



**Evaluation of the
2013 State of Missouri
MO HealthNet Division
Quality Improvement Strategy**

**Prepared by
The State of Missouri Department of Social Services
MO HealthNet Division (Missouri Medicaid)
June 2018**

The MO HealthNet Division (MHD) Quality Improvement Strategy (QIS) is a comprehensive plan incorporating quality assurance monitoring and ongoing quality improvement processes to coordinate, assess, and continually improve the delivery of quality care and services to members of the Managed Care Organizations (MCOs) participating in MHD's Managed Care Program. The QIS provides a framework to communicate the State's vision, objectives, and monitoring strategies addressing issues of health care cost, quality, and timely access.

The QIS is developed through collaborative partnerships with members, stakeholders, other state agencies, MCOs, and community groups, with a broad commitment to ensure that:

- Quality health care services are provided to Managed Care members;
- MCOs are in compliance with Federal, State, and contract requirements; and
- A collegial process is maintained to work collaboratively with the MCOs to improve care.

Missouri's current QIS was developed in 2013 and finalized after review and comment by the Centers for Medicare and Medicaid Services (CMS) in June 2014 <https://dss.mo.gov/business-processes/managed-care/bidder-vendor-documents/quality-improvement-strategy.pdf>. This document is an evaluation of that QIS. A full description of the MHD/MCO Quality Program is found in the 2018 QIS.

Data Collection and Review Process

Data for the QIS process and measures are collected from a variety of sources and are reviewed in multiple contexts throughout the year. These include the following:

Encounter Claims

The MHD uses encounter data for rate setting and quality improvement evaluation, and conducts a complex process for assuring validity of encounter claims submitted by the MCOs. This involves using software algorithms as well as conducting a review of medical records for a random sample of claims in order to assure completeness and accuracy of submitted data.

Quarterly Data Submissions

The MCOs are required to submit quarterly data on several different topics, including member grievances and appeals, provider complaints and grievances, care management activity, disease management services, fraud, waste, and abuse investigations, claims adjudications, prior authorizations, and member customer service calls.

Annual Healthcare Quality Data submissions

An extensive amount of healthcare quality data is required to be submitted by the MCOs in June of each year for the purposes of evaluating process measures, clinical outcomes, and service utilization rates, as well as geographic access to services and member satisfaction. The data submission includes both nationally defined as well as locally developed metrics. Most measures are stratified by consistent age groups and by general medical, behavioral health, and substance use disorders. A series of graphs are

prepared, comparing and contrasting the MCOs, and are provided to the MCOs as a final validation check of these data before they are posted to the MHD website.

Healthcare Effectiveness Data and Information Set (HEDIS)

Each MCO contracts with a certified HEDIS vendor to calculate scores for a variety of HEDIS measures each year, including an annual survey of members called the Consumer Assessment of Healthcare Providers and Systems (CAHPS). Data from selected measures (as specified in the MCO contract) are provided annually to both DHSS and MHD.

MO HealthNet Audits

The MHD Behavioral Health Program collaborates with Department of Mental Health staff to conduct reviews of behavioral health services within managed care, covering a variety of indicators addressing network adequacy, utilization, timely service availability, and hospitalization follow-up, among others. The resulting data from these efforts drive program and policy decisions and assist in identifying opportunities for quality improvement.

External Quality Review Organization (EQRO)

Federal and State regulatory requirements and performance standards as they apply to MCOs are evaluated annually for the State by an independent EQRO, including measurement of quality and appropriateness of MCO care and services, synthesis of results compared to the standards, and recommendations based on the findings. For the past three years, the EQRO has also performed a Secret Shopper Survey to evaluate the accuracy of MCO online provider directories and their adherence to contractual appointment standards.

Quality Assessment & Improvement (QA&I) Advisory Group

Results from quality data analysis and evaluation activities are compiled and presented through regularly scheduled meetings of the Quality Assessment & Improvement (QA&I) Advisory Group. The QA&I Advisory Group reviews these results to identify opportunities for improvement. It may also form task forces to review specific areas for improvement and to provide input to the QA&I Advisory Group regarding actions needed.

QIS Goals & Objectives

The above data collection and review processes are utilized in evaluating the goals and objectives of the MHD Quality Strategy:

Goal 1: To optimize the use of MHD services by members.

Objectives:

- Increase the rate of well-child visits for children and adolescents by 2% annually*
- Increase the percent of enrollees with a BMI recorded within the past 2 years by 5% annually
- Increase members' behavioral health utilization annually by 2%

*Healthcare Effectiveness Data and Information Set (HEDIS) Measures

- Increase behavioral health outpatient visits annually by 2%
- Decrease behavioral health inpatient readmission rates annually by 2%
- Decrease the number of preventable hospitalizations by 2% annually
- Decrease the number of preventable asthma hospitalizations for children by 2 % annually
- Decrease the number of emergency room visits by 2% annually
- Decrease the number of emergency room asthma visits for children by 2% annually
- Increase by 2% annually members having access to behavioral health providers within the geographic distances specified in the Network Adequacy Standards until > 90 percent have access to services

Missouri's objectives for this goal focused on increasing the rates of well-child visits, decreasing emergency room (ER) visits and preventable hospitalizations, increasing utilization of mental health services, decreasing psychiatric readmissions, and assuring geographic access to behavioral health providers. Missouri sought a 2% improvement annually on the associated measures.

Goal 2: To improve the range of care provided to the MHD members.

Objectives:

- Increase the use of appropriate medications for children with asthma by 2% annually*
- Increase the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screening rate by 2% annually
- Increase the percentage of children who had the HEDIS-recommended number of vaccines by their second birthday by 2% annually*
- Increase the percentage of enrolled members age 12-21 who had at least one comprehensive well-care visit with a primary care practitioner or an OB/GYN practitioner during the measurement year by 2% annually*
- Increase 7-Day behavioral health inpatient follow-up visits by 2% annually
- Increase 30-Day behavioral health inpatient follow-up visits by 5% annually
- Increase rate of medication management for enrolled members with a diagnosis of major depression by 2% annually
- Achieve rate of effective adherence to antipsychotic medications for enrolled members diagnosed with schizophrenia by 1% annually
- Increase breast cancer screenings by 2% annually
- Increase cervical cancer screenings by 2% annually*
- Decrease the percentage of self-identified tobacco users on the CAHPS survey by 2% annually
- Decrease the percentage of enrollees receiving opioid prescriptions from more than 5 different prescribers in a 90-day period by 5% annually
- Increase the percentage of enrollees with diabetes who receive an annual hemoglobin A1c test by 3% annually*
- Increase the percentage of enrollees with diabetes who receive an annual low density lipoprotein cholesterol control (LDL-C) screening test by 3% annually*
- Increase the percentage of enrollees with diabetes who have blood pressure reading <140/90 by 3% annually*

Missouri's objectives for this goal included increasing rates for immunizations and EPSDT visits, increasing usage of medications for asthma, increasing cancer screenings for breast and cervical cancer,

increasing monitoring and preventive care for persons with diabetes, and increasing rates of follow-up after psychiatric hospitalizations. Missouri also sought to decrease the rate of tobacco usage among our MCO members, and to improve medication adherence for major depression and schizophrenia. The reference to well-care visits among 12-21 year-olds was in error, as it is already covered in Goal 1, as “Adolescent Well-Care Visits”.

Goal 3: To improve the access/availability of care provided to the MHD members.

