominator do not measure the same thing. In the

description of this indicator the narrative suggests that for the 2011 (CY2010) HEDIS Measurement rate for Well Child Visits in the 3rd and 4th Year and Adolescent Well Care visits rates will "serve as the baseline rate for study indicator 2." There is no rationale or explanation about why this is an acceptable strategy, nor is it in any way related to the issue of determining which providers are encouraging members to have annual dental visits.

Study Population

The targeted population is not clearly defined, except as named in the numerator and denominator of the indicators. In one indicator the MCHP plans to pull cases for members ages 2 – 21.

- This is not consistent with the HEDIS specifications, which address children ages 2 – 20.

This discrepancy was pointed out during the on-site review but was never corrected. How these individuals, either member or providers, will be identified is not defined.

Sampling

The documentation states that the MCHP plans to use sampling in Indicator 2. It states that the sampling will be used to validate the results of the provider interventions. The method to be used is "random sampling." How cases are to be pulled, and how this meets the requirements to be a valid sample is unclear and questionable, based on the information provided.

Study Design and Data Collection Procedures

The documentation does specify that the data to be collected for Indicator 1 is generally related to their HEDIS data for Annual Dental Visits. CPT codes are included. There is a description of the MCHP's HEDIS certified software.

The data collection plan for Indicator 2 states that the data source is the Harmony Health Plan of Illinois claims system. **This is not valid as the Illinois system should not include Missouri members.**

There is no complete study design presented. Since the source of data appears to be coming from a system that should not include Missouri data, this entire section is coded as "Not Met." The "Data Analysis Plan" for Indicator #1 will be a comparison of the HEDIS rates. This does not specify the years involved, or any attempt to collect data on a quarterly basis, as required in the protocols.

Study Indicator #2 will analyze the data for the seventy-five case records reviewed. This will not occur until the second quarter of 2012. If this is the baseline year for this section of the PIP it is not compliant as the PIP was to begin with data from calendar year 2009.

Improvement Strategies

Interventions for Indicator #1 include:

- Eligible members between the ages of 2-20 who have not had a dental visit will receive a reminder postcard;
- Six to eight weeks following the mailing, members who are still non-compliant will receive a follow-up telephone call to schedule an appointment;
- Two to three attempts will be made by the dental vendor to contact the member; and
- If telephonic contact cannot be established an unable to reach letter will be sent to the member.

How these members will be identified and tracked is not included. The MCHP does mention that this approach was utilized by another Harmony plan with outstanding success.

Interventions for Indicator #2 include:

- EPSDT and Dental Education through Fax Blast and mailings to pediatricians and primary care providers to encourage outreach efforts to increase annual dental exams; and
- Provider face to face visits conducted by MCHP Provider Relations and Quality Improvement staff to educate providers on the importance of dental screening and completing all EPSDT/HCY examinations.

The described interventions may have a positive impact on provider actions. How they will be tracked and trended is difficult to follow in the narrative presented. In one section the narrative discusses targeting high-volume PCPs. In the "Sampling" discussion it describes family practioners and pediatricians who have claims for at least thirty (30) unique members with EPSDT/HCY visits in the last quarter of 2011. In this section there is more detailed information that gives greater confidence in the methodology presented.

Data Analysis and Interpretation of Results

The MCHP reports no results and they chose to begin this PIP in 2011.

CONCLUSIONS

QUALITY OF CARE

Both PIPs are designed to improve the quality of services to members. The non-clinical PIP has the stated focus of improving the MCHP's HEDIS rates. However, the information presented was so vague and inconclusive that it was not possible to determine if this project will improve the quality of healthcare available to members. In conclusion it appears that these PIPs are presented to satisfy the requirement of presenting projects for evaluation rather than improving the quality of care for members.

ACCESS TO CARE

The non-clinical PIP should have had a specific focus on access to care. The study was not well developed and could not be properly analyzed. The clinical

PIP could have a positive effect regarding better access to care for members with asthma, but this concept was not developed in the information presented. It is impossible to determine if either PIP will have a real impact on member access to care based on the information made available.

TIMELINESS OF CARE

Timeliness of care may be positively impacted if these performance improvement projects are operationalized. The improvement strategies presented have the potential of improving the timeliness of care. It is not possible to draw a conclusion about their impact at this time.

RECOMMENDATIONS

1. Harmony Health Plan was provided detailed technical assistance about the requirements of developing meaningful and beneficial Performance Improvement Projects. They were given the opportunity to completely rewrite the project narrative originally submitted. The results received, dated August, 2011, remained confusing and difficult to evaluate. It did not appear that the PIP protocol was used to develop these studies.
2. The development of Performance Improvement Projects should be taken seriously. The federal protocols state that the purpose of the PIP process is to assess and improve processes and outcomes of care. To achieve real improvements in care and for reviewers or the State Agency to have confidence in the reported outcomes, the PIP must be designed, conducted, and reported in a methodologically sound manner.
3. The interventions of each PIP should be focused and measureable. The interventions should include activities that are related to the issues the MCHP is attempting to improve. They should be concrete. Stated interventions should not be part of the normal MCHP operations. These interventions should be specifically designed to improve the performance of the MCHP with the ultimate goal of improving health care or services to

members. The MCHP should explicitly address how its projects are designed and are pertinent to the entire Managed Care Region served.

4. The MCHP should recognize that an important aspect of the PIP process is creating new methods of improving services that impact member behavior and that ultimately can then be incorporated into regular organizational activities.
5. The MCHP 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. The prior years' results should not be ignored because they were undesirable or because of a new subcontractor relationship.

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 February 16, 2011. The EQRO reviewed documentation between February 16, 2011 and June 30, 2011. 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 2010 data reporting year
- HealthCareData Company's NCQA HEDIS Compliance Audit Report for HEDIS 2010
- Harmony's information systems (IS) Policies and Procedures pertaining to HEDIS 2010 rate calculation
- Harmony's information services (IS) policies on disaster recovery
- Harmony's HEDIS committee agendas for 2010
- Harmony's HEDIS 2010 Training Manual for the medical record review process

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

- Tab_04WellCare_ADV_File1.txt
- Tab_04WellCare_AWC_File1.txt
- Tab_04WellCare_FUH_File1.txt
- Tab_05WellCare_ADV_File2.txt
- Tab_05WellCare_AWC_File2.txt
- Tab_05WellCare_FUH_File2.txt

- Tab_06WellCare_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, June 28, 2011. 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 2010 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. 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 2010 combined rate for Annual Dental Visits reported by Harmony was 28.13%, which is **significantly lower** than the statewide rate for MCHPs (39.03%, z = -1.19; 95% CI: 22.76%, 33.50%; $p < .05$). However, this rate has continued to rise to levels **higher** than those reported by the MCHP in 2008 and 2009 (16.94% and 20.68% respectively).

Harmony's reported rate for the HEDIS 2010 Adolescent Well-Care Visit reported to the SMA and the State Public Health Agency (SPHA) was 34.06%. This was **significantly lower** than the statewide rate for MCHPs (41.31%; z = -1.31 95% CI: 30.40%, 37.72%; $p < .05$). However, this rate has **increased** more than 4% over the rate of 28.17% reported by the plan in 2009, and is over 7% **higher** than the rate

reported in 2008 (25.06%).

The 7-day reported rate for Harmony for the HEDIS 2010 Follow-Up After Hospitalization for Mental Illness measure was 37.39% which was comparable to the statewide rate for all MCHPs (45.47%; z = -0.48, 95% CI: 29.80%, 44.99%; n.s.).

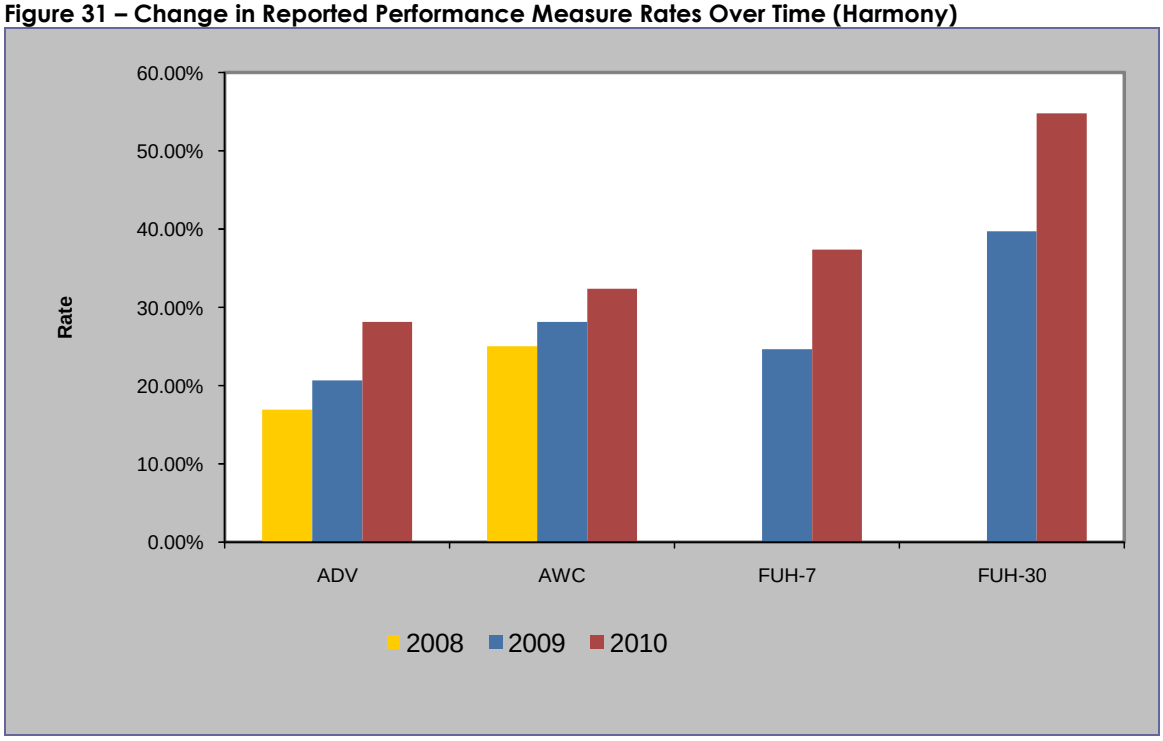
The HEDIS 2010 30-day rate for Follow-Up After Hospitalization for Mental Illness reported by Harmony was 54.78%, **significantly lower** than the statewide rate for MCHPs (69.50%, z = 1.35; 95% CI: 47.19%, 62.38%; p < .05).

Table 39 – Reported Performance Measures Rates Across Audit Years (Harmony)

Measure	HEDIS 2008 Rate	HEDIS 2009 Rate	HEDIS 2010 Rate
Annual Dental Visit (ADV)	16.94%	20.68%	28.13%
Adolescent Well-Care Visits (AWC)	25.06%	28.17%	32.36%
Follow-Up After Hospitalization for Mental Illness – 7-day (FUH7)	NA	24.66%	37.39%
Follow-Up After Hospitalization for Mental Illness – 30-day (FUH30)	NA	39.73%	54.78%

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

Figure 31 – Change in Reported Performance Measure Rates Over Time (Harmony)



Sources: BHC, Inc. 2008-2010 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. There were no biases or errors found in the manner in which they transferred data into the repository used for calculating the HEDIS 2010 measures.

Documentation of Data and Processes

Data and processes used for the calculation of measures were adequate. 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 .This involved the selection of eligible members for the services being measured. For the Follow-Up After Hospitalization for Mental Illness measure, 115 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 5,503 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 2010 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 2010 criteria. A medical record review was conducted for the Adolescent Well-Care Visit measure.

For the HEDIS 2010 Annual Dental Visit measure, the EQRO validated 1,546 hits from administrative data, while 1,548 were reported. The MCHP's reported rate was 28.13% and the EQRO validated rate was 28.09%, resulting in a bias (overestimate by the MCHP) of 0.04%.

For the Adolescent Well-Care Visit measure, Harmony reported 133 administrative hits from the sample of the eligible population; the EQRO's validation of the data yielded 139 hits. For the medical record review validation, the EQRO requested 7 records. A total of 7 records were received for review, and all 7 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 35.52%, while the plan reported a total rate of 34.06%. This represents a bias of

1.46%, an underestimate by the MCHP.

For the HEDIS 2010 Follow-Up After Hospitalization for Mental Illness measure (7-day rate), the MCHP reported 43 hits, and 41 were verified by the EQRO. This yielded a reported rate of 37.39% and a validated rate of 35.65%; an overestimated bias by the MCHP of 1.74%.

The number of hits reported by Harmony for the Follow-Up After Hospitalization for Mental Illness measure 30-day follow-up was 63; the EQRO found 60 valid hits. The rate reported by the MCHP was 54.78%and the rate validated by the EQRO was 52.17%, a bias (overestimate) of 2.61%.

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 Data Submission Tool (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 and Follow-Up After Hospitalization for Mental Illness measures were slightly overestimated and the Adolescent Well-Care Visit measure was underestimated, but these results still fell within the 95% confidence interval reported by the MCHP.

Table 40 - Estimate of Bias in Reporting of Harmony HEDIS 2010 Measures

Measure	Estimate of Bias	Direction of Estimate
Annual Dental Visit	0.04%	Overestimate
Adolescent Well-Care Visits	1.46%	Underestimate
Follow-Up After Hospitalization for Mental Illness (7-day)	1.74%	Overestimate
Follow-Up After Hospitalization for Mental Illness (30-day)	2.61%	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 41 shows the final audit findings for each measure. All three measures (Follow-Up After Hospitalization for Mental Illness, Adolescent Well-Care Visits and Annual Dental Visit) were determined to be Substantially Compliant.

Table 41 - 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	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 MCHP. 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 Managed Care Members qualified for the measure.

CONCLUSIONS

Three performance measure rates were reported and validated for Harmony. All three of these rates (Follow-Up After Hospitalization, Annual Dental Visit, and Adolescent Well-Care) were comparable to or **significantly lower** than the average for all MCHPs.

QUALITY OF CARE

Harmony's calculated rate for the HEDIS 2010 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.

The 7-day rate for this measure was comparable to the statewide average for all MCPHs. The 30-day rate reported by the MCHP for this measure was **significantly lower** than the average for all MCHPs. Both rates were below both the National Medicaid and National Commercial Averages. This indicates that Harmony members are receiving **lower** quality of care, for both the 7-day and 30-day timeframes, than the average National Medicaid and National Commercial members.

Within the 7-day timeframe, Harmony members are receiving a quality of care comparable to the quality received by the average member, but a **lower** quality of care in the 30-day timeframe.

ACCESS TO CARE

The calculated rate by Harmony for the HEDIS 2010 Annual Dental Visit rate was substantially compliant with specifications; this measure is categorized as an Access/Availability 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 MCHP's reported rate for this measure was **significantly lower** than the average for all MCHPs. Harmony members are receiving a quality of care that is **lower** than the level of care delivered to the average Managed Care member. This rate is also **lower** than the National Medicaid Average, indicating the MCHP's members receive a **lower** access to care than the average Medicaid member nationwide.

TIMELINESS OF CARE

The MCHP's calculation of the HEDIS 2010 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 MCHP's reported rate for this measure was **significantly lower** than the overall 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 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.

RECOMMENDATIONS

1. Three (FUH 30-day, ADV, and AWC) of the four rates validated for this MCHP were **significantly lower** than the all MCHP averages. The EQRO recommends that the MCHP focus on these rates to reverse this trend.
2. Although the MCHP's rates are **lower** than the all MCHP averages, substantial **increases** have been observed in all rates from the MCHP's previous year's rates. Continue to evaluate programs in place to ensure this trend continues in future years.
3. The AWC rate validated for this MCHP showed a bias of underestimation and both FUH rates showed a bias of overestimation. The EQRO recommends that the MCHP review their data collection, integration, and measure calculation practices to help alleviate this issue.
4. Continue to conduct and document statistical comparisons on rates from year to year.
5. Continue to utilize the Hybrid methodology for calculating rates when allowed by the specifications.