Objectives:

- Increase the number of primary care providers enrolled in the MHD program by 2% annually
- Increase the number of children who receive annual dental visits by 3% annually*
- Increase the number of pregnant members receiving prenatal and postpartum care by 2% annually
- Increase the number of members using ambulatory care by 2% annually*
- Increase the percentage of enrollees with targeted conditions who receive case management services by 10% annually
- Increase the identification of alcohol and other drug services by 2% annually
- Increase the number of participants who self-select a primary care provider by 5% annually
- Increase by 2% annually the full time equivalent (FTE) of behavioral health providers (e.g. psychiatrists, psychologists, other behavioral health providers) per 1000 members
- Increase the number of psychiatrists accepting new patients by 2% annually
- Increase the number of psychiatric practices with appointment availability for emergent (non-life threatening) appointments within 6 hours, urgent appointments within 48 hours, and routine appointments within 10 business days, by 2% annually
- Increase the number of primary care physician (PCP) practices with appointment availability for emergent (non-life threatening) appointments within 6 hours, urgent appointments within 48 hours, and routine appointments within 10 business days, by 2% annually
- Increase the percentage of PCP practices that offer early morning, evening, and weekend appointments by 2% annually
- Increase the percent of patients who are seen within 30 minutes of their scheduled outpatient appointment time by 5% annually

Missouri’s objectives for this goal consisted of increasing the percentage of members who access ambulatory (outpatient) care, increasing dental care, increasing appropriate care for pregnant women and new mothers, increasing care management services for targeted conditions, improving access to primary care and psychiatric care services, and improving access to services for substance use disorders. Missouri also sought to increase availability of behavioral health providers and member self-selection of PCPs, as well as increase service availability through extended hours and shorter waiting times. The reference to ambulatory care above is already addressed in Goal 2 under “Outpatient and ER Utilization.”

Goal 4: Promote member satisfaction with the experience of care.

Objectives:

- Annual Case Management Satisfaction Survey shows improvement on at least 50% of the measures
- Annual CAHPS MCO Survey, Child Version* shows improvement on at least 50% of the measures

Missouri’s objectives for this goal involved improved satisfaction with the MCOs’ care management services, and on a variety of measures gathered annually through the CAHPS survey.

Findings

Goal 1: To optimize the use of MHD services by members.

The data show variable performance with regard to improving well-child visits (see Figure 1). The rate of adolescent well-child visits rose 5% between 2014-2015, and an additional 1% in 2016, to 48.53%. For children ages 3-6, the rate of well-child visits similarly increased by about 5% between 2014-2015, but then fell by more than two percentage points in 2016 (62.77%). The rate for infants ages 0-15 months who had at least six well-child visits rose by over eight percentage points between 2014-2015, declining only slightly to 57.17% in 2016.

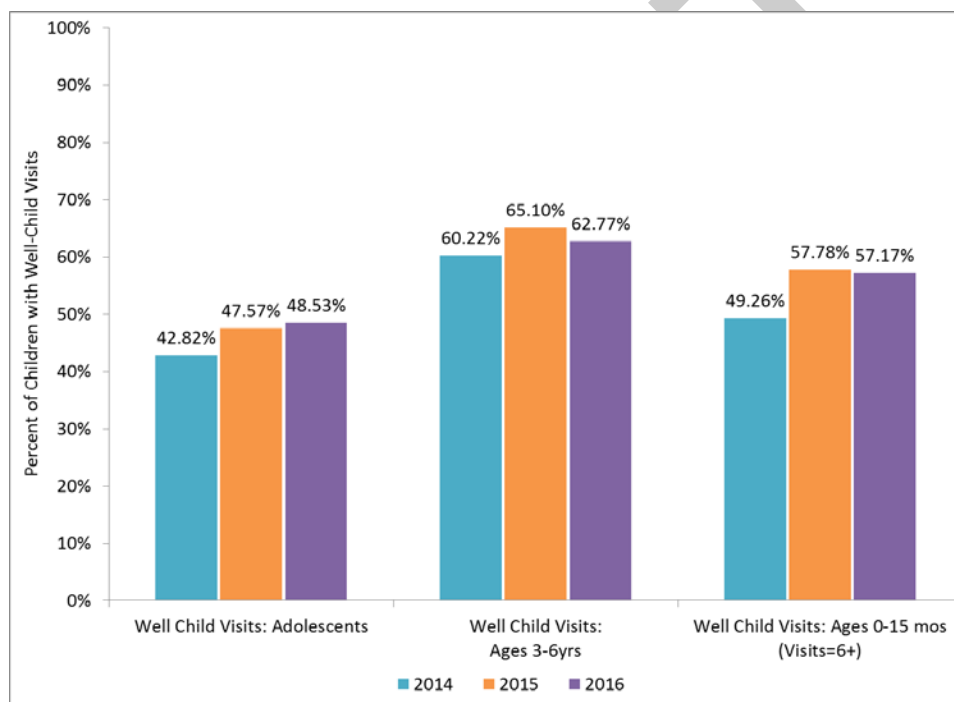


Figure 1: Well-Child Visits

The MCO providers are sufficiently distributed throughout the state and an annual measure of geographic access for 2014-2016 shows 90% of members are within the designated radius for specified service provider types for all behavioral health services, with one exception. For one region of one plan in 2016, the rate for “Ambulatory Mental Health Treatment Facilities” was at 72%. The contract for this plan ended in 2017, and it is likely that their impending exit impacted their contracts with service providers during the waning months of their MHD participation.

The percentage of plan members receiving behavioral health services vacillated slightly between 2014-2016, falling between 12%-15% each year. The goal of a 2% annual increase was met for 2016 (see Figure 2).

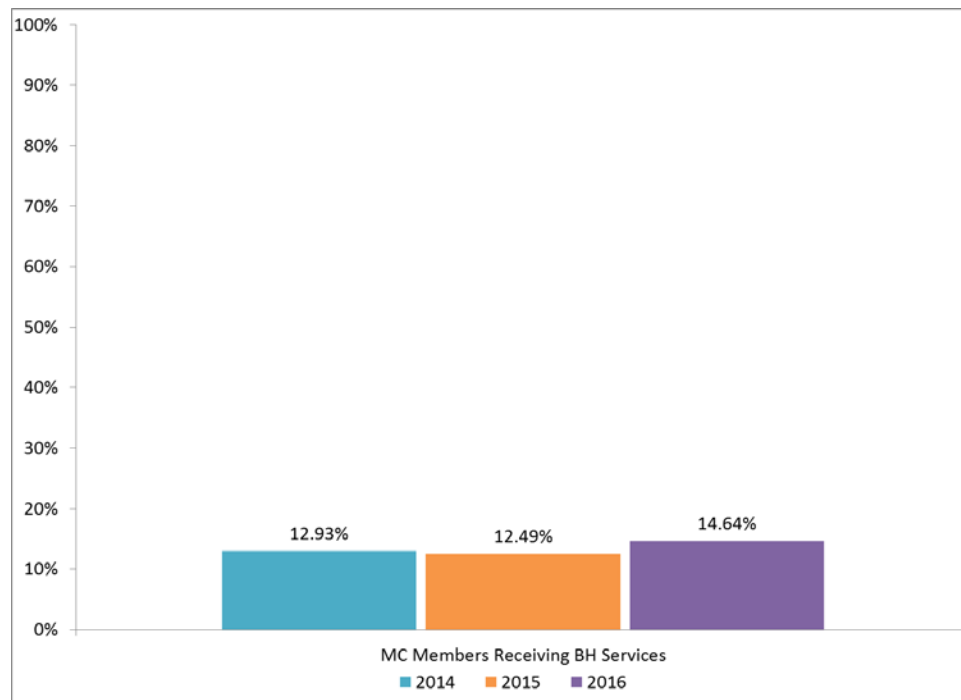


Figure 2: Behavioral Health Services Penetration Rate

Inpatient readmissions varied depending on the type of issues being treated (see Figure 3). Readmissions related to behavioral health concerns fell slightly from 2014-2015 and then increased in 2016 to 1.71 readmissions per 1,000 member months. Those for medical issues jumped significantly in 2015, and then dropped again slightly in 2016. Rates for substance use disorders are comparatively small, although show a large proportional increase, from 0.1 readmissions per 1,000 members in 2014 to 0.17 in 2016.