8.3 MCHP Compliance with Managed Care Regulations

METHODS

Prior to the site visit, documentation was received and reviewed regarding the 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 MCHP. 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 MCHP's 2010 Annual Appraisal of the Quality Improvement Program, occurred prior to the on-site review. The MCHP 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 MCHP Case Management policy. Interviews queried staff in an effort to ensure that all pertinent elements of the federal regulations were addressed in the MCHP 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 Health Plan of Missouri's Annual Evaluation, and the SMA's Quality Improvement Strategy.

Document Review

The MO HealthNet Division supplied:

- State of Missouri Contract Compliance Tool (including MHD responses and comments)
- 2010 Harmony Health Plan of Missouri's Managed Care Annual Report

The following documents were requested for on-site review:

- Member Handbook
- Provider Handbook
- 2010 Marketing Plan and Materials
- Case Management Policies
- 2010 Quality Improvement Committee Minutes
- Grievance and Appeals Policies and Procedures

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 Plan of Missouri's St. Louis offices on both June 28 and 30, 2011 with Case Management and Member Engagement Staff, Grievance and Appeals Staff, and Plan Administration.

FINDINGS

Enrollee Rights and Protections

Harmony Health Plan of Missouri 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 .

The MCHP reported having approximately 16,000 members at the time of the on-site review. The predominant MCHP 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 MCHP reports to be striving to upgrade their service delivery system and to ensure that staff and programs provide quality care for their members. The MCHP 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.

Harmony has a 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 MCHP 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 MCHP 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. When the EQRO made its on-site visit during the prior year's review there was a case manager located in the Missouri office of the MCHP who made community and direct member contact when a member's situation dictated this level of intervention, as of the time of this year's site visit, that person was no longer employed at the Missouri Office.

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The rating for Enrollee Rights and Protections (100.0%) reflects the first year that Harmony has complete and approved policy and procedures. This is the MCHP's fourth compliance review.

Table 42 – Subpart C: Enrollee Rights and Protections Yearly Comparison (Harmony)

Federal Regulation	Harmony		
	2008	2009	2010
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	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	0	1	2
438.100(b)(2)(iv,v) Rights to Refuse Services/Advance Directives	1	1	2
438.100(b)(3) Right to Services	1	1	2
438.100(d) Compliance with Other Federal/State Laws	2	2	2
Number Met	9	9	13
Number Partially Met	3	4	0
Number Not Met	1	0	0
Rate Met	69.2%	69.2%	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 MCHPs (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.

Access Standards

Harmony continues to make an effort to improve in the area of access standards. The MCHP has submitting policies and procedures pertaining to this area of review to the SMA as required. The MCHPis actively working to increase their provider panel throughout the Managed Care Eastern Region, including active recruitment in the counties outside of St. Louis City and St. Louis County.

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 MCHP was able to contract with urgent care centers that provide after-hours access to care. However, the MCHP still continues to operate without a hospital in their network that is in close proximity to many of their out-lying Eastern Region counties.

Ratings for compliance with Access Standards (70.6%), see Table 43, have improved **significantly** over the 2009 rate of 47.05%. The MCHP has complete and approved policy in many of the areas that it had lacked during prior year's reviews. However, in reviewing case management records and interviewing staff, full evidence of assessments and treatment planning for members was not available.

Table 43 – Subpart D: Quality Assessment and Performance Improvement: Access Standards Yearly Comparison (Harmony)

Federal Regulation	Harmony		
	2008	2009	2010
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	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	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	2
438.210(b) Authorization of Services	1	1	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	1	2
438.114 Emergency and Post-Stabilization Services	2	2	2
Number Met	9	8	12
Number Partially Met	8	9	5
Number Not Met	0	0	0
Rate Met	52.9%	47.05%	70.6%

Note: 0 = Not Met; 1= Partially Met; 2 = Met
Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient MCHPs (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 MCHP assures that all providers maintained licensure and the right to practice in Missouri. The MCHP developed a work plan to ensure that the remaining provider list would be current during the coming year. The MCHP reported that they are current on all providers due for credentialing and that NCQA standards are utilized in conducting credentialing audits.

The MCHP 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.

MCHP 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.

The rating for Structure and Operation Standards (100.0%) reflects the completed and approved policy in this area.

Table 44 – Subpart D: Quality Assessment and Performance Improvement: Structure and Operation Standards Yearly Comparison (Harmony)

Federal Regulation	Harmony		
	2008	2009	2010
438.214(a,b) Provider Selection: Credentialing/Recredentialing	1	0	2
438.214(c) and 438.12 Provider Selection: Nondiscrimination	1	1	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	1	1	2
438.230(a,b) Subcontractual Relationships and Delegation	2	0	2
Number Met	7	6	10
Number Partially Met	3	2	0
Number Not Met	0	2	0
Rate Met	70%	60%	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 MCHPs

(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 2010`review. 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 MCHP providers.

Harmony is continuing to develop their Quality Assessment and Performance Improvement activities during 2010. Their Quality Improvement group meets regularly and includes local physicians who actively participate. The MCHP's goal of providing quality services to members was a significant focus of the MCHP's discussions. The MCHP reports that the Quality Improvement section is an active and essential part of operations.

Harmony did submit two Performance Improvement Projects (PIPs) for validation. These PIPs lacked many of the components necessary for evaluation and those submitted were difficult to decipher. The structure of both PIPs did not follow the federal protocol. These PIPs indicated a lack of understanding of the importance of the PIP process in improving operations and health care services to members.

The MCHP 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. 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 (72.7%), see Table 45, is an improvement of the 2009 rate of 63.63%. This rating reflects the fact that the MCHP has submitted and received approval on policy in the majority of the areas evaluated, the only outstanding policy was in the area of Utilization Management. Although Harmony exhibits practices that have improved, and appear to be in accordance with the Managed Care contract requirements, and the federal regulations, they cannot be considered as fully compliant until all aspects of their Quality Improvement program can be validated.

Table 45 – 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	0
438.240(b)(4) QAPI: Basic Elements regarding Special Healthcare Needs	1	1	2
438.240(e) QAPI: Program Review by State	NA	NA	NA
438.242(a) Health Information Systems	1	2	2
438.242(b)(1,2) Health Information Systems: Basic Elements	1	2	2
438.242(b)(3) Health Information Systems: Basic Elements	1	2	2
Number Met	4	7	8
Number Partially Met	7	4	2
Number Not Met	0	0	1
Rate Met	36.4%	63.63%	72.7%

Note: Regulation 438.240(e) refers to program review by the state. The regulation requires the state to review, at least annually, the impact and effectiveness of each MCO's quality assessment and performance improvement program. The regulation refers to the state QA & I program review process and is not applicable to External Quality Review of the MC+ Managed Care Program. This percent is calculated for the regulations that are applicable tot the MC+ Managed Care Program. 0 = Not Met; 1= Partially Met; 2 = Met
Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient MCHPs (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 (33.3%) indicate that the health did not complete most of the requirements regarding policy and practice. Although this is an improvement over the prior year's rating of 11.1%, the 2009 rating was based on lack of approved policy, not on the practice validated at the on-site. This review year's rating is based on approved policy that did not correspond to evidence of correct practice during the on-site

review.

The EQRO reviewed grievance and appeals files while on-site at Harmony , in St. Louis, MO on Tuesday, June 28, 2011. The EQRO Project Director, Amy McCurry Schwartz, read 29 files and completed an analysis tool for each file reviewed. These files were reviewed for compliance with Federal Regulations and the MCHP's State Contract. The table below summarizes the findings of this file review.

Table 46 – Compliance File Review, Harmony

MCHP	# of records reviewed	# with issue	% with issues	% Correct
Harmony	29	19	65.52%	34.48%

The specific issues identified by the Project Director in Harmony's files included the following:

- Written notice of disposition of Grievance letter included the **Illinois** Department of Healthcare and Family Services as whom the member should contact with a request for Appeal (14 files)
- No information regarding the member's right to request continued benefits included in NOA (2 files)
- Timeline for mailing of Notice of Action letter not upheld (1 file)
- No written acknowledgement of receipt of an appeal sent (1 file)
- Incomplete file (1 file)
- Required re-fax from provider's office because information was sent to wrong Harmony department (1 file)

Although not specifically attributable to this MCHP, it is noted that the mandatory language required by the State of Missouri in all Notice of Action letters is considered confusing by the EQRO. The language contained in the clause related to the member's right to "Continuation of Services" and the requirement to list all legal aid offices in the State of Missouri and not the one specific to the member's address both serve to make the letter confusing.

Information regarding a member's grievance is recorded and forwarded to the Grievance Department in Tampa, Florida. Written information from members regarding grievances and appeals are received by fax, mail and e-mail, all of this information must be sent to Tampa, FL. It can only be assumed by the review team that the location of the staff in Tampa is the reason why such a high percentage of Notice of Action letters informed members to contact the **Illinois** Department of Healthcare and Family Services and not the MO HealthNet Division as required by the Managed Care contract.

Case management staff relates that they most often become involved if 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 33.3% is an improvement over the prior year's (0.0%) rating, however, this is only because approval was received for the policy and procedures required to meet Managed Care contract requirements and federal policy. Practices observed at the time of the on-site review indicated that Harmony lacks an understanding regarding operation of a grievance and appeals system. However, policy submission, revisions, and approval were complete.

Table 47 – Subpart F: Grievance Systems Yearly Comparison (Harmony)

Federal Regulation	Harmony		
	2008	2009	2009
438.402(a) Grievance and Appeals: General Requirements	1	1	2
438.402(b)(1) Grievance System: Filing Requirements - Authority	1	1	2
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	0
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	2
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	1	1
438.410 Expedited Resolution of Appeals	1	1	2
438.414 Information about the Grievance System to Providers and Subcontractors	1	1	1
438.416 Recordkeeping and Reporting Requirements	1	1	2
438.420 Continuation of Benefits while Appeal/Fair Hearing Pends	1	1	1
438.424 Effectuation of Reversed Appeal Resolutions	1	1	2
Number Met	1	0	6
Number Partially Met	17	17	11
Number Not Met	0	0	1
Rate Met	5.6%	0%	33.3%

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 MCHPs (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 MCHP in the Managed Care system. The staff is able to articulate their MCHP's goals and the requirements for service delivery associated with the Managed Care contract and the federal guidelines. The MCHP 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.

The policy approval process is now only lacking the Utilization Management policy. However, the approved policy in the area of Grievances and Appeals was the only positive the reviewers could find in that section of the review. The files reviewed on-site clearly showed that the policies were not being implemented by the Staff that were responsible for delivering those services to Harmony's members. In addition, the MCHP 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 2010.

QUALITY OF CARE

The Harmony staff state an awareness of their responsibility to ensure adequate access to quality healthcare in a timely manner. They voiced their awareness that creating an environment where all member services meet their quality standards must continue.

However, it was not evident in practice that Harmony was providing the quality of services of which they spoke. Case Management and Grievance/Appeals files were frought with issues. There was little to no evidence of Assessments or Treatment Plans in the Case Management review. In most of the Case

Management files there were few if any attempts to contact members and offer services.

In both Grievance and Appeals files, clerical errors, abound. Members were directed to appeal cases to the State of Illinois and not Missouri.

ACCESS TO CARE

Harmony has improved their provider network and continues to fully develop all service delivery in their Managed Care region. The MCHP does however, still lack a hospital that provides services to many of the out-lying counties in the Eastern Region. The case management staff does express an understanding of the importance of access to care for members and provide examples of their efforts in meeting this requirement. The information obtained during the on-site review reflects improved collaboration between departments within the MCHP. However, no evidence of Case Management and Care Coordination was present in the case files reviewed by the EQRO.

TIMELINESS OF CARE

Harmony staff stated an awareness 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 a question, and a timely turnaround on issues such as grievances and appeals. However, in practice, this was not seen at Harmony. In the areas of grievances and appeals:

- Written notice of disposition of Grievance letter included the **Illinois** Department of Healthcare and Family Services as whom the member should contact with a request for Appeal (14 files)
- No information regarding the member's right to request continued benefits included in NOA (2 files)

- Timeline for mailing of Notice of Action letter not upheld (1 file)
- No written acknowledgement of receipt of an appeal sent (1 file)
- Required re-fax from provider's office because information was sent to wrong Harmony department (1 file)

RECOMMENDATIONS

1. Review all CMS Protocols related to the EQR audit, it is evident that many of the requirements for Performance Improvement Projects and Grievance Systems have not been employed at Harmony .
2. Ensure that staff (located outside of the State of Missouri) who serve MO HealthNet Managed Care members are adequately trained in the specifics of responding to the member's concerns.
3. Utilize the resources at Harmony to complete all necessary policy documentation and submission to the SMA.
4. Continue development of efforts to improve community relations.
5. Provide oversight for behavioral health services to ensure that members maintain provider relationships, and continue to receive the services required.

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9.0 Healthcare USA

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9.1 Performance Improvement Projects

METHODS

DOCUMENT REVIEW

HealthCare USA supplied the following documentation for review:

- Decreasing Non-Emergency/Avoidable Emergency Department Utilization
- Statewide Performance Improvement Project – Improving Oral Health

INTERVIEWS

Interviews were conducted with the project leaders for each Performance Improvement Project (PIP) by the EQRO team on June 29, 2011, during the on-site review, and included the following:

- Rudy Brennan – Quality Improvement Coordinator
- Carol Stephens-Jay – Health Care Consultant
- Laurel Ruzas – Director, Quality Improvement
- Dale Pfaff – Quality Improvement 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 as requested by the MCHP.

The PIPs submitted for validation included a substantive amount of information which allowed for a significant portion of the evaluation to occur prior to the time of the on-site review. The MCHP was instructed, at the on-site review, that they could submit additional data that included enhanced outcomes of the interventions. The final evaluation was based on the updated information

received.

FINDINGS

Clinical PIP – Decreasing Non-Emergent/Avoidable Emergency Department Utilization

Study Topic

The first PIP evaluated was the clinical PIP submission entitled "Decreasing Non-Emergent/Avoidable Emergency Department Utilization." The study topic presentation explained the research completed, thereby justifying the decision for topic selection. The narrative included national, state and MCHP specific data that provided support for topic choice. This topic choice was based on an evaluation of claims data after the MCHP identified a local trend indicating an increase in the number of Emergency Department (ED) visits in the past few years. The topic choice supports the goal of improving access to care and quality of care by ensuring members obtain the most appropriate health care in the correct setting. Reducing inappropriate ED utilization is designed to help members access the most appropriate level of care at the right time and assist them in establishing a medical home. The MCHP found that establishing a medical home results in better health on both the individual and population level and reduces healthcare disparities.

Study Question

The original study questions for this project was: "Will member education regarding ED utilization decrease inappropriate and avoidable ED utilization as evidenced by a 2% reduction in HEDIS utilization rate?" The updated questions for the 2010 study were:

- "Will member education regarding ED utilization decrease inappropriate and avoidable ED utilization as evidenced by a 2% reduction in the HealthCare USA ED Visits/1000 Member rate?"; and

- "Will member education regarding ED utilization decrease inappropriate and avoidable ED utilization as evidenced by a 2% reduction in the average number of ED Frequent Flyer visits?"

These updated study questions are clear and measureable. The study questions for the original PIP and remeasurement years consider the population the MCHP wishes to serve or impact, and the goal for effecting change.

Study Indicators

The study indicators and their goals were defined and explained. Each indicator provided numerators, denominators, and explained how current data would be compared to the 2006 baseline year. Data was provided by each Managed Care region and statewide. What was being measured and the information each indicator will provide was explained. The baseline indicator and the specifications of its development were included in the information provided. The information provided included adequate documentation to determine if the indicators would measure a change in health status. This information also explained how the indicators were associated with improved member outcomes. The third indicator and its goals were explained in detail. The indicators for this PIP are:

- HEDIS ED Utilization Rate (original and ongoing PIPs)
- HCUSA ED Visits/1000 Member Rate (Updated for 2010)
- Average Number of ED Frequent Flyer Visits (Updated for 2010)

Study Population

The performance improvement project is focused on any member who has an Emergency Department claim. The study population includes all members with ED claims. The population definition is inclusive and was stated clearly and succinctly. The methodology designed to capture all members to whom the study applies was included and explained.

Sampling

The study included no sampling.

Study Design and Data Collection Procedures

A description of the MCHP's claim system, and the controls that exist to ensure valid and reliable data were included. The process ensures accuracy. The main source of original data will come from the HEDIS certified software provided by

Catalyst. This will be used to identify and count the target population and to query the MCHP's claims system. The claims data alone will be used to create the data used to measure the PIP outcomes. How the final data is collected and reviewed is included in the narrative.

The claims data will be run quarterly, and run charts will be used to monitor the impact of the planned interventions. This data will be used to assess ongoing effectiveness of the project. The Frequent Flyer average numbers are determined through a process that was described in detail. An error was detected in the original data. The MCHP described a scrubbing process that will be used to ensure that all data reported are accurate and complete. The corrections developed ensured that collection requirements were effective. The data was rerun to ensure complete and accurate data was produced. All the processes explained in the PIP narrative ensure valid and reliable data collection and reporting. Although claims data is being utilized solely to measure outcomes, how the systems work together to produce consistent and accurate data was clearly documented.

The study design specifies the sources of data and why they are applicable. A systematic method of collecting valid and reliable data was verified. The instruments and data collection tools that were used are provided. The prospective data analysis plan summarized how data will be gathered, the process for ensuring valid data, and how it will be analyzed. This was provided for all three indicators. The MCHP will evaluate the ongoing effectiveness of the interventions implemented. Information is then sent to the Emergency Department Performance Improvement Team and the outcomes are reported to the Quality Management Committee at least quarterly. These explanations are contained in the study design, and enhance the prospective data analysis plan.

The name of the project leader was provided. All team members and their qualifications or role in completion of the study were specified.

Improvement Strategies

The interventions utilized in this study, their rationale, and the manner in which

they were implemented is described. The interventions are listed by date of inception and by the member group to be impacted. Member interventions include development of an ED outreach program and educational materials. Provider interventions include education efforts and targeting brochures to provider offices (PCP offices) with a high number of Frequent Flyers. These interventions were described in detail. Barrier analysis occurred after each measurement period. This section of the narrative provided a great deal of information allowing an assessment of what is being done, the desired outcome, who was responsible for the intervention, and the date of implementation.

Data Analysis and Interpretation of Results

A yearly analysis of the data is included in the narrative. It was clearly based on the prospective data analysis plan. The analysis begins in 2007 and goes through 2010. Each indicator is explored independently. A thoughtful analysis is presented. The analysis discussed the interventions that were successful, as well as those that did not have the expected impact. The 2011 HEDIS rate for ED utilization decreased in all three regions. The Central Region showed the greatest decrease and met the MCHP's stated goals. How the interventions interact with one another and the effect they may have had on the HEDIS measure was discussed and analyzed.

The ED Visits/1000 members trended downward in all three regions. Variations and regional differences were analyzed. The probable impact of continued and future interventions on reaching and exceeding stated goals was included. The narrative explains that they have not yet had the desired positive impact on the Frequent Flyer population. The planned future interventions, which the health plan hopes will create more impact on this population, were included. Continued trends and opportunities for improvement are woven into the discussion. The study documentation included tables and graphs regarding the information collected. The results were explained in sufficient detail in the

documentation provided. The analysis was thoughtful and included barrier identification, factors influencing outcomes, and an overall evaluation of the success of the project to date. The analysis provided evidence that the interventions have had an interim impact. The next steps and 2011 interventions were described in detail.

Assessment of Improvement Process

The MCHP's narrative report presents information on interventions utilized through 2010. Positive results have been sporadic in some cases. Interventions that appear to have had a positive impact will be continued. These will be enhanced and expanded as required to continue to achieve positive results. The MCHP intends to continue and expand interventions that have had an impact in targeted populations.

Conclusion

The MCHP recognizes that they have not yet achieved a level that can be considered as sustained improvement. The PIP narrative does indicate a plan to improve and continue this project until their goals can be achieved. This PIP was well constructed and included detailed information on the improvement processes implemented. There is high confidence that this project will continue to have a positive impact on services to members, and that it will report a valid and reliable study.

Non-Clinical PIP – Improving Oral Health

Study Design

The second PIP evaluated was the HealthCare USA approach to the Statewide PIP "Improving Oral Health." This study is a non-clinical project clearly focused on improving members' health care. The decision to choose this study topic was supported by information provided regarding the Managed Care Statewide PIP combined report documentation. The MCHP personalized their rationale in the

topic justification to explain how it is pertinent to their members. The study topic discussion was complete and focused on the needs and circumstances relevant to MCHP members. Regional and national information was utilized from a literature review. This information presented evidence validating the need to improve Annual Dental Visits. The MCHP presented convincing evidence that this is an important area of concern.

Study Question

The specific study questions presented are:

- Statewide – "Will providing the proposed interventions to MO HealthNet Managed Care eligible members from the ages of 2 through 20 years old increase the number of children who receive an annual dental visit by 3% between HEDIS 2010 (data from calendar year 2009) and HEDIS 2011 (data from calendar year 2010)?"

The narrative points out that the 3% increase in the Annual Dental Visit total rates will be measured both as an aggregate of all MCHPs, as well as for each MCHP individually, as part of the statewide PIP initiative.

- The MCHP specific question is: "Will member and provider reminders and education improve the HEDIS rate of annual dental visits as evidenced by a 3% increase in 2011 HEDIS annual dental visits?"

This question is focused and related to HCUSA members.

Study Indicators

The indicator is presented and explained in the narrative in a clear and concise manner. It is concentrated on the HEDIS rates which are quantifiable and measureable. It draws a relationship between the interventions, their association with the study question, and the likelihood that a positive impact will occur. The numerator and denominator are provided.

Study Population

The study population will consist of all MCHP eligible members from the ages of 2

through 20 in the measurement year. No one is excluded.

Study Design

The study design presented all of the data to be collected and the methodology to be used. All of the information in the study design is captured in the prospective data analysis plan. Claims data is received from the subcontractor DentaQuest. This data is then loaded automatically into the Coventry Data Warehouse. It is sent through a series of system set-up controls and quality controls to ensure data accuracy. The narrative explains how the HEDIS Annual Dental Visit rate is calculated for the entire population, how this is loaded into NCQA certified software, with oversight by IT specialists. The HEDIS outcome reports are produced by a Coventry HEDIS team. Additional details, including the CPT codes to be queried, are provided. The informationprovides clear evidence that the MCHP is producing valid and reliable data. The MCHP does point out that their baseline data does not follow the HEDIS "allowable gap" criteria. It believes that all members in the managed care population should be educated on proper dental care. This section also states that the progress of each intervention will be tracked and updated on a quarterly basis. Coventry developed a new analysis tool in 2010 that allows the MCHP to review, analyze, and compare monthly HEDIS rates in order to monitor progress, identify barriers, and implement enhanced interventions sooner. All team members, their responsibilities, and qualifications are described in detail.

Improvement Strategies

The MCHP specific interventions implemented include:

- Floating Dentists (dentists who agree to rotate through rural areas);
- Partnering with Community Advocates and Events;
- Collaboration with schools/nurses; and
- After hours/weekend scheduling.

How these interventions are implemented, measured, and distributed in the MCHP was explained. The MCHP used a detailed barrier analysis to assist in determining the interventions that were applicable, and how these interventions will be utilized to overcome barriers.

Data Analysis and Interpretation of Results

The findings and an analysis of those findings were well presented in the documentation submitted. The MCHP 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 analyzed statewide outcomes. The information provided discussed the validity of the interventions. The data supporting the improvements in the HEDIS rates was understandable. This information was analyzed, in the manner presented in the prospective data analysis plan. The MCHP did achieve their 3% improvement rate in each region, as well as cumulatively on a statewide basis. The MCHP points out that it will continue the improvement strategies that were successful. In addition, the MCHP continues to pursue ways to get more of their membership to comply with obtaining annual dental visits. The MCHP intends to produce enhanced provider education, institute member reminder postcards, and to engage dental clinics to schedule appointments specifically for members.

Assessment of Improvement Process

The MCHP argues that real improvement is dependent upon continued education and a change in member behavior. They are committed to

continuing to provide educational efforts for this purpose. They have devised new interventions to enhance the improvements already achieved. Although this project has only one baseline and one remeasurement period, they believe the improvement experienced is real improvement. They can relate their interventions to the improvement in HEDIS rates. They plan to continue to improve on these efforts. They plan to continue the analysis process to create a stronger correlation between these activities and the ADV HEDIS rates. Sustained improvement cannot yet be determined.

Conclusion

The MCHP describes the criteria they will use to make the PIP a success in future measurement years. This is a well-constructed PIP. It is considered to have moderate confidence in the reported results. This is based on the amount of time the PIP has been in place, not on the quality of the documentation provided.

CONCLUSIONS

QUALITY OF CARE

Both PIPs seek to improve the quality of services delivered to members. The non-clinical PIP seeks to improve the rate of annual dental visits. The MCHP has experienced success with the interventions developed and hopes they will continue to positively impact member behavior. The focus of the clinical PIP was clearly targeted on improving the quality of health care for members by ensuring where and when care is provided. The MCHP recognizes that members who obtain care from their PCP are more likely to receive preventive care and screenings. The MCHP's goal is to help members access the most appropriate level of care at the right time in the right place.

Access to Care

The clinical PIP, focuses on decreasing the use of inappropriate ED visits. It has a specific focus on access to care. The study sought to ensure that members receive health care from their PCP at the time it is needed. Providing education on how to develop a medical home improves access to care for members. The non-clinical PIP was based on the theory that improving availability and access to dental care will improve the overall health of the members served. The documentation supplied supports that these PIPs will improve access to services. The documentation also details the importance of improving access as it relates to improved member care.

Timeliness of Care

The services and interventions used in the clinical PIP, Decreasing Non-Emergent/Avoidable Emergence Department Utilization, had the specific outcome of improving the timeliness of appropriate services for any member. In this PIP the areas of access, quality, and timeliness of care were of the utmost importance. The outcomes were positive although not consistent. This spurred the MCHP to continue this PIP with new and enhanced interventions for the 2011 calendar year. Timely access to care was an important focus of this project. The non-clinical PIP, Improving Oral Health, considered timeliness in looking at the members obtaining dental screenings yearly. The narrative discussed how the interventions employed would improve the members' awareness of the need for annual screenings, and how the improvement processes utilized reduces barriers to obtaining these services.

Recommendations

1. PIPs should look for identified opportunities for improvement and capitalize on these to develop improvement strategies. Narrative information, responding to the requirements of the PIP protocols was well developed and should be continued.

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 MCHP should continue to address how their projects are extended to and pertinent to all managed care regions served. Projects involving HEDIS measures assist in this as rates are provided for each Region. Analysis of the regional differences would benefit the project.
4. The MCHP indicates that the processes described in both PIPs are to be incorporated into the regular agency processes. This is an important aspect of the PIP process and should occur to ensure that improvement strategies continue.

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 February 16, 2011. The EQRO reviewed documentation between February 16, 2011 and June 30, 2011. 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 2010 data reporting year
- HealthcareData.com LLC's Compliance Audit Report for HEDIS 2010
- HCUSA's information systems policies and procedures with regard to calculation of HEDIS 2010 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 2010 Data Submission Tool
- HEDIS 2010 product work plan

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

- HCUSA-Central_ADV_enrl.txt
- HCUSA-COMBINED_ADV_Den.txt
- HCUSA-COMBINED_FUH_Den.txt
- HCUSA-COMBINED_FUH_enrl.txt
- HCUSA-Eastern_ADV_enrl.txt
- HCUSA-Western_ADV_enrl.txt
- HUCSA-COMBINED_AWC_Den.txt
- HUCSA-COMBINED_AWC_enrl.txt

The numerator file submitted by HCUSA for the ADV measure did not contain valid service dates.

INTERVIEWS

The EQRO conducted on-site interviews at HCUSA in St. Louis on Tuesday, June 28, 2011 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 2010 performance measures.

FINDINGS

All three of the HEDIS 2010 measures being reviewed (Annual Dental Visit, Adolescent Well Care 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. Although

numeric values were provided in the service date field, the data proved to be invalid service dates. This prohibited the EQRO from validating this measure; however, a modified "validation" was performed to provide data for comparison.

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 2010 Annual Dental Visit measure reported by HCUSA to the SMA and the State Public Health Agency (SPHA) was 41.87%. This was **significantly higher** than the statewide rate for all MCHPs (39.03%, z = 0.85; 95% CI: 36.50%, 47.24%; $p > .95$). This rate has trended upward or remained steady over the past four EQR report years: from 32.23% in 2007 to 36.93% in 2008 to 36.37% in 2009 to 41.87% in 2010 (see Table 48 and Figure 32).

The reported Adolescent Well-Care Visit rate was 42.07%; this is comparable to the statewide rate for all MCHPs (41.31%; z = 0.44, 95% CI: 38.41%, 45.73%; n.s.). This reported rate is **higher** than the rates reported in each of the last three HEDIS review years (36.37% in 2007, 39.10% in 2008, and 38.19% in 2009; see Table 48 and Figure 32).

The 7-day rate reported for the Follow-Up After Hospitalization for Mental Illness measure by HCUSA was 48.41%, which is comparable to the statewide rate for all MCHPs (45.47%; z = 0.68, 95% CI: 40.82%, 56.01%; n.s.). This rate was also **higher** than the rates reported by the MCHP during the last periods this measure was audited in HEDIS 2006, 2007, and 2009 (29.04%, 27.35%, and 43.80% respectively; see Table 48 and Figure 32).

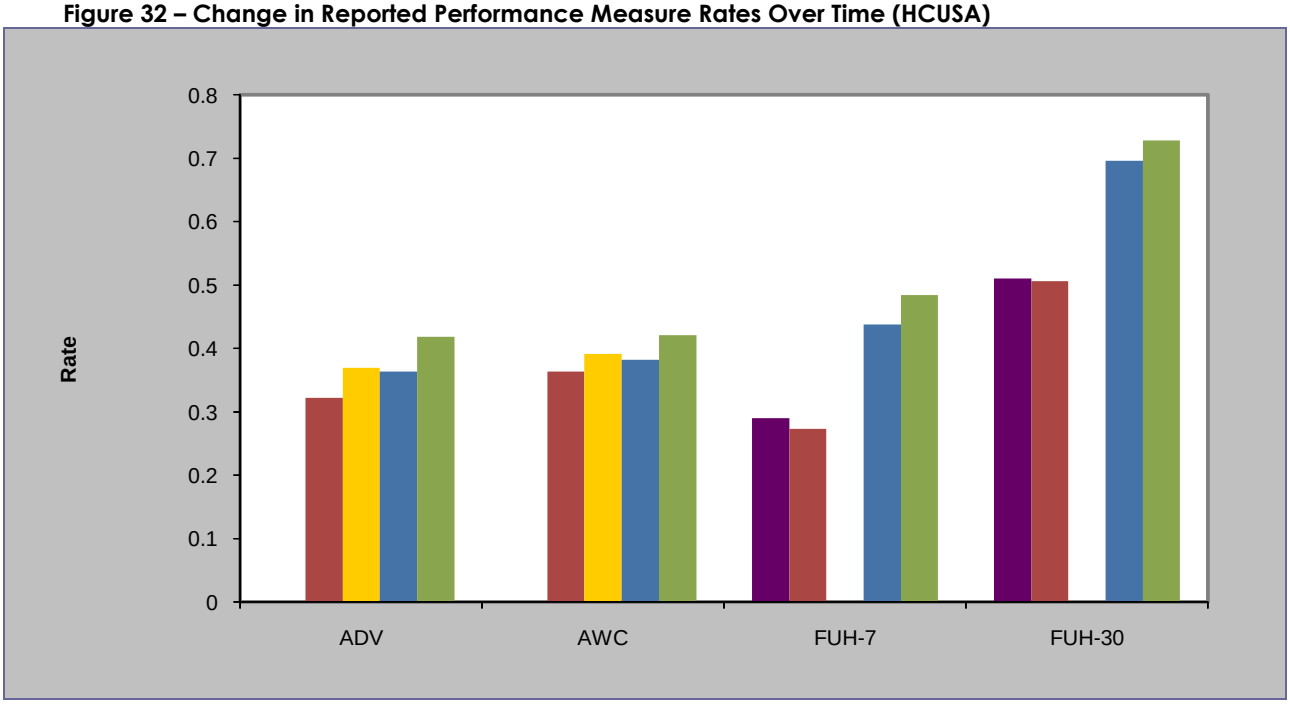
The Follow-Up After Hospitalization for Mental Illness measure 30-day rate reported by the MCHP (72.84%) was also comparable to the statewide rate (69.50%; z = 3.23, 95% CI: 65.24%, 80.43%; n.s.). This rate has also continued to trend upward overall, from 51.03% in 2006 to 50.58% in 2007 to 69.62% in 2009 to 72.84% in 2010 (see Table 48 and Figure 32).