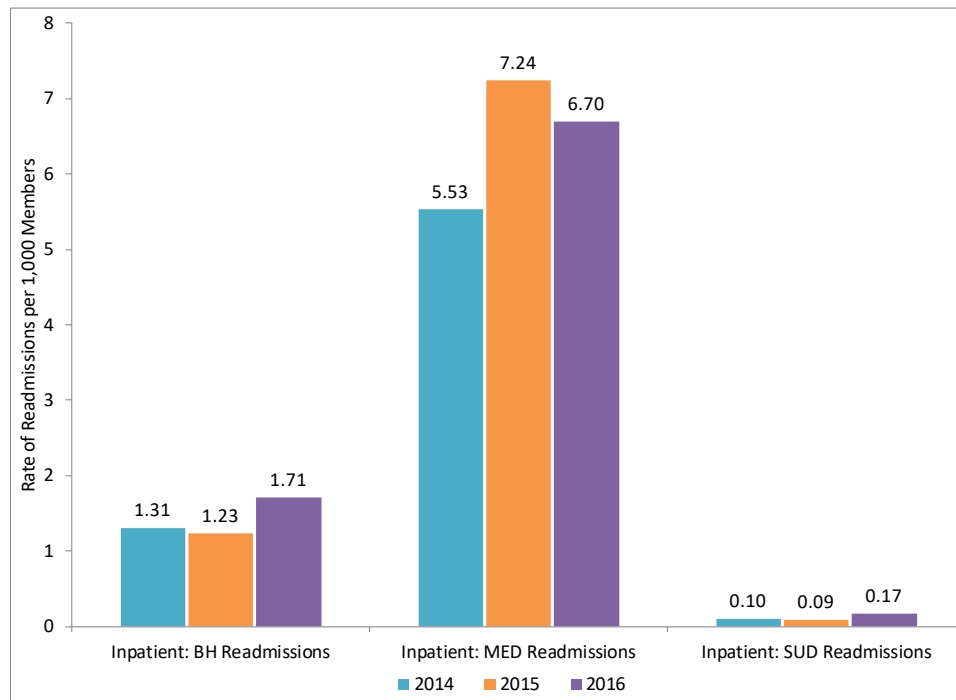


Figure 3: Inpatient Readmissions Per 1,000 Members

Preventable hospitalizations are tracked by the Department of Health and Senior Services (DHSS), although the available data are for the Medicaid program as a whole, and are not broken out by Fee-For-Service (FFS) or Managed Care. The data show that preventable hospitalizations for asthma are currently at their lowest for the last three years (4.15 per 10,000 populations for 2015), and fluctuate between 4.15 and 4.68. Overall, preventable hospitalizations show a slight increase for 2015 (from 36.88 to 38.88 per 10,000 population) after dropping slightly from 38.09 in 2013 (see Figure 4).

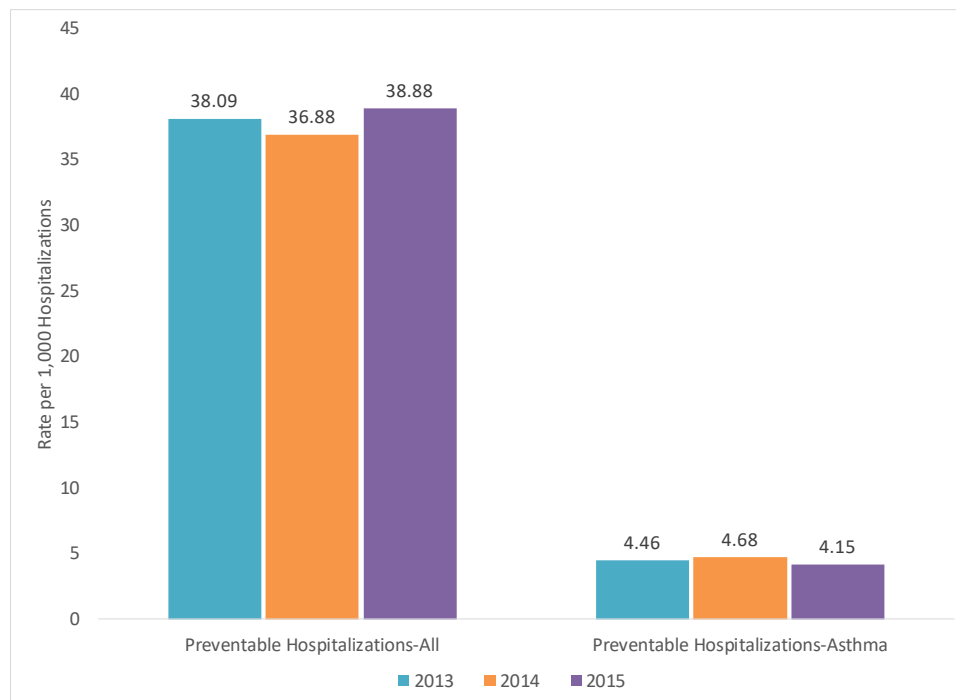


Figure 4: Preventable Hospitalizations Per 1,000 Members

While Missouri set a goal to increase the rates of enrollees with a recorded BMI, this data is not reliably reported in claims data. While there is access to EHR data for a subset of MHD members, this is a small population and mostly outside of the Managed Care Program.

Goal 2: To improve the range of care provided to the MHD members.

The data show increases in the rate of adolescent immunizations each year from 2014-2016, meeting the goal of a 2% annual increase. Conversely, immunizations for children have decreased every year since 2014 with a rate of 24.67% in 2016 (see Figure 5).

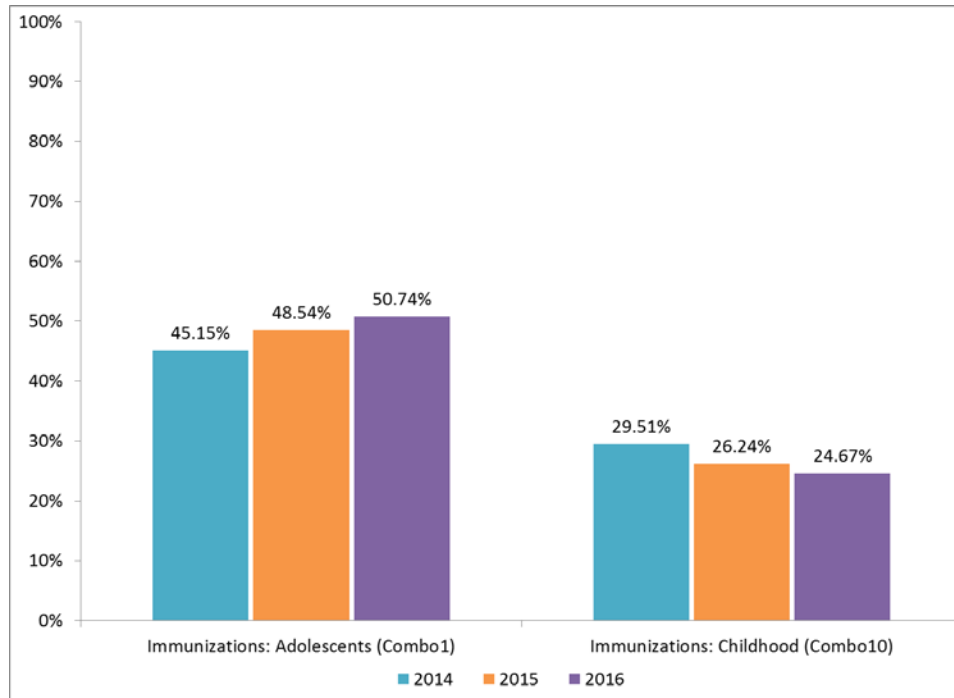


Figure 5: Immunizations for Children and Adolescents

Upon further review of our measures, we decided that EPSDT rates were too similar to the HEDIS measures of Well-Child visits to warrant separate measurement and analysis, and have removed that measure from our QIS. The HEDIS Well-Child data are discussed above with the Goal 1 measures.

The measure selected for monitoring medication usage in asthma, “Use of Appropriate Medications for Persons with Asthma”, was discontinued by the National Committee for Quality Assurance (NCQA) in 2014, but performance increased each year from 2012-2014. In 2015, two different NCQA measures that monitor medication possession ratios (MPRs) for asthma medications, using MPR cutoffs of .50 (MPR50) and .75 (MPR75). There was an increase in both measures between 2015-2016, with the MPR75 measure increasing by three percentage points (see Figure 6).