Table 48 – Reported Performance Measures Rates Across Audit Years (HCUSA)

Measure	HEDIS 2006 Rate	HEDIS 2007 Rate	HEDIS 2008 Rate	HEDIS 2009 Rate	HEDIS 2010 Rate
Annual Dental Visit (ADV)	NA	32.23%	36.93%	36.37%	41.87%
Adolescent Well-Care Visits (AWC)	NA	36.37%	39.10%	38.19%	42.07%
Follow-Up After Hospitalization for Mental Illness – 7-day (FUH7)	29.04%	27.35%	NA	43.80%	48.41%
Follow-Up After Hospitalization for Mental Illness – 30-day (FUH30)	51.03%	50.58%	NA	69.62%	72.84%

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

Figure 32 – Change in Reported Performance Measure Rates Over Time (HCUSA)



Sources: BHC, Inc. 2006-2010 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 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. There were no biases or errors found in the manner in which HCUSA transferred data into the repository used for calculating the HEDIS 2010 measures.

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. 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. 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 105,068 eligible members reported and validated for the denominator of the Annual Dental Visit measure.

A total of 37,585 eligible members were reported and validated for the Adolescent Well-Care Visits measure.

A total of 1,134 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 of the measures were calculated using the Administrative Method (ADV, AWC, and FUH). 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 2010 Technical Specifications. No medical record reviews were necessary.

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 and the final audit for this rating is Not Valid.

As requested by the SMA, a modified validation procedure was performed (assuming valid service dates) to provide a basis for comparison. HCUSA reported a total of 43,995 administrative hits for the Annual Dental Visit measure; under the modifided validation, all of these hits were validated by the EQRO. This resulted in both a reported and "validated" rate of 41.87% with no bias present.

For the HEDIS 2010 Adolescent Well-Care Visits measure, there were a total of 15,811 administrative hits reported and 15,490 hits found. This indicates a reported rate of 42.07% and a validated rate of 41.21%, showing a bias (overestimate) of the rate of 0.85% by the MCHP.

The number of administrative hits reported for the 7-day rate for the HEDIS 2010 Follow-Up After Hospitalization for Mental Illness measure was 549; the EQRO found 538. This resulted in a reported rate of 48.41% and a validated rate of 47.44%. This represents a bias (overestimate) of 0.97% for this measure.

The Follow-Up After Hospitalization for Mental Illness 30-day calculation showed 826 reported hits; of these, the EQRO was able to validate 820 of them. This yielded a reported rate of 72.84% and a validated rate of 72.31%, an overestimated bias of 0.53%.

Submission of Measures to the State

HCUSA submitted the Data Submission Tool (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 49, the MCHP overestimated the Adolescent Well-Care Visits and Follow-Up After Hospitalization for Mental Illness measures. No bias was observed in the Annual Dental Visit measure.

Table 49 - Estimate of Bias in Reporting of HCUSA HEDIS 2010 Measures

Measure	Estimate of Bias	Direction of Estimate
Annual Dental Visit	No bias	N/A
Adolescent Well-Care Visits	0.85%	Overestimate
Follow-Up After Hospitalization for Mental Illness (7-day)	0.97%	Overestimate
Follow-Up After Hospitalization for Mental Illness (30-day)	0.53%	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 50). 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 and Adolescent Well-Care Visits measures were overestimated, but still fell within the confidence intervals reported by the MCHP. Therefore, these measures were determined to be Substantially Compliant.

Table 50 - Final Audit Rating for HCUSA Performance Measures

Measure	Final Audit Rating
Annual Dental Visit	Not Valid
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 MCHP. 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 Managed Care Members qualified for the measure.

CONCLUSIONS

Two of the three of the MCHP's performance measure reported rates (AWC and FUH) were consistent with the average for all MCHPs; the remaining rate (ADV) was **higher** than the average.

QUALITY OF CARE

HCUSA's calculation of the HEDIS 2010 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 MCHPs. The MCHP's members are receiving the quality of care for this measure

consistent with the care delivered to all other Managed Care members. Both the 7-day and 30-day rates were above National Medicaid Averages and below the National Commercial Averages for this measure.

The MCHP'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 continue

to rise from the rates reported by the MCHP during the audit of the HEDIS 2006, 2007, and 2009 measurement years, indicating a continuing improvement in the quality of services received by members.

ACCESS TO CARE

The Annual Dental Visit measure was determined to be Not Valid due to missing data needed by the EQRO; however, the SMA requested that the EQRO calculate the measure as if the missing service dates had been found to be within range. If valid service dates were supplied this measure would have been fully compliant with specifications. This measure is categorized as an Access/Availability 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 MCHPs.

This rate was **higher** than the rates reported by the MCHP during the 2007, 2008, and 2009 reports. This shows that HCUSA members are receiving more dental services than in the past. The MCHP'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 Managed Care members. This rate was below the National Medicaid Average for this measure; the MCHP's members are receiving a **lower** access to care than the average National Medicaid member.

Due to missing service dates, 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 MCHP's calculation of the HEDIS 2010 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 MCHP's reported rate for this measure was consistent with the average for all MCHPs. The rate was **higher** than the rates reported in the 2007, 2008, and 2009 reporting years.

HCUSA's members are receiving the timeliness of care for this measure consistent with the care delivered to all other Managed Care members. However, this rate was **lower** than both the National Medicaid and National Commercial averages for this measure. The MCHP's members are receiving a **lower** timeliness of care than the average Medicaid or Commercial member across the nation.

RECOMMENDATIONS

1. The MCHP should utilize the Hybrid methodology for calculating rates when allowed by the specifications.
2. Continue to conduct and document statistical comparisons on rates from year to year.
3. Work to increase rates for the Annual Dental Visit and Adolescent Well-Care Visit measures; although they were consistent with the average for all MCHPs, they were at or below the National Medicaid averages.
4. 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, and will allow the EQRO to conduct a full analysis.

9.3 MCHP Compliance with Managed Care Regulations

METHODS

Prior to the site visit, documentation was received and reviewed regarding the 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 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 MCHP Interviews occurred with Case Management Staff, Grievance and Appeals 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 and Grievance and Appeals 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 and Grievance/Appeals staff were generated by the cases reviewed as well as the review of MCHP policy. Interviews queried staff in an effort to ensure that all pertinent elements of the federal regulations were addressed in the MCHP 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 HealthCare USA Annual Evaluation Report and the SMA's Quality Improvement Strategy.

Document Review

The MO HealthNet Division supplied:

- State of Missouri Contract Compliance Tool (including MHD responses and comments)
- HealthCare USA Annual Evaluation Report (2010)

The following documents were requested for on-site review:

- Member Handbook
- Provider Handbook
- 2010Marketing Plan and Materials
- Case Management Policy
- Grievance and Appeals Policy
- Quality Improvement Committee Meeting Minutes - 2010

Additional documentation made available by HealthCare USA 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

FINDINGS

Enrollee Rights and Protections

A strong commitment to member rights continues to be a cornerstone of HealthCare USA's service philosophy. The emphasis placed on continuous quality improvement by the MCHP 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. HealthCare USA views cultural diversity as an essential component of their interactions with members. The MCHP maintains cultural diversity as a

cornerstone of initial and ongoing staff training. HealthCare USA 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 MCHP's approach to their work and to their interactions with members.

HealthCare USA 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.

HealthCare USA is making efforts to leverage community relations in all three Managed Care regions. They work with the FQHCs in these regions and have developed a number of special projects. The MCHP is working with LINC in the Western 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 Managed Care Central Region to address issues specific to the rural population. One example is that HealthCare USA providers are conducting dental screening at community based activities.

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Case managers and the social worker, physically located, 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 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 MCHP does have case management staff located in all three Managed Care regions. They utilize the Health Risk Assessment received through the SMA as much as possible. The MCHP 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 HealthCare USA continues to make a concerted effort to improve their compliance in this area. The MCHP 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.

Table 51 – Subpart C: Enrollee Rights and Protections Yearly Comparison (HealthCare USA)

Federal Regulation	HealthCare USA		
	2008	2009	20010
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 MCHPs (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 MCHP, in collaboration with MHNet, its BHO, reports making a concerted effort to offer adequate case management services between the two agencies. HealthCare USA reports that having a MHNet liaison on-site has improved coordination of care issues.

Access Standards

HealthCare USA continues to work with both members and providers to ensure proper access to services is available. The MCHP maintains a large provider network throughout all three 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 MCHP does authorize the use of out-of-network providers when this will best meet a member's healthcare needs.

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 MCHP. 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.

The rating regarding Compliance with Access Standards regulations is (76.5%). Health Care USA submitted required policy and procedures to the SMA for their approval.

- In reviewing records and interviewing staff full evidence of assessments and treatment planning for members was not available.

These findings are detailed more specifically in the Special Project, Section 4 of this report. During the on-site review the commitment to good case management practice was observed by the staff involved.

Table 52 – Subpart D: Quality Assessment and Performance Improvement: Access Standards Yearly Comparison (HealthCare USA)

Federal Regulation	HealthCare USA		
	2008	2009	2010
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	1
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	13
Number Partially Met	0	0	4
Number Not Met	0	0	0
Rate Met	100.0%	100.0%	76.5%

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 MCHPs (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

The MCHP 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 when required, appropriate corrective action is prescribed.

On-site reviews continued to be conducted by Provider Relations staff during 2010 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 MCHP 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 MCHP reviews areas related to member safety and cleanliness, which reflect the majority of issues. Some delegated credentialing occurs with larger providers.

HealthCare USA's provider advisory group is operational in all three 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 MCHP 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 fourth year.

Table 53 – Subpart D: Quality Assessment and Performance Improvement: Structure and Operation Standards Yearly Comparison (HealthCare USA)

Federal Regulation	HealthCare USA		
	2008	2009	2010
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 MCHPs (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

HealthCare USA continues to have a well-developed internal written quality assessment and improvement program. The MCHP 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. 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 MCHP maintained a record of activities, recommendations, accomplishments, and follow-up.

The MCHP did report data for Validating Performance Measures, which is validated in the appropriate section of this report.

- One Performance Measure could not be validated as the data was submitted erroneously.
- This was the second consecutive year that a Performance Measure was not submitted correctly.

The details of this audit are located in the appropriate section of this report.

The MCHP did submit clinical and non-clinical Performance Improvement Projects. The details of the audit are located in the appropriate section of this report. HealthCare USA continues to operate a health information system that meets required standards.

Ratings for compliance with Measurement and Improvement regulations (90.90%) reflect the completion of all policy and procedures in this area. This is the second year that this rating reflects the MCHPs inability to submit all data for validation of Performance Measures in the correct format. The MCHP did submit the remainder of required data in requested formats, allowing the proper validation processes to occur.

Table 54 – Subpart D: Quality Assessment and Performance Improvement: Measurement and Improvement Yearly Comparison (HealthCare USA)

Federal Regulation	HealthCare USA		
	2008	2009	2010
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	1	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	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 MC+ Managed Care Program. This percent is calculated for the regulations that are applicable to the MC+ Managed Care Program. 0 = Not Met; 1= Partially Met ; 2 = Met
Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient MCHPs (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 (88.9%) indicate that the MCHP completed most of the requirements regarding policy and practice. This is the first in six years that the MCHP is not fully compliant in this section of the review.

The EQRO reviewed grievance and appeals files while on-site at HealthCare USA, in St. Louis, MO on Tuesday, June 28 and Thursday, June 30, 2011. The EQRO

Project Director, Amy McCurry Schwartz, read 35 files and completed an analysis tool for each file reviewed. These files were reviewed for compliance with Federal Regulations and the MCHP's State Contract. The table below summarizes the findings of this file review.

Table 55 – Compliance File Review, HCUSA

MCHP	# of records reviewed	# with issue	% with issues	% Correct
HCUSA	35	4	11.43%	88.57%

The specific issues identified by the Project Director's file review included:

- No acknowledgement of a grievance letter sent (2 files)
- Letter doesn't meet language level requirements for member correspondence (plain language was not used in medical description) (2 files)

Although not counted as contract or regulation issues, the EQR Project Director observed several letters sent to members and providers that contained numerous typographical errors and grammar issues. Additionally, although not specifically attributable to this MCHP, it is noted that the mandatory language required by the State of Missouri in all Notice of Action letters is considered confusing by the EQRO. The language contained in the clause related to the member's right to "Continuation of Services" and the requirement to list all legal aid offices in the State of Missouri and not the one specific to the member's address both serve to make the letter confusing. In fact, in this MCHP's letters the addition of all legal aid offices caused all Notice of Action letters to be three pages in length with a long break between the last two pages.

Case Management and Administrative 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 member services staff tries to assist them so the member is aware of 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, i.e. a provider complaint, the staff advises them of the importance of filing a grievance.

Table 56 – Subpart F: Grievance Systems Yearly Comparison (HealthCare USA)

Federal Regulation	HealthCare USA		
	2008	2009	2010
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	1
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	1
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	16
Number Partially Met	0	0	2
Number Not Met	0	0	0
Rate Met	100%	100%	88.9%

Note: 0 = Not Met; 1= Partially Met; 2 = Met
Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient MCHPs (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

HealthCare USA continues 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 MCHP maintained improvements to achieve 100% compliance in two sections of the protocol for the fifth year.

The MCHP 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 Managed Care contract and federal regulations.

However, a few issues were identified during this year's review, including:

- Missing treatment plans and assessments from Case Management files.
- Incomplete data submission for the Validation of Performance Measure: Annual Dental Visit
- Missing or incorrect information included in responses to Grievances and/or Appeals.

QUALITY OF CARE

The staff at HealthCare USA 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 MCHP 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.

However, the EQRO did not receive documentation of all the quality services described by MCHP staff. By not providing complete case management files, the EQRO could not validate that case management was being delivered when appropriate or to the degree required by the Managed Care contract

Access to Care

HealthCare USA 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 MCHP 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 HealthCare USA, 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

HealthCare USA 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. HealthCare USA 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 MCHP recognizes the importance of timely and adequate services.

RECOMMENDATIONS

1. Make every effort to supply the EQRO with all relevant information for every case file, grievance file, policy or procedure requested. The lack of information that was provided to the reviewers explains many of HCUSA's **lower** rates in this year's review.
2. Provide all requested Performance Measure information in the format requested by the EQRO.
3. Retain the focus on complying with documentation requirements to the same standards as those reflected in the daily practice within the MCHP.
4. Continue to track policies and other materials required for annual review.
5. 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.
6. Maintain involvement in community-based services and activities.
7. The EQRO recommends that the SMA examine the "Mandatory Language" required in each MCHP's member handbook for compliance with all Federal Regualtions.
8. The EQRO recommends that the SMA examine the "Mandatory Language" contained in each Notice of Action letter (specifically in the "Continuation of Benefits" clause and Legal Aid office listings) and make changes as to ensure less confusion.
9. Continue training efforts with front line staff to ensure that they are versed in MCHP policy and procedures and remain confident in their interactions with and advocacy for members. Be sure that staff who are responsible for written communication with members display an attention to detail so that those letters represent the quality of HCUSA's service delivery.