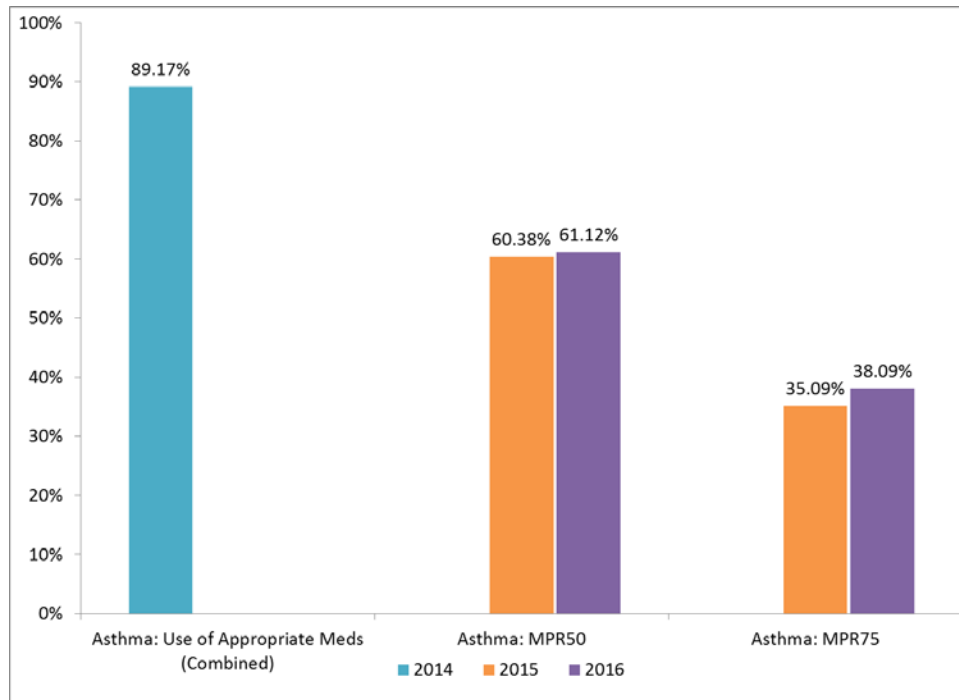


Figure 6: Asthma Medication Measures

Asthma-related ER visits for MCO members under the age of four has decreased during this review period, from a rate of 26 visits per 1,000 members in 2014 to 18.9 in 2016. A similar decrease occurred for members age 4-17 (see Figure 7).

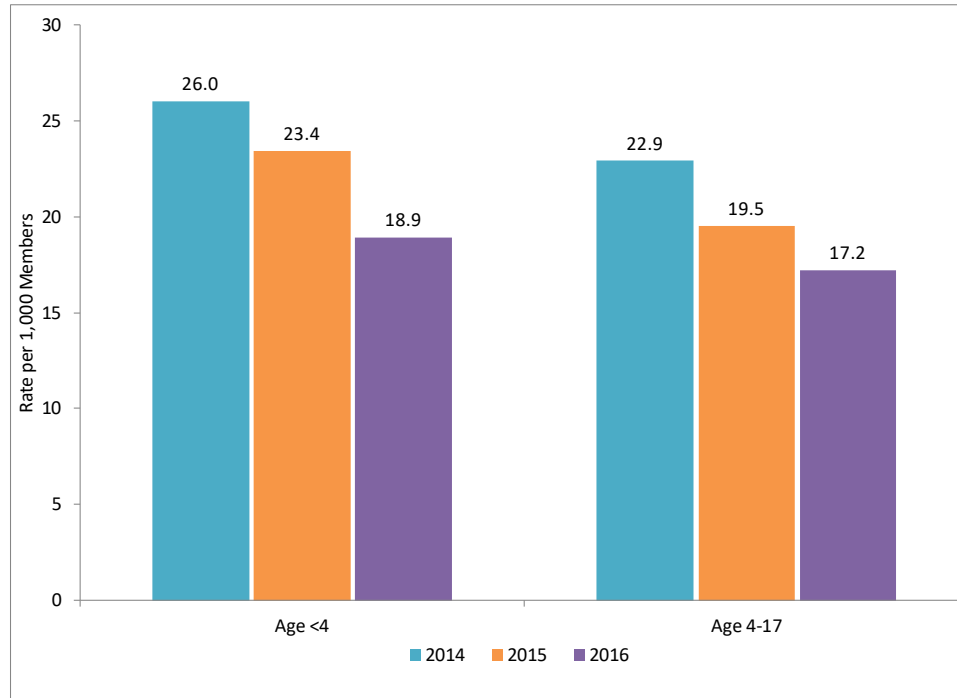


Figure 7: Asthma-Related ER Visits

Rates for cancer screenings have decreased during this review period. Cervical cancer screenings have declined from 57% in 2012 to 50% in 2016. Breast cancer rates are not reliably reported by all MCOs. The NCQA specifications for the breast cancer screening measure yields a small population for analysis (due partly to a 3-year continuous eligibility requirement with the same MCO), and results are not always reportable as a result. For this reason, these rates were calculated internally, combining all three MCOs, and using their supplied encounter claims. The results varied across the review period, increasing in the second year from 27.3% to 44.55%, and then decreasing eight points in year three to 36.46%. Chlamydia screenings have declined by about 2% each year during this review period (see Figure 8).

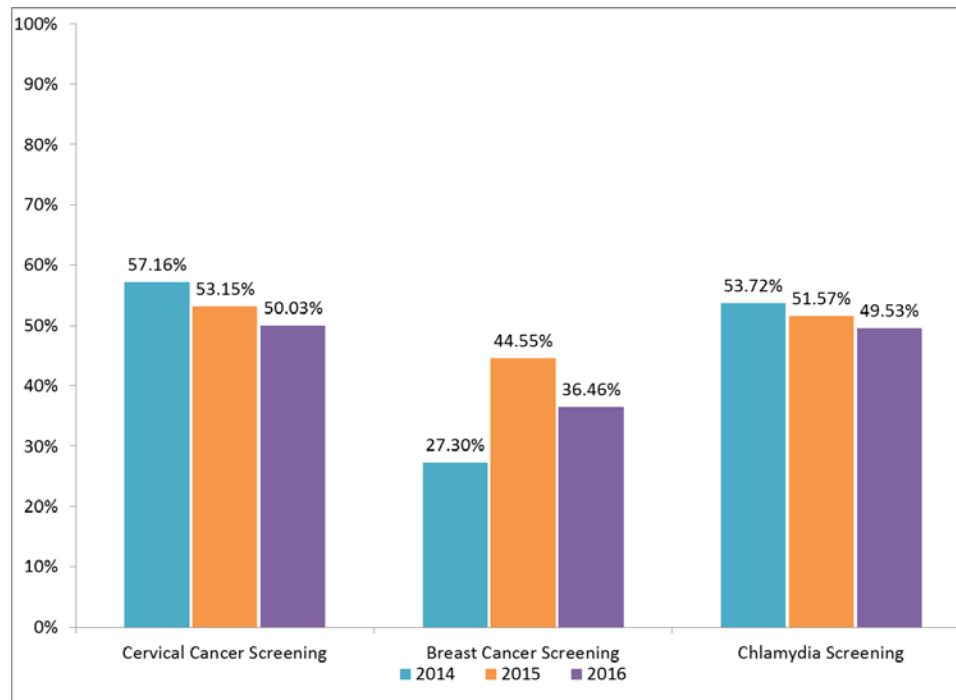


Figure 8: Women's Health Screenings

Use of opioid medications has become a serious national issue, but MHD (both Managed Care and FFS members) has been monitoring and intervening with this problem for at least the past decade. As a result, the total number of MHD participants taking opioid medications for each year from 2015-2017 has declined by 31.4% (as measured in December of each year). A similar decrease was seen in the percentage of participants receiving opioids who obtain their opioid prescriptions from five or more different providers, which was at 0.9% at the end of 2017 (see Figures 9-10). Note that these data are collected for the entire MHD population, and are not separated by Managed Care or FFS populations.