10.0 Missouri Care MCHP

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10.1 Performance Improvement Projects

METHODS

Document Review

Missouri Care supplied the following documentation for review:

- Increased Use of Controller Medication for Members with Persistent Asthma
- Statewide Performance Improvement Project – Improving Oral Health

Interviews

Interviews were conducted with the project leaders for each Performance Improvement Project (PIP) by the EQRO team on June 23, 2011, during the on-site review, and included the following:

- Karen Holt – Accreditation and Quality Management
- Christina Schmidl – Quality Coordinator
- Dena Jennings – Quality Nurse Consultant
- Shaunda Hamilton—Quality Analyst
- Mark Kapp – Quality Project Manager, NCQA
- Stephanie Householder, Quality Audit Consultant

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 as requested by the MCHP.

The PIPs submitted for validation did contain significant information to allow for

evaluation prior to the on-site review. The MCHP was instructed during the site visit that they could submit additional data that included updates to the outcomes of the interventions or additional data analysis. Additional information was received for these PIPs.

FINDINGS

Clinical PIP – Increased Use of Controller Medication for Members with Persistent Asthma

Study Topic

The first PIP evaluated was, "Increased Use of Controller Medication for Members with Persistent Asthma." This PIP is a clinical project. The introductory information explained that the MCHP recognized a decrease in their 2009 HEDIS rates regarding asthma treatment issues. They researched possible causal factors and possible ameliorating factors. The study topic was well constructed. It was based on a previous PIP, current research, and the MCHP's intention to re-evaluate causes and interventions for members with asthma. Clearly stated information, including a national literature review, helped to construct the argument for pursing this Performance Improvement Project. The PIP is focused on decreasing adverse events for members with asthma. The review of previous efforts, which led to a need to reassess the approach to correct a deficiency in member services, was based on the data in a previous PIP and the current HEDIS measures.

Study Question

The PIP sought to answer the following study question: "Has incorporating focused member and provider education regarding managing asthma symptoms, triggers, and environmental control increased member medication compliance and understanding of their disease process?" The MCHP will look at members being prescribed, and obtaining inhaled corticosteroid prescriptions. The quantitative data, as specified for the Use of Appropriate Medications for

People with Asthma (ASM) HEDIS technical specifications, will provide the results.

Study Indicators

Three quantifiable measures, or indicators, will be used to evaluate the effectiveness of the proposed interventions. These measure are:

- The percentage of enrolled members 5 – 50 years of age during the measurement year, who were identified as having persistent asthma and who filled a controller medication during the measurement year;
- The percentage of enrolled member 5 – 11 years of age during the measurement year who were identified as having persistent asthma and who filled a controller medication during the measurement year; and
- The percentage of enrolled members 12 – 50 years of age during the measurement year who were identified as having persistent asthma and who filled a controller medication during the measurement year.

These indicators are explained, they included a definition of the numerators and denominators. The narrative also included an explanation of changes that occurred in the HEDIS population definitions in 2010. The indicators define the goal of encouraging members to correctly use controller medications. Correctly using controller medications should have a positive effect on avoidance of emergency department visits, or other acute encounters that indicate inadequate asthma management. This is strongly associated with improved member health status.

Due to the changes made to the ASM measure a direct comparison with the previous year's ASM HEDIS rates is not possible. Therefore the MCHP will use HEDIS 2010 (calendar year 2009 data) for baseline data for Indicators 1 – 3, and will continue to measure their impact annually.

Study Population

The study population, all members with asthma ages 5 – 50, 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.

Study Design and Data Collection Procedures

The study design clearly identified the data to be collected and the sources of this data. The QNXT and the encounter and claims systems are the primary source of information for data collection. The State of Missouri's pharmacy system will be queried. The data elements are determined by the HEDIS technical specifications. Each indicator will provide data consisting of the measurement period, the numerator, the denominator, and the rate. The MCHP explains that they can make some assumptions concerning the collection of valid and reliable data. They must assume that providers correctly bill all services, use correct and standard CPT codes, and all data transfers for pharmacy claims from the state vendor are captured appropriately into QNXT.

How the HEDIS data is captured and validated through their vendor is included. Through the means explained in the narrative, it can be assumed that the MCHP is making every effort to collect and provide valid and reliable data. The data is available through Catalyst Technologies software. The PIP team obtains the data and updates the PIP. Instruments used and the methodology employed by the team were explained in detail. Current data is reviewed monthly to monitor the effectiveness of the interventions, based on rate trends throughout the year.

A prospective data analysis plan was described, including all planned analysis and a prospective look at the definition of success of the intervention. The confidence level in all data obtained and evaluated was discussed. The MCHP 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.

Improvement Strategies

The proposed improvement strategies to begin in 2010 included:

- Member letters and asthma flyers – A new letter and enclosing the Asthma flyer. This will be mailed on a quarterly basis to members identified as having asthma;
- Phone calls to members with follow-up by QM Nurse – The QM nurse will call all members identified with asthma who are not filling prescriptions for an inhaled corticosteroid. They will provide education and answer questions;
- Provider rosters – Continued intervention with a new letter from the MCHP's Chief Medical Officer encouraging providers to assess the appropriateness of their patients for an inhaled corticosteroid. This is a quarterly mailing; and
- Disease Management Newsletters – these are sent to all members

identified with asthma on a quarterly basis.

The MCHP reassessed the interventions employed from 2006 – 2009, these had originally shown success in a previous PIP that was completed. After moving to delivering services on a statewide basis and with the addition of counties in the Central Region, the MCHP reassessed their approach. They chose to modify the original interventions and implemented focused member and provider education regarding managing asthma. The interventions chosen were stated clearly. Although this is a multi-tiered approach, the MCHP believes that this holistic method will have a concentrated impact of the targeted population.

Data Analysis and Interpretation of Results

The analysis started with assessing their findings in accordance with their prospective data analysis plan. The numerator and denominator were provided for each indicator. The analysis included a quantitative and qualitative approach. The MCHP observed that the baseline data indicated significant room for improvement for all three indicators. They felt that this information alone provided objective information that enhanced the focus of their PIP. All figures are labeled clearly. The information presented is enhanced by the narrative included. The first remeasurement period, calendar year 2010, indicated a statistically significant improvement in the HEDIS measure for Indicators 1 and 3.

The MCHP undertook additional research. It identified problems for improving Indicator 2, which measures the use of the asthma medications by age group 12-50. They learned that adolescents, in particular, do not adhere to their self-care regimens. Their research concluded that most of those interviewed believed that compliance with prescribed medication was extremely important but formed that belief after having a negative experience. This assisted with barrier analysis and in developing the next steps for this project.

Assessment of Improvement Process

The MCHP believes that the outcome of this PIP does indicate real improvement. They compared results and used multiple methods to analyze their data. They do not believe their efforts to create change in member behavior are complete, but they are going in the correct direction and are making progress.

Conclusion

The MCHP will continue to measure the impact of their enhanced practices on a yearly basis. They will assess progress and make the changes needed to continue showing improvement. This process provides a high degree of confidence that this PIP is successful, although it needs to be continued to validate this assertion.

Non-Clinical PIP – Improving Oral Health

Study Topic

The second PIP evaluated was the Missouri Care approach to the Statewide PIP "Improving Oral Health." This is a non-clinical project. The decision to choose this study topic was supported by information provided in the Managed Care Statewide PIP documentation. The study topic description incorporates the documentation presented in the Statewide PIP into a discussion of its relevance to MCHP members. Information is presented about the importance of this topic to members. A literature and research review occurred and the pertinence of the information gathered to the MCHP's population is included.

The study topic presentation includes the relevant population who are members ages 2 – 20 and pregnant women. The stated goal of the PIP is to educate members on the importance of dental health to overall health. The MCHP intends to provide information to enable members to obtain necessary care. Although this is a non-clinical PIP, the narrative clearly focuses on improved

health services for members.

Study Question

The hypothesis presented was that members aged 2 – 20 and pregnant women will be more likely to schedule a dental visit after being educated about the medical risks involved from no dental prevention and wellness visits.

The study question presented was "Will providing educational interventions concerning dental hygiene and the importance of annual preventive dental visits to Missouri Care members from the ages of 2 through 20 years old and pregnant women result in a 3% increase as measured by the 2011 Annual Dental Visit (ADV) HEDIS measure as well as a decrease in the number of preventable dental-related trips to the emergency room?"

The outline of the intentions of this PIP and its goals are clearly reflected in this study question. It is somewhat complex, but is also comprehensive.

Study Indicators

The primary study indicator will be improved rates in the ADV HEDIS measure. The MCHP explains that this is actually a reflection on improving members' understanding of the importance of good oral hygiene, and obtaining regular dental care. They reflect that the effectiveness of their interventions is measured using the HEDIS ADV measure. Their explanation is direct and defines the importance of this measure. The indicator is designed to improve the process of obtaining regular oral health visits, which will improve the overall health care of members.

Study Population

The narrative clearly delineates that the focus of this PIP is on members ages 2 – 20 and pregnant women. The outcomes will be measured using the HEDIS data. The population will be captured in the most efficient manner possible using this methodology.

Study Design and Data Collection

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 lacks the complete sense of a true study design. This section is coded as "Met" because the required information is included. The study described the process used by the MCHP to extract data monthly and report quarterly. The specific elements of the HEDIS technical specifications that relate to the Annual Dental Visit measure were included. The database reports described will be generated from DentaQuest's claims processing system. This claims system and the MCHP system are to be queried. The information provided gives confidence that consistent and accurate data will occur throughout the study. Claims data for the study will be queried from the QNXT system, which is the MCHP's claims processing system. The reviewers, their qualifications, and the inter-rater 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 comprehensive prospective data analysis plan was presented. It addressed information about specific activities to occur. The success of this project is to be demonstrated through quantitative reflection about the increased service rates for the PIP, and increases in the rolling 12-month administrative data. All this information will be shared as it is available. The prospective data analysis plan provides details and insight into what outcomes the MCHP is seeking, and how it will analyze data to evaluate the success of the project.

Improvement Strategies

The interventions for 2010 include:

- Use of a Dental Van for services and outreach; and
- Show-Me Smiles collaboration.

In the first intervention the MCHP will partner with DentaQuest to provide dental services on the spot to members in areas that have few or no providers. The second intervention presented, discusses a partnership with Head Start, daycares, and preschools throughout the service area. It focuses on early education, oral health information, and handing out toothbrushes and toothpaste to each child in the program. The MCHP presentation features a fun, interactive production about oral hygiene, healthy foods, cavities, and snacks. The MCHP's goal is to have direct contact with seven thousand (7,000) children. They plan for this process to become part of their yearly outreach initiatives. Targets for activities, such as Show-Me Smiles, were indicated. The narrative did not relate identified barriers to the interventions included.

Data Analysis and Interpretation of Results

The study results were provided in the update received after the on-site review. This analysis was complete and did correspond to the data analysis plan. Although there was not a great deal of data to review, the analysis looked at factors that affect the ADV rate and included tracking and trending of the data over time. The resulting outcomes were presented.

A graph of the MCHPs annual dental visit rate from 2003 through HEDIS 2011 was presented. This indicated a significant increase, particularly from HEDIS 2009 through HEDIS 2011, which resulted in a rate of 42.15%. This exceeded the 3% goal set out in the statewide project. The percentages for the baseline year and the two re-measurement years were presented. Statistical significance testing was completed. Factors that influenced the outcomes were presented, including outside factors that may have created some improvement on their own. The validity of the data is not in question. There is some question about the direct impact of the interventions, this is explained and considered in the overall analysis.

Assessment of Improvement Process

The narrative does include an analysis of the data, and a thoughtful interpretation of the effect of the interventions implemented on the outcome. The narrative included a plan for follow-up activities and additional interpretation as new data becomes available. The assessment of the success of this PIP is somewhat limited by its on-going nature. It currently appears that the ADV rate is improving.

Conclusion

The MCHP believes additional review of the interventions should be conducted for their continued success and sustainability. The PIP is well constructed and appears to have the elements required to be a successful project.

CONCLUSIONS

QUALITY OF CARE

The issue of quality was a primary focus of the two PIPs undertaken by this MCHP. The quality of health care and the quality of life of MCHP members were both addressed in these PIPs. This MCHP looked at prior PIPs and observed that there was a decline in the HEDIS rates related to the issue of asthma. They then instituted a new PIP to impact this issue. This activity is a clear indicator that this MCHP takes member services and quality of care seriously. In both projects the MCHP stated their planned intention to incorporate these interventions into normal daily operations as the data indicates positive outcomes. Undertaking performance improvement projects that will develop into enhanced service programs 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 enhanced access to care for the MCHP members. Although each PIP approached the respective problems differently, each created a potential for improved access to appropriate services, in the least restrictive environment. Utilizing a mobile dental unit to reach underserved areas is a strong indicator of the MCHPs understanding of access as a problem, and a creative member focused approach to problem resolution.

TIMELINESS OF CARE

A major focus of these performance improvement projects was ensuring that members had timely access to care. Implementing strategies to ensure that members obtain important health care interventions in a timely manner will positively impact member health. The projects indicate that the MCHP has a commitment to assisting members in engaging in timely treatment. By working with providers to encourage patients to make timely appointments for

themselves and their children, better health care outcomes should follow.

RECOMMENDATIONS

1. Continue to utilize the protocols to develop and evaluate performance improvement studies. The quality of the studies submitted has improved. Both studies provide evidence that there was thought and consideration put into planning these studies, developing appropriate interventions, and creating a positive environment for the potential outcomes. Continue to use this process to ensure that as the studies are completed, effective data collection and analysis will occur.
2. Continue the process of looking at MCHP statistics and data to analyze the best use of resources in creating performance improvement initiatives. This internal research is clear evidence of the MCHP's commitment to quality member service.
3. Continue to utilize a creative approach to developing projects and 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 February 16, 2011. The EQRO reviewed documentation between February 16, 2011 and June 30, 2011. 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 2010
- 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

INTERVIEWS

The EQRO conducted on-site interviews with Karen Holt, Accreditation and Quality Management Manager; Christina Schmidl, Quality Coordinator; Mark Kapp, Quality Coordinator; and Tammy Weisse, HEDIS, Aetna at MO Care in Columbia, MO on Wednesday, June 22,2011. This group was responsible for the process of calculating the HEDIS 2010 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.

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 38.21%; this was comparable to the statewide rate for MCHPs (39.03%, z = 0.31; 95% CI: 32.84%, 43.58%; n.s.). This rate was a substantial **increase** over the rates reported in the 2007, 2008, and 2009 EQR report years (27.26%, 27.50%, and 27.41% respectively; see Table 57 and Figure 33).

The HEDIS 2010 rate for MO Care for the Adolescent Well-Care Visits measure was 44.21%, which was **significantly higher** than the statewide rate for all MCHPs

(41.31%; z = 0.91, 95% CI: 40.55%, 47.87%; p > .95). Although this rate is **higher** than the one reported in 2009 (43.06%), it remains **lower** than the rates reported in both 2007 and 2008 (44.91% and 49.54%, respectively; see Table 57 and Figure 33).