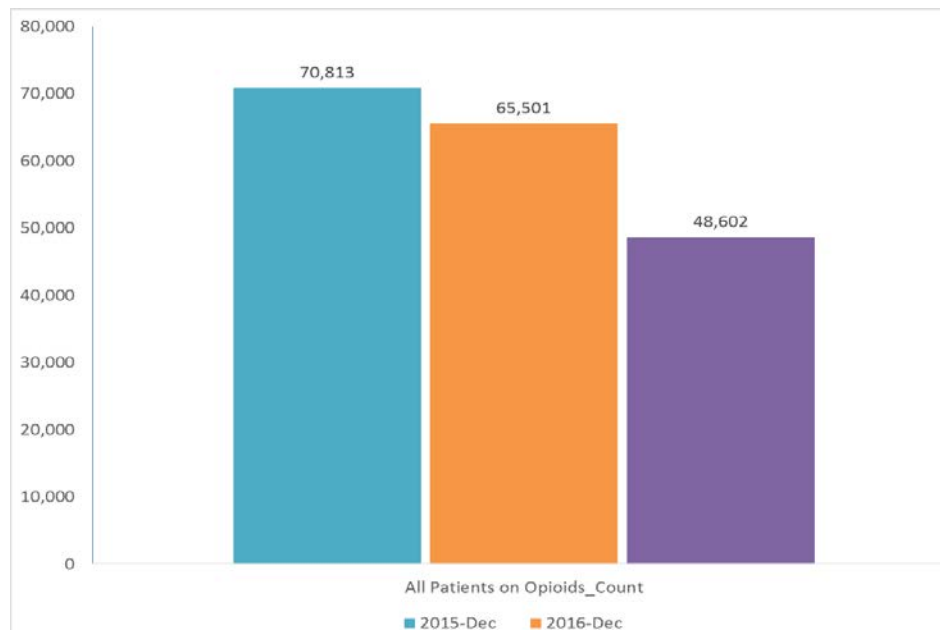


Figure 9: Use of Opioid Medications among MHD Participants

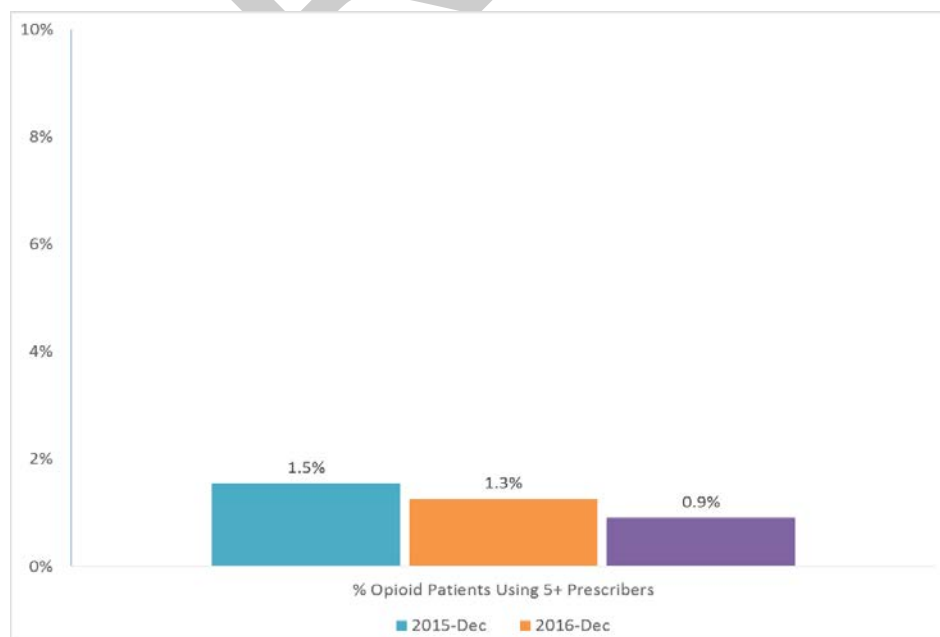


Figure 10: MHD Participants Using Multiple Prescribers for Opioid Medications

Measures of diabetes care and prevention also varied between 2014-2016 (see Figures 11-12). The rate of blood pressure control in persons with diabetes rose by nearly 11 percentage points during that time period, but remains extremely low, at just 11.92% in 2016. The rate of LDL-C control is similarly low (7.75% in 2016), although LDL-C screening was at 54.54% in 2016. Both of these measures show variability between 2014-2016, which is due to confusion about the reporting requirement for these measures. NCQA discontinued LDL-C reporting for diabetes beginning in calendar year 2015, but the MHD continued to require its reporting from the health plans. It is therefore difficult to draw a conclusion based on this information.

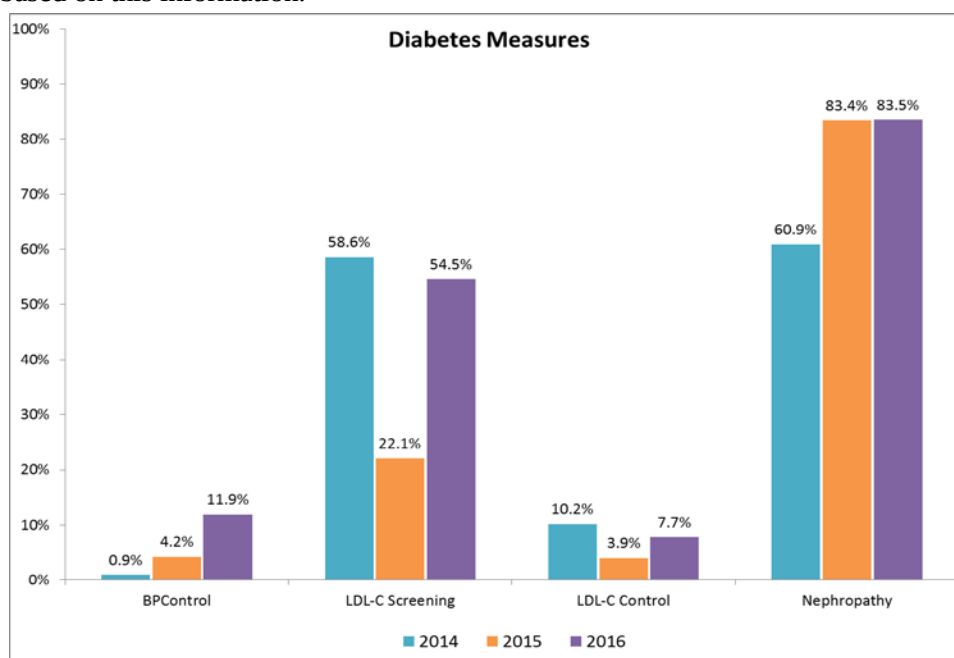


Figure 11: Care and Prevention for Members with Diabetes

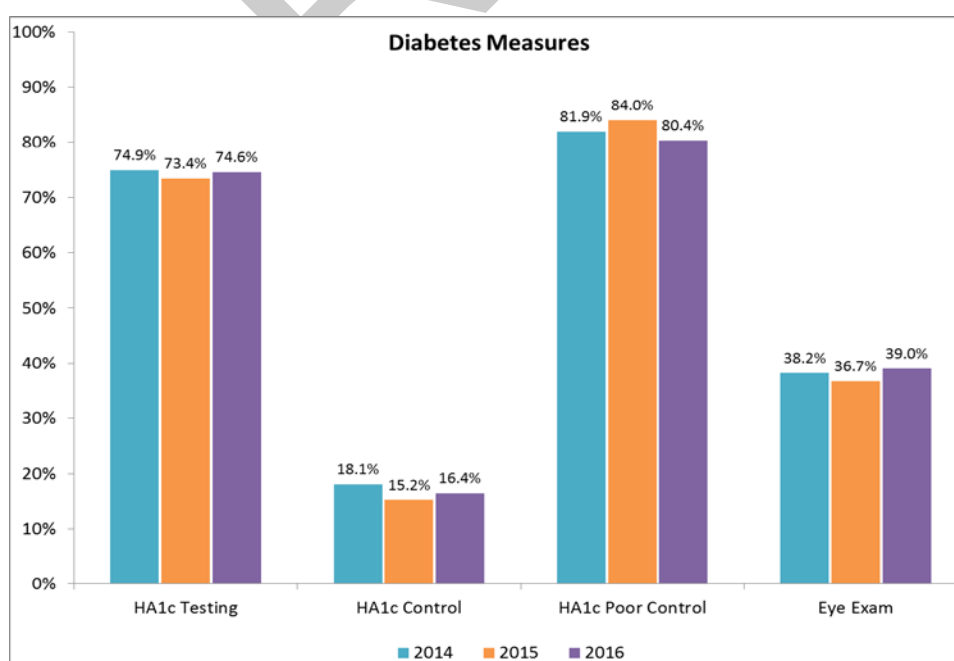


Figure 12: Care and Prevention for Members with Diabetes (cont.)