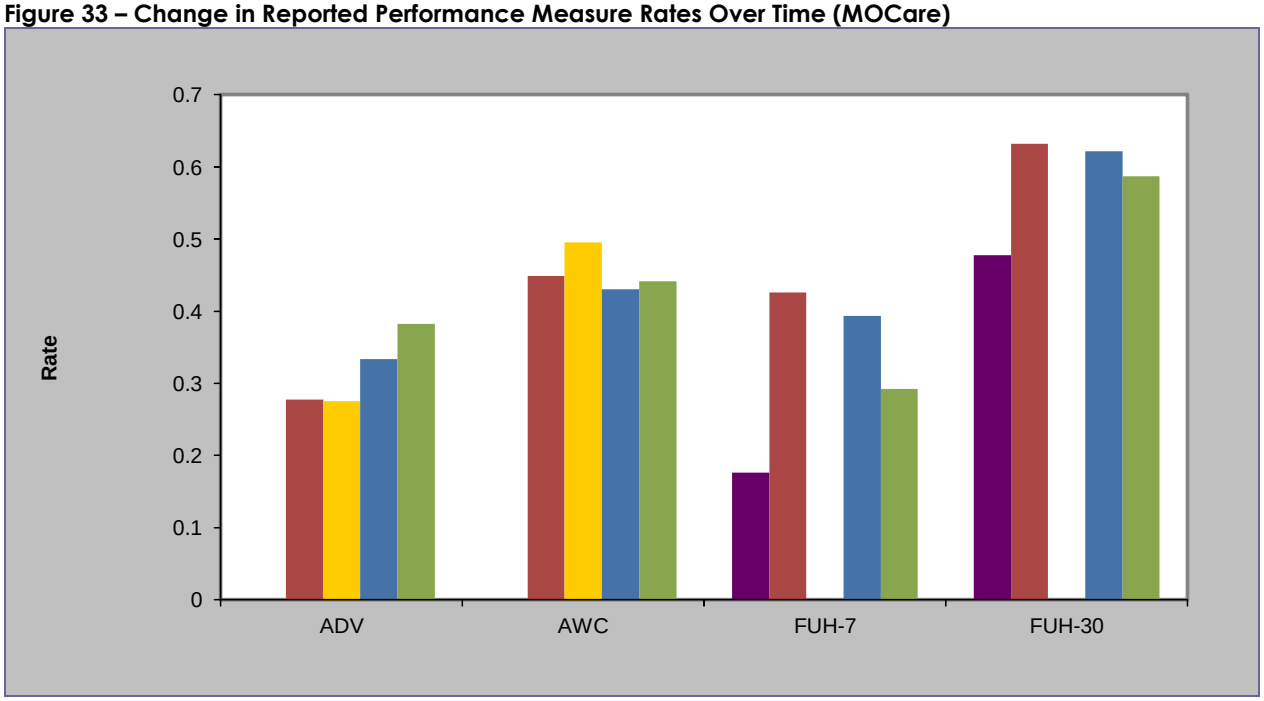
The Follow-Up After Hospitalization for Mental Illness measure 7-day rate reported to the SMA and the State Public Health Agency (SPHA) by MO Care was 29.20%. The rate reported was **significantly lower** than the statewide rate for all MCHPs (45.47%; z = -1.34, 95% CI: 21.61%, 36.80%; p < .05). The rate was **higher** than the rate of 17.65% reported in 2006, but has **decreased** from the rates reported in the 2007 and 2009 audit years (42.58% and 39.34%, respectively). The 30-day reported rate was 58.70%, which was also **significantly lower** than the statewide rate for all MCHPs (69.50%; z = 1.77, 95% CI: 51.11%, 66.30%; p < .05). This rate was **lower** than the rates reported in 2007 and 2009 (63.16% and 62.13%, respectively), but **higher** than the same rate reported for the HEDIS 2006 audit (47.79%; see Table 57 and Figure 33).

Table 57 – Reported Performance Measures Rates Across Audit Years (MOCare)

Measure	HEDIS 2006 Rate	HEDIS 2007 Rate	HEDIS 2008 Rate	HEDIS 2009 Rate	HEDIS 2010 Rate
Annual Dental Visit (ADV)	NA	27.76%	27.50%	27.41%	38.21%
Adolescent Well-Care Visits (AWC)	NA	44.91%	49.54%	43.06%	44.21%
Follow-Up After Hospitalization for Mental Illness – 7-day (FUH7)	17.65%	42.58%	NA	39.34%	29.20%
Follow-Up After Hospitalization for Mental Illness – 30-day (FUH30)	47.79%	63.16%	NA	62.13%	58.70%

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

Figure 33 – Change in Reported Performance Measure Rates Over Time (MOCare)



Sources: BHC, Inc. 2006-2010 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 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. There were no biases or errors found in the manner in which MO Care transferred data into the repository

used for calculating the HEDIS 2010 measures.

Documentation of Data and Processes

MO Care used Catalyst, an NCQA-certified software program in the calculation of the HEDIS 2010 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. 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. This involved the selection of members eligible for the services being measured.

For the HEDIS 2010 Annual Dental Visit measure, there were a total of 21,642 eligible members reported and validated by the EQRO.

For the HEDIS 2010 Adolescent Well-Care Visits measure, there were a total of 7,388 eligible members listed by the MCHP 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 2010 Follow-Up After Hospitalization for Mental Illness measure, a total of 339 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 2010 criteria. A medical record review was conducted for the Adolescent Well-Care Visit measure.

For the HEDIS 2010 Annual Dental Visit measure, the EQRO validated 8,248 of the 8,270 reported administrative hits. The MCHP's reported rate was 38.21% and the EQRO validated rate was 38.11%, showing a bias (overestimation) by the MCHP of 0.10%.

For the Adolescent Well-Care Visit measure, MO Care reported 174 administrative hits from the sample of the eligible population; the EQRO validation showed 173 hits. For the medical record review validation, the EQRO requested 17 records. A total of 17 records were received for review, and all 17 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 43.99%, while the rate reported by the MCHP was 44.21%. This represents a bias of 0.22%, an overestimate by the MCHP for this measure.

For the HEDIS 2010 Follow-Up After Hospitalization for Mental Illness measure 7-day rate, the MCHP reported 99 administrative hits from the eligible population; the EQRO was able to validate all 99 of these hits. The reported and validated rates were therefore 29.20%, with no bias.

The 30-day rate showed the reported number of administrative hits as 199; the EQRO validated 199 hits. This represents a reported rate of 58.70% as well as a validated rate of 58.70%, again showing no bias 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 Data Submission Tool (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 MCHP for these measures.

Table 58 - Estimate of Bias in Reporting of MOCare HEDIS 2010 Measures

Measure	Estimate of Bias	Direction of Estimate
Annual Dental Visit	0.10%	Overestimate
Adolescent Well-Care Visits	0.22%	Overestimate
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 for each measure. The following table summarizes Final Audit Ratings based on the Attachments and validation of numerators and denominators.

Table 59 - 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	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 MCHP. 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 Managed Care Members qualified for the measure.

CONCLUSIONS

Three rates were validated for the MCHP. The Adolescent Well-Care rate was **significantly higher** than the average for all MCHP, the Follow-Up After Hospitalization rate was **significantly lower**, and the Annual Dental rate was consistent with the average for all MCHPs.

QUALITY OF CARE

MO Care's calculation of the HEDIS 2010 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.

The MCHP's rate for this measure was **significantly lower** than the average for all MCHPs. Therefore, MO Care's members are receiving a **lower** quality of care for this measure than the average MCHP member.

Both the 7-day and 30-day rates were **lower** than both the National Medicaid and National Commercial averages; the MCHP's members are receiving a **lower** quality of care than the average Medicaid or Commercial member across the

country. Both the 7-day and 30-day rates are also **lower** than the rates reported in the HEDIS 2007 and 2009 audits, but **higher** than the 2006 rates.

Access to Care

The HEDIS 2010 Annual Dental Measure for MO Care was substantially compliant with specifications; this measure is categorized as an Access/Availability 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 MCHP for this measure was consistent with the average for all MCHPs. Therefore, MO Care's members are receiving a quality of care for this measure that is on level with the average Managed Care member. However, this rate was much **lower** than the National Medicaid rate for this same measure, indicating the MCHP's members are receiving a **lower** access to care than the average Medicaid member across the nation. This rate has continued to fall over the last three HEDIS audit years (2007, 2008, and 2009).

Timeliness of Care

The MCHP's calculation of the HEDIS 2010 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 MCHP's reported rate for this measure was **significantly higher** than the average for all MCHPs. Therefore, MO Care's members are receiving a **higher** timeliness of care for this measure than the care delivered to the average Managed Care member.

The rate was **lower** than both the National Medicaid and National Commercial averages; the MCHP's members are receiving a **lower** timeliness of care than the

average Medicaid or Commercial member across the country. The rate reported was **lower** than the rates reported by the MCHP during 2007 and 2008 review periods, but rose **higher** than the rate reported in the last (2009) review period.

RECOMMENDATIONS

1. The MCHP's rate for the Annual Dental Visit measure rose substantially from the previous three review periods. The MCHP should continue the programs implemented that have helped to reverse the previously seen downward-trend in this measure.
2. Continue to conduct and document statistical comparisons on rates from year to year.
3. Continue to participate in training of MCHP 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. The rates for both the 7-day and 30-day Follow Up After Hospitalization for Mental Illness measure were not only **significantly lower** than the average All MCHP rate, but have also continued to drop over the last several review periods. The EQRO recommends that the MCHP focus on interventions that might stop and reverse this downward trend in the FUH rate.

10.3 MCHP Compliance with Managed Care Regulations

METHODS

Prior to the site visit, documentation was received and reviewed regarding the 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 Managed Care 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 MCHP Interviews occurred with Case Management Staff, Grievance and Appeals 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 and Grievance and Appeals 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 and Grievance/Appeals staff were generated by the cases reviewed as well as the review of MCHP policy. Interviews queried staff in an effort to ensure that all pertinent elements

of the federal regulations were addressed in the MCHP 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 Missouri Care 2010 Annual Evaluation Report and the SMA's Quality Improvement Strategy.

Document Review

The MO HealthNet Division supplied:

- State of Missouri Contract Compliance Tool (including MHD responses and comments)
- Missouri Care MCHP 2010 Annual Evaluation

The following documents were requested for on-site review:

- Member Handbook
- Provider Handbook
- 2010 Marketing Plan and Materials
- Case Management Policies and Instructions
- Grievance and Appeals Policies and Procedures
- 2010 Quality Improvement Committee minutes

Additional documentation made available by Missouri Care MCHP included:

- Missouri Care Organizational Chart
- Missouri Care Provider Directory
- 2010 Member and Provider Newsletters

FINDINGS

Enrollee Rights and Protections

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.

Missouri Care continues to participate in community-based programs throughout all three Managed Care regions. They were involved in school-based health clinics whenever possible. The MCHP 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. A quarterly newsletter for school nurses was developed and continues to be distributed by the MCHP.

The rating for Enrollee Rights and Protections (100%) reflects that the MCHP 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 MCHP appears to be fully compliant with Medicaid Managed Care Contract requirements and federal regulations in this area.

Table 60 – Subpart C: Enrollee Rights and Protections Yearly Comparison (Missouri Care)

Federal Regulation	Missouri Care		
	2008	2009	2010
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 MCHPs (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

Missouri Care MCHP 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.

Missouri 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 MCHP 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.

Access Standards

The MCHP continues to work to develop new and additional resources for their members. The Missouri 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 MCHP contracts with Doral Dental. The company understands the MCHP's population. Missouri Care has a liaison from Doral who understands local needs and issues, and is able to effectively improve the local network. The Doral Dental staff responds to members needs in a timely manner. Doral Dental has also developed a strong working relationship with PCPs in the area, which is a benefit for members.

The rating regarding Compliance with Access Standards regulations is (76.5%). Missouri Care 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 was not available. During the on-site review the commitment to good case management practice was observed.

Table 61 – Subpart D: Quality Assessment and Performance Improvement: Access Standards Yearly Comparison (Missouri Care)

Federal Regulation	Missouri Care		
	2008	2009	2010
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	1
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	13
Number Partially Met	0	0	4
Number Not Met	0	0	0
Rate Met	100.0%	100.0%	76.5%

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 MCHPs (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 Missouri 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 MCHP 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.

The MCHP 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 Managed Care contract requirements and federal regulations. The MCHP 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 62 – Subpart D: Quality Assessment and Performance Improvement: Structure and Operation Standards Yearly Comparison (Missouri Care)

Federal Regulation	Missouri Care		
	2008	2009	2010
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 MCHPs (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

Missouri Care continues to operate 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 MCHP initiatives.

The MCHP 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. Missouri 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 MCHP discussed instances of fraud and abuse discovered during 2010. In most of these cases an investigation uncovered billing errors as the causal factor. The MCHP did conduct follow-up through the Provider Relations unit. The MCHP 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 Managed Care contract and the federal regulations.

Table 63 – Subpart D: Quality Assessment and Performance Improvement: Measurement and Improvement Yearly Comparison (Missouri Care)

Federal Regulation	Missouri Care		
	2008	2009	2010
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 MC+ Managed Care Program. This percent is calculated for the regulations that are applicable to the MC+ Managed Care Program.
0 = Not Met; 1= Partially Met; 2 = Met
Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient MCHPs (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 (88.9%) indicate that the MCHP completed most of the requirements regarding policy and practice. This is the first in six years that the MCHP is not fully compliant in this section of the review.

The EQRO reviewed grievance and appeals files while on-site at Missouri Care, in Columbia, MO on Wednesday, June 22, 2011. The EQRO Project Director,

Amy McCurry Schwartz, read 35 files and completed an analysis tool for each file reviewed. These files were reviewed for

compliance with Federal Regulations and the MCHP's State Contract. The table below summarizes the findings of this file review.

Table 64 – Compliance File Review, MOCare

MCHP	# of records reviewed	# with issue	% with issues	% Correct
MOCare	35	5	14.29%	85.71%

The specific issues identified by the Project Director's file review included:

- Date stamped receipt date did not match Acknowledged letter rec'd date (1 file)
- No description of reason for decision listed in letter to member, stated decision made "due to policies and procedures" (1 file)
- Timeline for acting on Grievance and providing written notice not met (2 files)
- No acknowledgement of receipt of grievance sent (1 file)

Although not specifically attributable to this MCHP, it is noted that the mandatory language required by the State of Missouri in all Notice of Action letters is considered confusing by the EQRO. The language contained in the clause related to the member's right to "Continuation of Services" and the requirement to list all legal aid offices in the State of Missouri and not the one specific to the member's address both serve to make the letter confusing.

Case Management and Administrative 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 member services staff tries to assist them so the member is aware of 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, i.e. a provider complaint, the staff advises them of the importance of filing a grievance.

Table 65 – Subpart F: Grievance Systems Yearly Comparison (Missouri Care)

Federal Regulation	Missouri Care		
	2008	2008	2010
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	1
438.404(b) Notice of Action: Content	2	2	2
438.404(c) Notice of Action: Timing	2	2	1
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	16
Number Partially Met	0	0	2
Number Not Met	0	0	0
Rate Met	100.0%	100.0%	88.9%

Note: 0 = Not Met; 1= Partially Met; 2 = Met
Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient MCHPs (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

Missouri Care continues to maintain compliance in all areas of policy, procedure, and practice required by the Managed Care contract and the federal regulations. The MCHP 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 Missouri Care exhibits a commitment to quality and integrity in their work with members. The MCHP 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. Missouri Care has created tools to educate and inform the community and providers.

However, a few issues were identified during this year's review, including:

- Missing treatment plans and assessments from Case Management files.
- Missing or incorrect information included in responses to Grievances and/or Appeals.
- Required timelines not followed in all Grievances and/or Appeals files reviewed.

QUALITY OF CARE

Quality of care is a priority for Missouri 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

Managed Care regions. Missouri 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 MCHP staff, who express enthusiasm for their roles in producing sound healthcare for their members.

However, missing assessments and treatment plans in Case Management files indicates that an improvement can be made in this area to ensure that the evidence exists to support that the quality of care received by members in Case Management matches that delivered in other areas of the organization.