A similar pattern is seen for hemoglobin A1c screening and control, with screening rates at around 74% for 2014-2016, while control rates are between 15%-18% for all three years. Both of these measures fall below national averages. The percentage of persons with poor control of their hemoglobin A1c is high (lower rates are better for this measure), although there was an improvement of four percentage points between 2015-2016, from 84.02% to 80.38%.

Rates of screening for eye and kidney disease in members with diabetes fall at around 38% and 83%, respectively. These are slightly less than national averages, although the rate for screening of kidney disease represents a significant increase from 2014, when it was at 60.89%.

Measures of follow-up after a psychiatric hospitalization show improvement between 2014-2016, with 30-day follow-up at 60.52%, and 7-day follow-up at 39.16% in 2016 (see Figure 13).

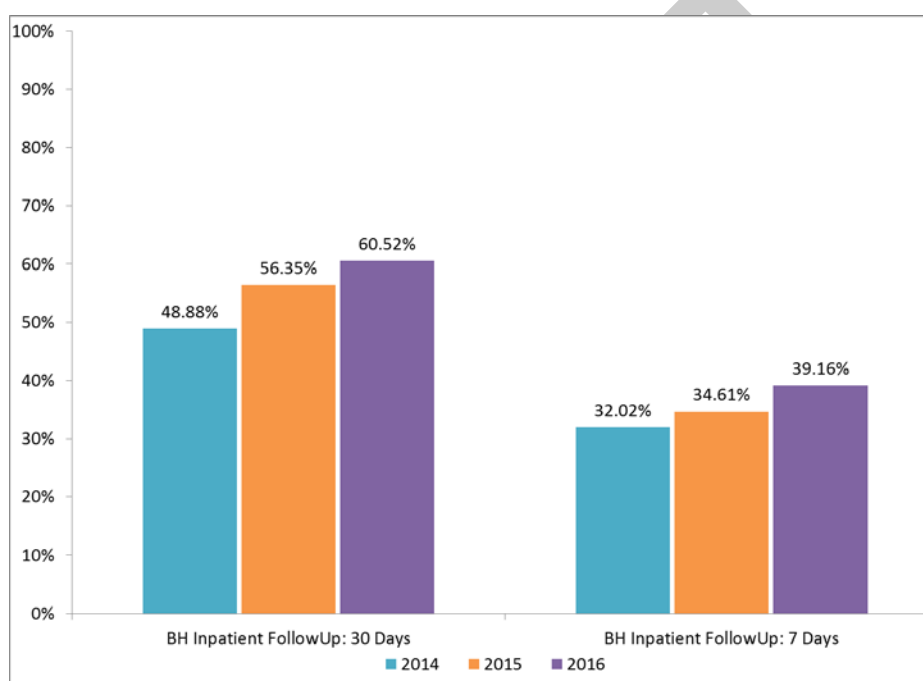


Figure 13: Follow-Up After a Psychiatric Hospitalization

Metrics examining adherence to medications for participants with major depression show a slight decrease for each year of this review period (see Figure 14). It is noted that a large number of participants discontinue their antidepressant medications after just a few weeks of use, and sooner than is desirable from an efficacy standpoint. Rates of adherence to antipsychotic medications for participants with schizophrenia dropped in 2015, but bounced back in 2016 to exactly the same percentage as 2014, 40.4%.

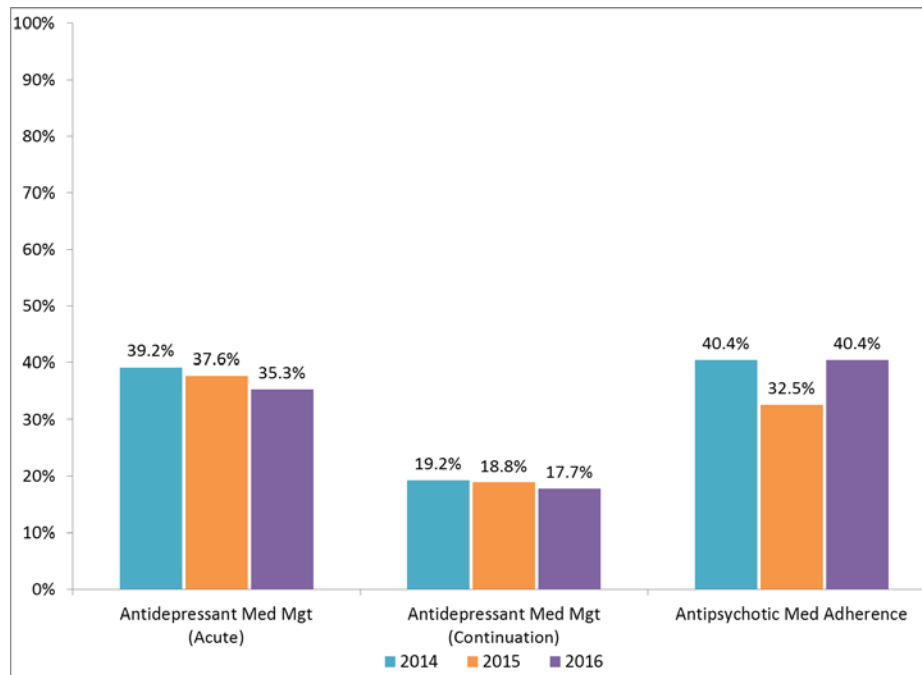


Figure 14: Medication Adherence for Major Mental Illnesses

Goal 3: To improve the access/availability of care provided to the MHD members.

Data for ER utilization and outpatient visits are shown in Figures 15-17. The rate of outpatient visits for behavioral health issues declined significantly between 2014-2015, and then rebounded in 2016, to 675 visits per 1,000 members. A similar trend was seen for medical concerns, although the number of members accessing outpatient services jumped in 2015, even while the number of overall visits declined slightly. The rate of outpatient visits for substance use disorders rose throughout the three years, jumping substantially for 2016.