Access to Care

Missouri Care has made concerted efforts to ensure that members throughout their Managed Care Regions have adequate access to care. They have recruited additional hospitals and individual providers into their network. The MCHP has participated in community events to promote preventive care and to ensure that members are aware of available services. The MCHP exhibits an awareness and commitment to resolving issues that are barriers to member services.

Timeliness of Care

Missouri 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 MCHP has engaged in a number of activities to ensure that organizational processes support the delivery of timely and quality healthcare.

Recommendations

1. Make every effort to supply the EQRO with all relevant information for every case file, grievance file, policy or procedure requested. The lack of information that was provided to the reviewers explains many of MOCare's **lower** rates in this year's review.
2. Supply training regarding contract requirements to the

Grievance/Appeals staff to ensure compliance with all timelines and content standards.

3. Continue MCHP development in the area of predictive modeling. This will drive change and create opportunities for further service development.

4. Continue monitoring access to dental care and assist in recruitment of providers throughout all Regions.
5. 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 HealthCare of Missouri 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 1, 2011 during the on-site review. Interviewees included the following:

- Tina Gallagher – Plan President
- Robert Profumo, MD – Chief Medical Officer
- Jennifer Goedeke – Director, Quality Improvement
- Christine Cybulski – Manager, Delegation Oversight
- Mary Luley – Manager, Utilization Management
- Lynn Weisner – Quality Improvement Analyst

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 as requested by the MCHP.

The PIPs presented did contain significant documentation. Additional data analysis was presented to reviewers at the time of the on-site review. This new

data was utilized in the final evaluation of these PIPs.

FINDINGS

Clinical PIP – Members at High Risk for Cesarean Wound Infection

Study Topic

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 MCHP'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. This is the second evaluation of this PIP, as a continuing and enhanced project. This 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 MCHP members. A strong argument is presented for addressing this problem. The research includes the methodology for determining the risk factors. The study topic justification was presented in a thorough and competent manner. The research review and statistical analysis supporting this decision were well presented.

The documentation presented does explain the costs associated with unnecessary hospitalizations and the costs associated with Cesarean Section Wound Infection (CSWI). 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 member health issue and a costly issue for the MCHP. The topic selection was largely generated by recognizing CSWIs as a serious health care issue for members and recognizing that this problem can be impacted by a MCHP 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 further surgical interventions," is not in the members' best interest.

Study Question

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 members at high risk of CSWI, decrease the rate of re-hospitalizations due to cesarean section wound infection?" This study question enhances the previous project. This PIP focuses on preventing re-hospitalization of members with identified high risk of CSWI. The approach builds on the success of the previous year's PIP, and shows promise for further impacting these members' healthcare in a positive manner.

Study Indicators

The MCHP defines their measurable indicators as:

1) Any Molina member admitted to the hospital with specific diagnosis codes; and
2) Members who deliver by Cesarean Section and have one or more CSWI risk factors.

The MCHP continues serving members with any CSWI risk factors. Through obstetrical case management members found to have any CSWI risk factors were identified and received additional home health visits. These additional visits focused on proper wound care, provider follow-up and antibiotics. The outcome to be measured was the rate of re-hospitalization.

Study Population

The population for the PIP included all pregnant members who received OB case management. These members receive a thorough assessment that includes an evaluation for seven (7) factors that increase the rate of CSWI. When any of these 7 factors were found, the member was considered high risk. Additional tracking and services were provided to any identified member. The

team following these members included nurses with extensive obstetrical experience. There were no identified exclusions.

Study Design and Data Collection Procedure

The documentation included a comprehensive study design. It included all the methods and type of data that would be collected. Data is available through a variety of sources. This study is designed to be all inclusive, yet reliable. Data is gathered and added any time a pregnancy is known, and it meets the criteria to be included in the study. Members who have risk factors, women having a cesarean section, and women requiring hospitalization are the main targets of the study.

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 MCHP will also utilize their claims system to ensure that all eligible members are identified. The MCHP 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. Although identifying pregnant member is not error free, all known pregnant member are entered into a HIPAA compliant data base. The MCHP is making every attempt to provide consistent and accurate data. The MCHP uses the Amisys system to track data. This data collection process has been reliable for several years.

A description of the study design and prospective data analysis plan are included in the data collection section of the MCHP's narrative. This information includes data collection and barrier analysis descriptions. All members of the MCHP team, including the team leader, are identified, including their roles and qualifications.

Improvement Strategies

The interventions and improvement strategies listed are as follows:

- Communication and advocacy between members and providers in identifying those members who have one or more of the factors that increase CSWIs;
- 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;
- Assessment of the member's educational level and understanding of proper wound care as well as signs and systems of infection;

- Identification of language barriers and provision of translation when needed for members during education on wound care;
- Assessment of the member's ability to cleanse and care for wound through demonstration;
- Provision of 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;
- Data analysis to ensure that CSWI rate is not due to individual provider or facility issues, which would require more, focused educational efforts;
- Education of Molina's Provider Services in promoting provider compliance in completing pre-natal assessment forms and returning these to Molina OBCM to identify members who are at risk for developing CSWIs;
- Informing providers, via the provider newsletter, of the purpose of this performance improvement project and the importance of notifying Molina's OBCM of members who are at risk for developing a CSWI.

Data Analysis and Interpretation of Results

This is an ongoing PIP. All data was analyzed according to the steps outlined in the data analysis plan. The analysis is thoughtful and reflects an attention to the details of the PIP. There are tables and graphs that clearly indicate what data source is included in the results. These are clear and understandable. Some of the original data presented was confusing. The additional analysis obtained at the on-site review does seem to indicate a continued downward trend. The narrative could more clearly explain the numerical outcomes presented.

The analysis did include statistical significance testing and a discussion of the overall results. In comparing the results from 2008 to 2010 there was a decrease in the total number of hospitalizations of 22%. This was not statistically significant. There are small numbers to compare, which makes achieving a statistically significant change difficult. The MCHP does identify that the number of inpatient hospital days decreased and the average length of stay associated with CSWIs

shows improvement.

In one month, during 2010, four members were hospitalized, which negatively affected the overall statistics. These four members did not have a prenatal risk assessment, receive education and/or outreach prior to the MCHP being notified of their admission to the hospital with CSWIs. Although this had a negative impact on the statistics reported, it does have the unintended consequence of validating that education and early intervention have a positive impact on the study population.

Assessment of Improvement process

Overall the MCHP has demonstrated the ability to manage the process and to maintain the number of members experiencing CSWI below the national average (1.5%) from year to year. The methodology used was the same throughout the project including the baseline and subsequent measurement years. The final report does include a more comprehensive analysis than previous submissions.

The MCHP believes this project has demonstrated that the process and activities developed for this PIP have created real improvement. By making the commitment to incorporate these activities into regular MCHP operations they will achieve sustained improvement. Although there was a slight spike in numbers for one month, these members were not enrolled in the MCHP prior to their delivery and were not engaged to the OBCM services preparing them for better post-natal outcomes. The MCHP further asserts that this validates that the assessment, education, and outreach they offer topregnant members has a positive impact on member behavior and attributes to improved health care.

Conclusion

Due to consistent data tracking, extensive outreach, and use of the Obstetrical Case Management and home health visits for education and wound assessment, the MCHP has been able to achieve results that will create sustained improvement. This will result in decreased hospitalization for CSWI. The results of the activities of this PIP have continued to improve the overall health of members during the post-partum period. This PIP provides a high degree of competency in its validity.

Non-Clinical PIP – Improving Oral Health

Study Topic

The second PIP evaluated was the Molina individual approach to the Statewide

PIP: "Improving Oral Health." This is a non-clinical project. The decision to choose the study topic was supported by information provided regarding the Managed Care Statewide PIP documentation. The narrative documented the importance of the topic and its relationship to the population

served by the MCHP. The documentation discussed the resources that might be most helpful in creating the desired outcomes. The narrative presented describes how this subject is relevant to MCHP members.

Study Question

The study question stated is "Will providing interventions to MO HealthNet Managed Care eligible members from the ages of 2 through 20 years old increase the number of children who receive an annual dental visit by 3% between HEDIS 2010 and HEDIS 2011?" The question formulates what is to occur and the desired outcome. It could be more focused on MCHP related interventions, but is acceptable.

Study Indicators

The identified indicator is the Molina HEDIS rate for Annual Dental Visits (ADV). The MCHP narrative states this clearly and concisely. It refers to the technical specifications as stated in the MCHP information. The denominator and numerator are presented. The data to be analyzed is specific and understandable. The narrative does not describe any monthly or quarterly measures to be used. The PIP presentation focuses directly on children receiving annual dental visits. How the improvement will be tracked and measured is presented. 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.

Study Population

The population to be served includes children ages 2 through 20. The PIP is designed to capture all eligible enrollees. The data to be used is explained. The system to be utilized to gather HEDIS data is defined.

Study Design and Data Collection Procedures

The study design clearly indicates the data to be collected and its sources. This

includes claims information and the specific CPT and ICD9 codes. The QNXT system and the process for obtaining and validating HEDIS rates were presented. By adhering to the HEDIS technical specification and following the study design, the MCHP produced valid and reliable data for the applicable population. The methodology to generate this rate and the data are explained in the narrative. This portion of the documentation discusses data collection within the scope of the HEDIS specifications in great detail. The MCHP used their HEDIS validated rate, which is collected systematically. This process provides confidence that the data is accurate over time. There is narrative supporting this assertion. The narrative provides information about all of the processes utilized by the MCHP to manage and analyze data. This includes obtaining information through their subcontractor, DentaQuest.

A prospective data analysis plan is presented. The names and titles of those who participate in the analysis process are included. Potential barriers to data collection were described. Controls for these issues were detailed. All PIP team members and their roles and responsibilities were presented. This included local and corporate team members.

Improvement Strategies

The PIP narrative presented a discussion of the interventions to be used to increase annual dental visits. However, they were vague and it was impossible to tell what the MCHP intended to measure or even to count as focused interventions.

Barriers to improving the rate of members obtaining annual dental visits were not presented. Assumptions were made that provider and member education would be instrumental in raising this rate. The MCHP did not describe any focused interventions to achieve this goal. For example, "education" was not defined.

Data Analysis and Interpretation of Results

The PIP narrative did present an analysis of the preliminary findings. This is presented clearly as described in the data analysis plan. The documentation calls out that this is preliminary data, as audited data was not yet available. The tables that were presented were clear and understandable. Narrative was included to explain these findings.

The information presented did not include a discussion of statistical testing. However, the initial and repeat measurement periods and the percentage of improvement are documented. There was a discussion that some complicating data existed. There was no credible explanation. The data indicates that the MCHP HEDIS rate has improved, the narrative indicates a statewide improvement of 4%, which exceeds the original goal of 3%. The narrative states, "The implementation of interventions contributed to the ADV rate increase. " There is no information or any interpretation about why this PIP was successful, or how these interventions contributed to this success. No follow-up activities were mentioned.

Assessment of Improvement Process

It is unclear, based on the information presented, whether the MCHP has attained "real" or sustained improvement. The narrative concludes that the MCHP implemented interventions and improvement strategies contributed to the improved dental rates. This is stated, but not explained. The MCHP did not include information from the HEDIS 2011 (data from calendar year 2010). They were given additional time to submit this information, but did not send any updates.

Conclusion

The design of this PIP is sound. A final assessment was not available as no additional data was received. The PIP has promise, but a final conclusion about its effectiveness is not yet possible.

CONCLUSIONS

QUALITY OF CARE

The best care in the most appropriate environment is the focus of the first PIP. The intervention methods ensure that members obtain 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 the MCHP is utilizing the PIP process to inform the organization about the most effective methods of improving and providing quality health care. The MCHP incorporated the activities leading to the 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 MCHP made an effort to improve information provided to members to assist them in obtaining annual dental visits, which will improve the members' overall health care. The MCHP did improve their reportable HEDIS rate, which they attribute to a combination of improved measurement and education to members and providers.

ACCESS TO CARE

The focus of the first PIP does address access to care. The interventions seek to ensure members have in-home services. These in-home services provide good healthcare and education, thereby improving the members' quality and access to care. Ensuring that members have access to additional services to prevent more complex and invasive treatment(s), and using an in-home method of providing these 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. The narrative lacked detail about how this was achieved.

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 prior to delivery, and increased in-home care as soon as they were home from the hospital. Appointments were made prior to the member leaving the hospital which 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. The MCHP must provide details of the interventions and link these interventions to the outcomes in order to produce a successful PIP.

2. Use monthly and quarterly measurements to ensure that interventions are effective throughout the measurement year. Continue this process to provide information on the ongoing effects of the planned program.
3. Data analysis should incorporate methods to ensure that any resulting change, or lack of change, was related to the intervention.

4. 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.
5. Narrative should be provided to defend the conclusions and defined outcomes of the study. Making a statement alone does not provide convincing evidence.

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 on or before the due date of February 16, 2011. The EQRO reviewed documentation between February 16, 2011 and June 30, 2011. 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 2010 HEDIS review year.
- Healthcare Research Associates' (HRA) HEDIS 2010 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 2010 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 Molina staff via teleconference and on-site in St. Louis, MO on Monday, June 27, 2011. Bridgeport Dental provided the Annual Dental Visit rate.

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. 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 31.66%. This was consistent with the statewide rate for MCHPs (39.03%, z = -0.67; 95% CI: 26.29%, 37.02%; n.s.). This rate is **higher** than the rates reported by the MCHP during the 2007 and 2008 reviews (30.45% and 30.53%, respectively) but **lower** than the rate (33.38%) reported in the 2009 review (see Table 66 and Figure 34).

The HEDIS 2010 rate for Molina Healthcare for the Adolescent Well-Care Visits measure was 38.12%, which was consistent with the statewide rate for all MCHPs (41.31%; z = -0.42, 95% CI: 34.46%, 41.78%; n.s.). This rate was **higher** than the rates reported by this MCHP during each of the last three review years: 29.49% in 2007, 34.83% in 2008, and 32.37% in 2009 (see Table 66 and Figure 34).

The HEDIS 2010 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 34.38%. This rate was **significantly lower** than the statewide rate for all MCHPs (45.47%; z = -0.80, 95% CI: 26.78%, 41.67%; $p < .05$). The 30-day rate reported was 60.63%, which was consistent with the statewide rate (69.50%; z = 1.97, 95% CI: 53.03%, 68.22%; n.s.).

Both the 7-day and 30-day rates were **lower** than the rates reported for HEDIS 2009 (36.95% and 61.69% respectively), but were **higher** than the rates reported in 2006 (25.30% and 49.10% respectively) and 2007 (24.68% and 46.31%, respectively; see Table 66 and Figure 34).

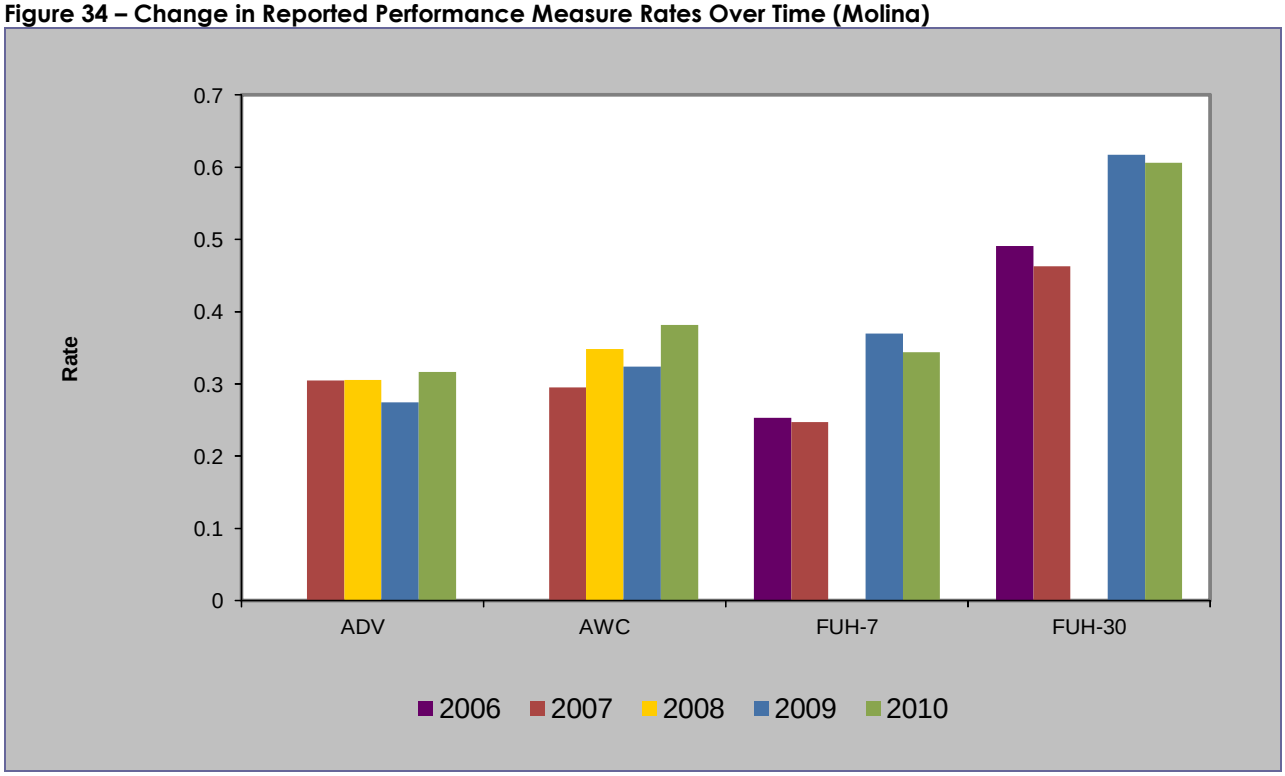
Table 66 – Reported Performance Measures Rates Across Audit Years (Molina)

Measure	HEDIS 2006 Rate	HEDIS 2007 Rate	HEDIS 2008 Rate	HEDIS 2009 Rate	HEDIS 2010 Rate
Annual Dental Visit (ADV)	NA	30.45%	30.53%	33.38%	31.66%
Adolescent Well-Care Visits (AWC)	NA	29.49%	34.83%	32.37%	38.12%
Follow-Up After Hospitalization for Mental Illness – 7-day (FUH7)	25.30%	24.68%	NA	36.95%	34.38%

Follow-Up After Hospitalization for Mental Illness – 30-day (FUH30)	49.10%	46.31%	NA	61.69%	60.63%

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

Figure 34 – Change in Reported Performance Measure Rates Over Time (Molina)



Sources: BHC, Inc. 2006-2010 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 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 . There were no biases or errors found in the manner in which Molina Healthcare transferred data into the repository used for calculating the HEDIS 2010 measures.

DOCUMENTATION OF DATA AND PROCESSES

Data and processes used for the calculation of measures were adequate . 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 . 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 2010 criteria.

A total of 40,530 eligible members were reported and validated for the Annual Dental Visit measure.

The Adolescent Well-Care Visits measure contained an eligible population of 1,359.

For the Follow-Up After Hospitalization for Mental Illness measure, a total of 160 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 2010 criteria .

The number of Annual Dental Visit hits reported by the MCHP was 12,830; the EQRO was able to validate a total of 12,815. The rate reported by the MCHP was 31.66% and the rate validated by the EQRO was 31.62%; this resulted in a 0.04% 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, 30 were received; all of these were able to be validated by the EQRO. As a result, the medical record review validated all 104 hybrid hits reported. The MCHP reported 414 administrative hits; of these, the EQRO was able to validate all 414. Thus, the rate validated by the EQRO and the rate reported by the MCHP were the same at 38.12%, representing no bias in the rate.

The Follow-Up After Hospitalization for Mental Illness measure 7-day rate contained a total of 55 administrative numerator events reported, of which all were able to be validated by the EQRO. Thus, the 7-day rates reported and validated were both 34.38%, showing no bias.

The 30-day rate showed reported administrative hits of 97; again, the EQRO was able to validate all hits. This yields a reported and validated rate of 60.63% with no bias evident in the rate.

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 Data Submission Tool (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. One measure was slightly overestimated, but these results still fell within the 95% confidence interval reported by the MCHP. The other two measures showed no bias in the rates.

Table 67 - Estimate of Bias in Reporting of Molina HEDIS 2010 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)	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 summarized in the Final Performance Measure Validation Worksheet for each measure.

Table 68 - Final Audit Rating for Molina Performance Measures

Measure	Final Audit Rating
Annual Dental Visit	Substantially Compliant
Adolescent Well-Care Visits	Fully 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 MCHP. 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 Managed Care Members qualified for the measure.

CONCLUSIONS

Three rates were validated for the MCHP. Two of these rates (ADV and AWC) were consistent with and one rate (FUH) was **significantly lower** than the average for all MCHPs.

QUALITY OF CARE

Molina Healthcare's calculation of the HEDIS 2010 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.

Molina's 7-day rate for this measure was **significantly lower** than the average for all MCHPs, while the 30-day rate was consistent with the average. This indicates the members are receiving a **lower** quality of care in the 7-day timeframe than the average member, but a quality consistent with the average member in the 30-day timeframe. The 7-day rate was **lower** than both the National Medicaid and National Commercial averages; the MCHP'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 MCHP'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.

Both rates have dropped **lower** than the rates reported for the same measure in 2009, indicating the quality of care to members has **decreased** in the past year. However, these rates are still **higher** than the rates reported in the 2006 and 2007 review years.

ACCESS TO CARE

Molina Healthcare's calculation for the HEDIS 2010 Annual Dental Visit measure was substantially complaint with specifications; this measure is categorized as an Access/Availability 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 MCHPs.

Molina's members are receiving access to care that is consistent with the access available to the average Managed Care member. This rate was **higher** than the rates reported by the MCHP during the 2007 and 2008 EQR audits. However, the rate was **lower** than the rate reported in the 2009 review period. The rate was also **lower** than the National Medicaid average rate, indicating the MCHP's members are receiving **lower** access to care than the average Medicaid member across the country.

TIMELINESS OF CARE

Molina Healthcare's calculation of the HEDIS 2010 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. Molina's reported rate for this measure was consistent with the average for all MCHPs.

Therefore, Molina's members are receiving a similar timeliness of care for this measure as the average MCHP member. This rate was **higher** than the rate reported in the last three review periods (2007, 2008, and 2009). However, the rate was below both the National Medicaid and National Commercial averages; the MCHP's members are receiving a **lower** timeliness of care than the average Medicaid or Commercial member across the nation.

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 MCHP's rates for both timeframes of the Follow-Up After Hospitalization for Mental Illness measure were **lower** than the previously audited rates. The MCHP should explore the possible reasons for this **decrease** to ensure the rates will not continue to decline.
4. Work to **increase** rates for all measures; although most measures were consistent with the average for all MCHPs, they were below the National Medicaid averages.

5. 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.

11.3 MCHP Compliance with Managed Care Regulations

METHODS

Prior to the site visit, documentation was received and reviewed regarding the 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 Managed Care 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 MCHP. 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 MCHP Case Management policy. Interviews queried staff in an effort to ensure that all pertinent elements of the federal regulations were addressed in the MCHP 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 HealthCare of Missouri's 2010 Annual Evaluation and the SMA's Quality Improvement Strategy.

DOCUMENT REVIEW

The following documents pertaining to Molina HealthCare of Missouri 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)
- Molina HealthCare of Missouri Annual Evaluation FY 2010

The following documents were requested and reviewed on-site:

- Member Handbook
- 2010 Marketing Plan and Materials
- Provider Handbook
- 2010 Quality Improvement Committee minutes
- Case Management Policy
- Grievance and Appeals Policies

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 MCHP is moving toward NCQA accreditation and indicated a significant change in quality focus.

FINDINGS

Enrollee Rights and Protections

Molina HealthCare of Missouri 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 MCHP 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.

Training is regularly provided to ensure that the Molina HealthCare of Missouri staff is knowledgeable about members' rights and responsibilities. Staff is also given self-help materials to utilize in their daily activities.

The rating for Enrollee Rights and Protections (100.0%), reflects a maintenance of this rating for the fourth consecutive year. This indicates that Molina HealthCare of Missouri 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 HealthCare of Missouri maintains a business-like approach and commitment to continued efforts in meeting all standards of policy development, submission and approval by the SMA.

Table 69 – Subpart C: Enrollee Rights and Protections Yearly Comparison (Molina HealthCare)

Federal Regulation	Molina HealthCare of Missouri		
	2008	2009	2010
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 MCHPs (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 HealthCare of Missouri for mental and behavioral health services for members. This was the fourth full year of the BHO's relationship with Molina HealthCare of Missouri. The MCHP reported no specific problems occurring in terms of members accessing services during the 2010 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.

Access Standards

Molina HealthCare of Missouri continues 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.

The MCHP 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 Health Care of Missouri has decreased the timeframes for responding to authorization requests. Tracking and trending of information occurred and is reviewed on a monthly basis.

Molina HealthCare of Missouri admits that they are continuing to work to have a complete network of specialty providers, particularly pediatric neurologists, rheumatologists, and orthopedic surgeons. The MCHP does negotiate for these services because the Provider Relations staff has developed individualized relationships with providers.

The MCHP continues to assess provider availability annually when producing their report to the Missouri Department of Insurance. The MCHP has improved the availability of 24-hour coverage by providers, as required in their Managed Care Contract. They continue monitoring activities that include review of provider telephone logs, blind telephone testing, and obtaining input directly from providers. The MCHP continues provider education.

A rating for Compliance with Access Standards (76.5%) is a **decrease** from both the 2009 and 2008 review years, where the MCHP rated 100.0% and 88.2%, respectively. Molina has 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 was not available During the on-site review the commitment to good case management practice

was observed by the staff involved

Table 70 – Subpart D: Quality Assessment and Performance Improvement: Access Standards Yearly Comparison (Molina HealthCare)

Federal Regulation	Molina HealthCare of Missouri		
	2008	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	1	2	1
438.208(c)(2) Care Coordination: Assessment	2	2	1
438.208(c)(3) Care Coordination: Treatment Plans	1	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	15	17	14
Number Partially Met	2	0	3
Number Not Met	0	0	0
Rate Met	88.2%	100.0%	76.5%

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 MCHPs (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 HealthCare of Missouri 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 MCHP 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 MCHP 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 MCHP assured that all providers maintained licensure and the right to practice in Missouri.

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 71 – Subpart D: Quality Assessment and Performance Improvement: Structure and Operation Standards Yearly Comparison (Molina HealthCare)

Federal Regulation	Molina HealthCare of Missouri		
	2008	2009	2010
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 MCHPs (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 HealthCare of Missouri continued to maintain specific practice guidelines with providers at the time of the 2010 review.

Molina HealthCare of Missouri modified their Quality Improvement Committee (QIC) structure in 2010. They developed 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.

Molina HealthCare of Missouri submitted two Performance Improvement Projects (PIPs) for validation. One of these PIPs was considered very successful, while the other was in need of some improvement. However, they both showed continued improvement in utilization of this process as a tool for MCHP growth. The MCHP 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 MCHP operations and health care services to members.

The MCHP 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 HealthCare of Missouri continued to operate a health information system within the guidelines of that protocol. 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 (100%), was an improvement over the 2009 and 2008 review years' ratings of 90.9%. This reflects an improvement in diligence toward meeting the requirements of the 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 72 – Subpart D: Quality Assessment and Performance Improvement: Measurement and Improvement Yearly Comparison (Molina HealthCare)

Federal Regulation	Molina HealthCare of Missouri		
	2008	2009	2010
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	1	1	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	10	10	11
Number Partially Met	1	1	0
Number Not Met	0	0	0
Rate Met	90.90%	90.90%	100.0%

Note: Regulation 438.240(e) refers to program review by the state. The regulation requires the state to review, at least annually, the impact and effectiveness of each MCO's quality assessment and performance improvement program. The regulation refers to the state QA & I program review process and is not applicable to External Quality Review of the MC+ Managed Care Program. This percent is calculated for the regulations that are applicable tot the MC+ Managed Care Program. 0 = Not Met; 1= Partially Met; 2 = Met
Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient MCHPs (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 (88.9%) indicate that the MCHP completed most of the requirements regarding policy and practice. This is the first in five years that the MCHP is not fully compliant in this section of the review.

The EQRO reviewed grievance and appeals files while on-site at Molina MCHP of Missouri, in St. Louis, MO on Monday, June 27 and Friday, July 1, 2011. The EQRO

Project Director, Amy McCurry Schwartz, read 30 files and completed an analysis tool for each file reviewed.

These files were reviewed for compliance with Federal Regulations and the MCHP's State Contract. The table below summarizes the findings of this file review.

Table 73 – Compliance File Review, Molina

MCHP	# of records reviewed	# with issue	% with issues	% Correct
Molina	30	6	20.00%	80.00%

The specific issues identified by the Project Director's file review included:

- No "opportunity to examine the case file" language in decision letter sent to member
  (4 files)
- No written acknowledgement of receipt of grievance sent to member (2 files)

Although not specifically attributable to this MCHP, it is noted that the mandatory language required by the State of Missouri in all Notice of Action letters is considered confusing by the EQRO. The language contained in the clause related to the member's right to "Continuation of Services" and the requirement to list all legal aid offices in the State of Missouri and not the one specific to the member's address both serve to make the letter confusing

Case Management and Administrative 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 member services staff tries to assist them so the member is aware of 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, i.e. a provider complaint, the staff advises them of the importance of filing a grievance.

Table 74 – Subpart F: Grievance Systems Yearly Comparison (Molina HealthCare)

Federal Regulation	Molina HealthCare of Missouri		
	2008	2009	2010
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	1
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	1
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	16
Number Partially Met	0	0	2
Number Not Met	0	0	0
Rate Met	100.0%	100.0%	88.9%

Note: 0 = Not Met; 1= Partially Met; 2 = Met
Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient MCHPs (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 HealthCare of Missouri was substantially compliant in all areas measured in 2008. In 2009 there was only one area that remained rated as "Partially Met." In 2010, Molina had five areas that were rated as "Partially Met." This reflects deficiencies in practice that were observed during the on-site review. Although changes and enhancements have been introduced that focus on improving services to members, and improving their quality initiatives, at the time of this year's review improvement in many areas of performance were not observed.

The specific issues were identified during this year's review, including:

- Missing treatment plans and assessments from Case Management files.
- Missing or incorrect information included in responses to Grievances and/or Appeals.

Molina HealthCare of Missouri is committed to members and to providing healthcare services in an effective manner by demonstrating an atmosphere of respect and dignity toward members. The MCHP'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.

QUALITY OF CARE

During the previous year's on-site review Molina HealthCare of Missouri exhibited an improvement in the development of policies and procedures, and an upgrade in their organization's performance. However, during the 2010 review, the commitment to these goals was evident, but many of the promised progress was not clearly seen

The MCHP 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 MCHP 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 MCHP 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 HealthCare of Missouri did make a number of changes during the past few 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 MCHP instituted a method of contacting primary care physicians for members when members experience problems obtaining appointments.

However, the EQRO did not receive documentation of all the quality services described by MCHP staff. By not providing complete case management files, the EQRO could not validate that case management was being delivered when appropriate or to the degree required by the Managed Care contract.

Timeliness of Care

An attention to the issue of timeliness of care was also evident at the MCHP. 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. Although timeliness of healthcare improved as the result of changes and expansions within the organization, there is still room for improvement in the area of grievance/appeal responses.

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 MCHP's operations.
2. Continue to develop and enhance the Quality Improvement program within the Molina HealthCare.

3. 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.
4. Continue to utilize available data and member information in order to drive, change, and measure performance.
5. Be sure to supply all available information when requested by an auditing agency, if it is not in the file, it cannot be counted as meeting the requirements.
6. Monitor the areas of Grievances and Appeals for compliance with contract timelines and letter content.