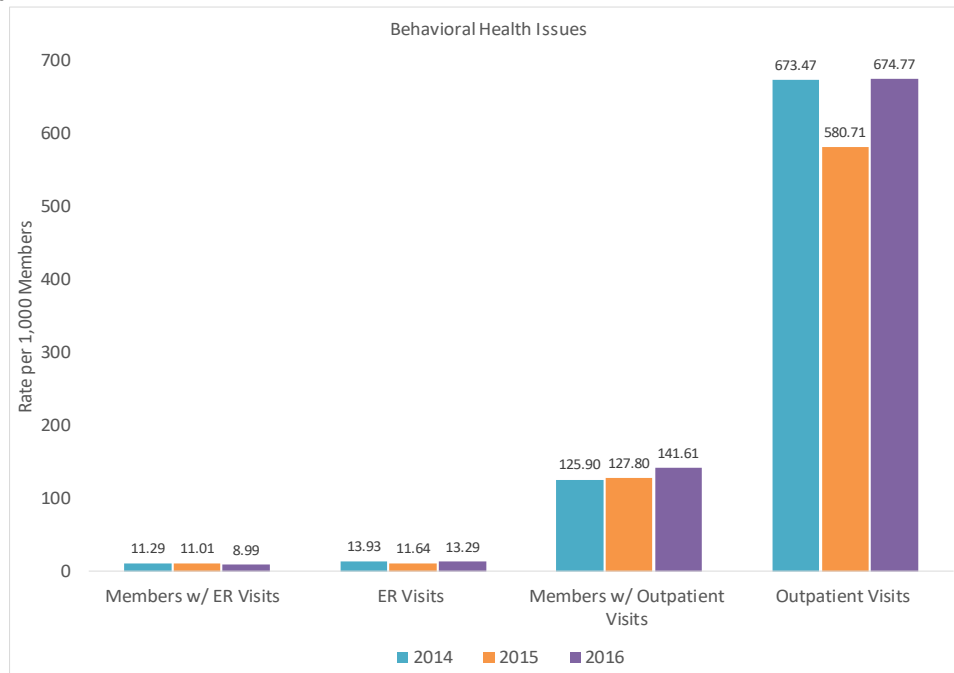


Figure 15: ER and Outpatient Visits for Behavioral Health Issues

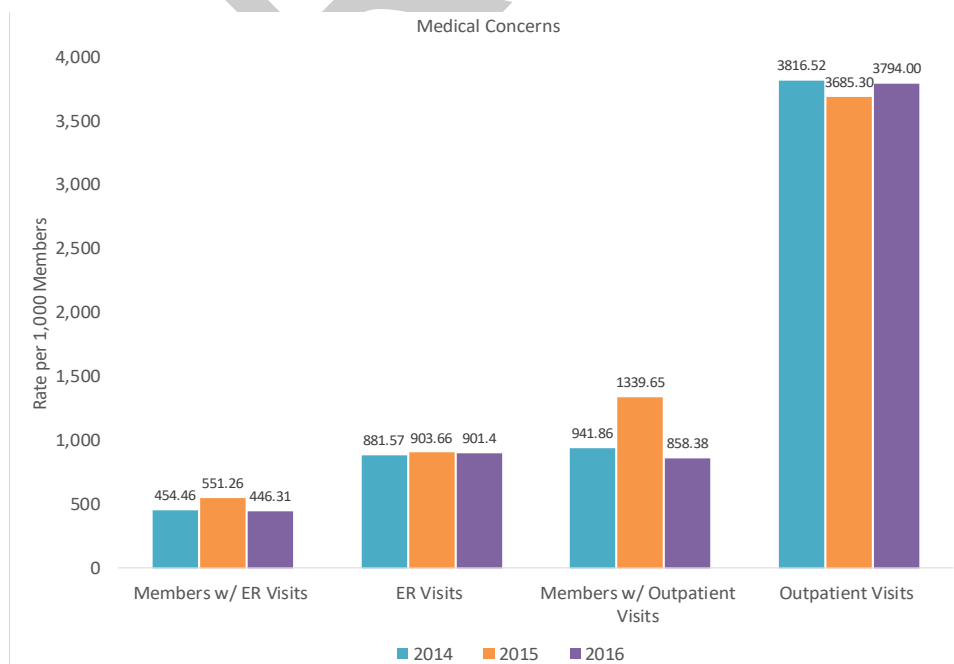


Figure 16: ER and Outpatient Visits for Medical Concerns

The rate of ER utilization for behavioral health issues shows little fluctuation across the 2014-2016 period, for both the number of ER visits as well as the number of members using ER services. Some fluctuation is seen in utilization for medical issues, with the number of members using the ER varying across this review period between approximately 450-550 members for 1,000 members. The number of ER visits for medical issues per 1,000 members is up since 2014. The rates for substance use disorders show increases between 2014-2016 for both the number of members using ER services as well as the number of ER visits.

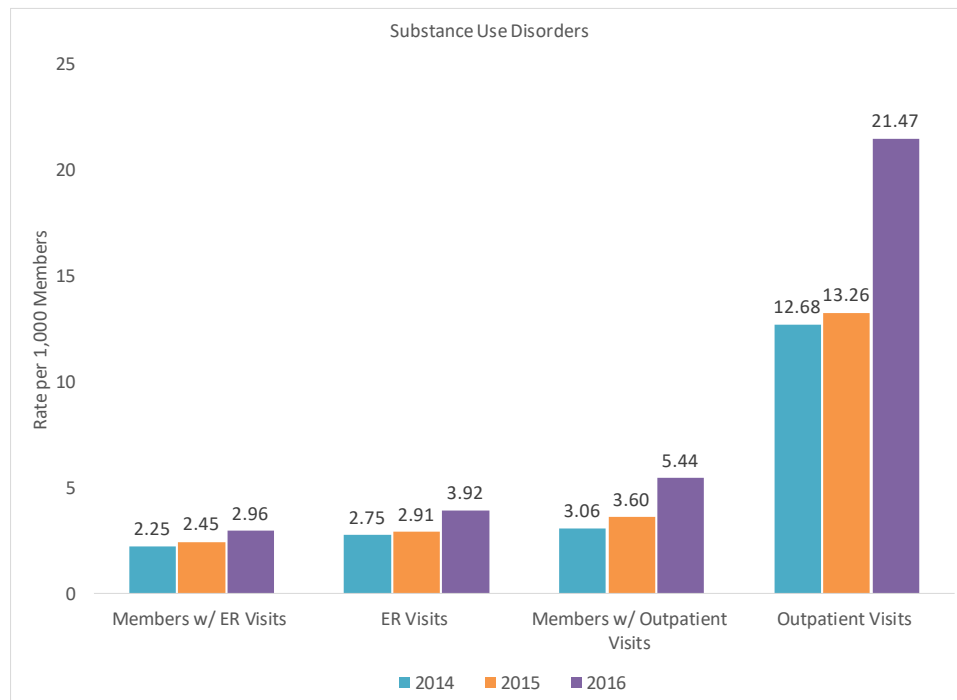


Figure 17: ER and Outpatient Visits for Substance Use Disorders

The rate of annual dental visits was 47.28% in 2016, and shows little change during this review period (see Figure 18), despite the presence of a focused Dental Performance Improvement Project (PIP). The managed care contract requires that all three MCOs collaborate on a Dental PIP that increases the use of dental services by children. However, no increase in utilization has occurred.

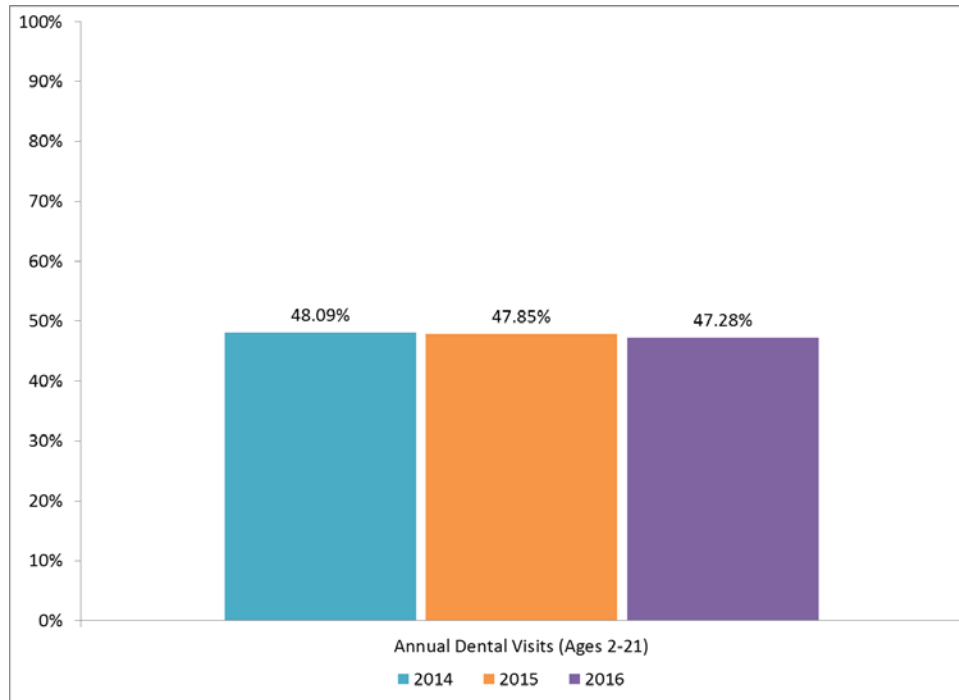


Figure 18: Annual Dental Visits

Prenatal care timeliness has decreased six percentage points since 2014, although it is up slightly from 2015 to 78.02% for 2016. Postpartum care has decreased nearly four percentage points a year since 2014, to a rate of 60.47% for 2016 (see Figure 19).

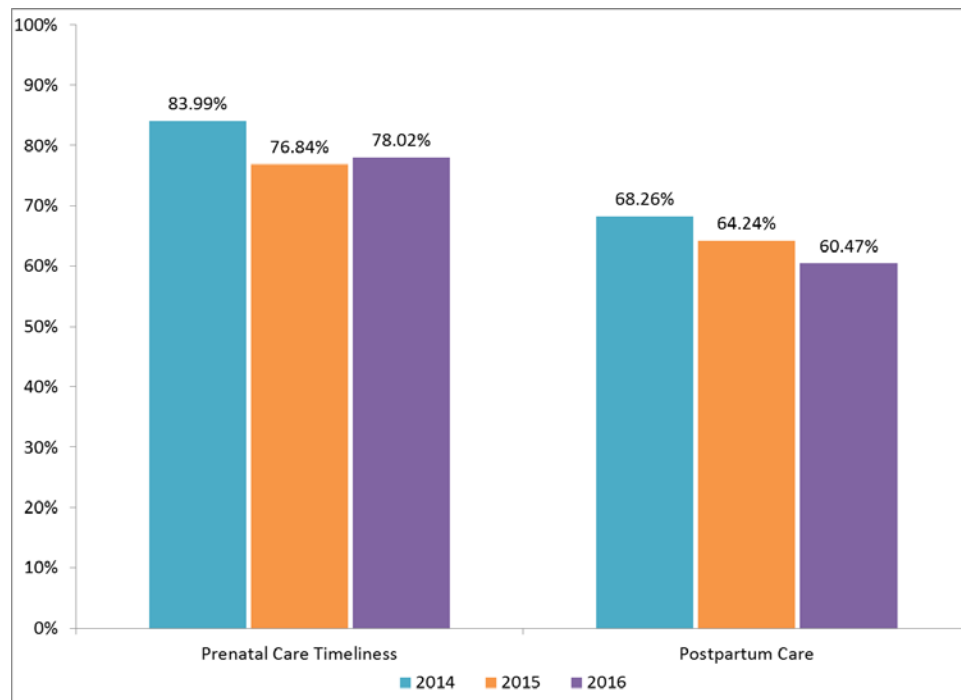


Figure 19: Prenatal and Postpartum Care

One of the methods for evaluating access to care has been through the use of a “Secret Shopper” survey conducted by Missouri’s EQRO for the past three years. The survey examines the accuracy of MCO online provider directories, and the availability of routine, sick, and urgent appointments for PCPs, and of routine appointments for psychiatrists (see Figures 20-21). Comparison of website accuracy between the 2015 and 2017 surveys shows an improvement in information regarding the PCPs’ physical location and office address/phone number. However, surveys show a decrease in the number of providers accepting new patients and the number of providers who report that they accept the health plan’s insurance, despite being listed by the plan as an active provider on the MCOs website. Rates for psychiatrists decreased for accuracy of provider location and office address/phone, as well as for psychiatrists accepting new patients. The rate of psychiatrists who report accepting the MCO insurance increased.

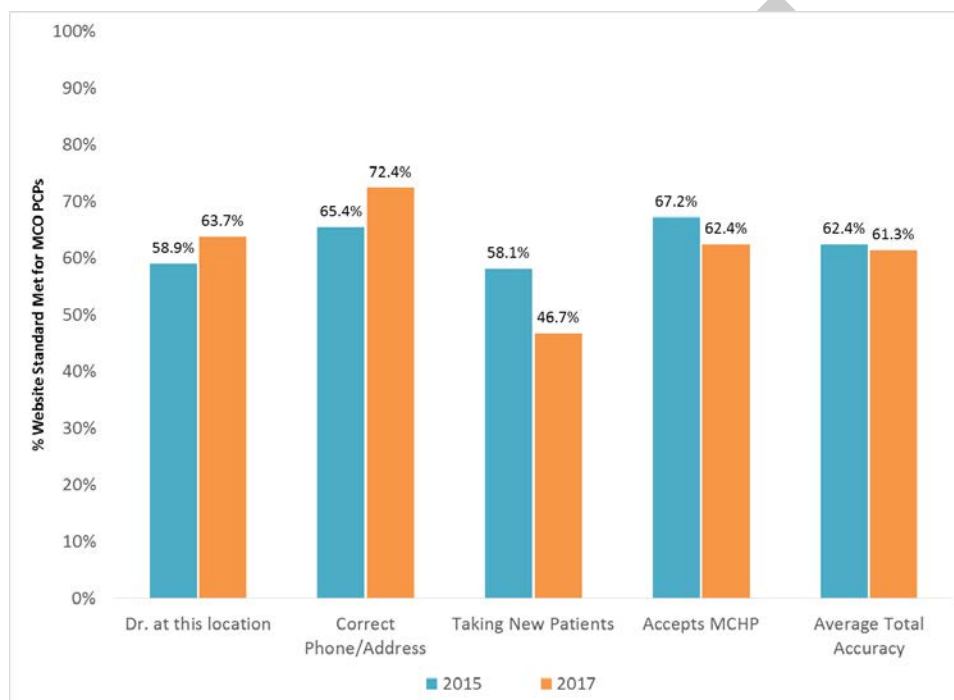


Figure 20: Accuracy of MCO Online Provider Directories (PCPs)

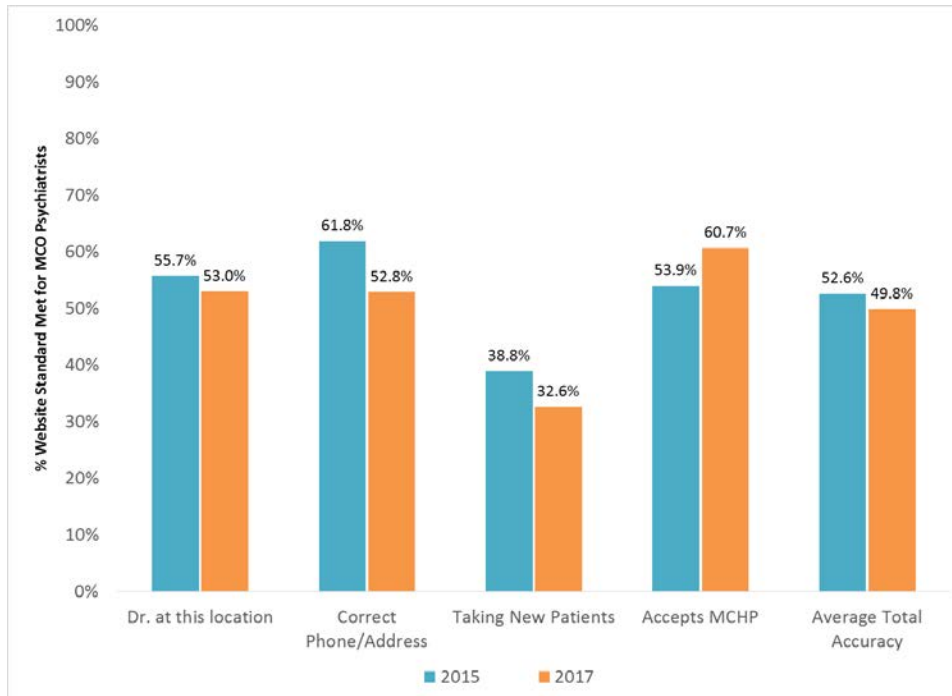


Figure 21: Accuracy of MCO Online Provider Directories (Psychiatry)

The rate of PCPs who met contractual appointment standards for routine, sick, and urgent care appointments decreased between the 2016 and 2017 surveys. However, the rates for those providers who were offering appointments increased between the two surveys, and such providers met appointment standards for all three appointment types nearly all of the time in 2017 (see Figure 22).

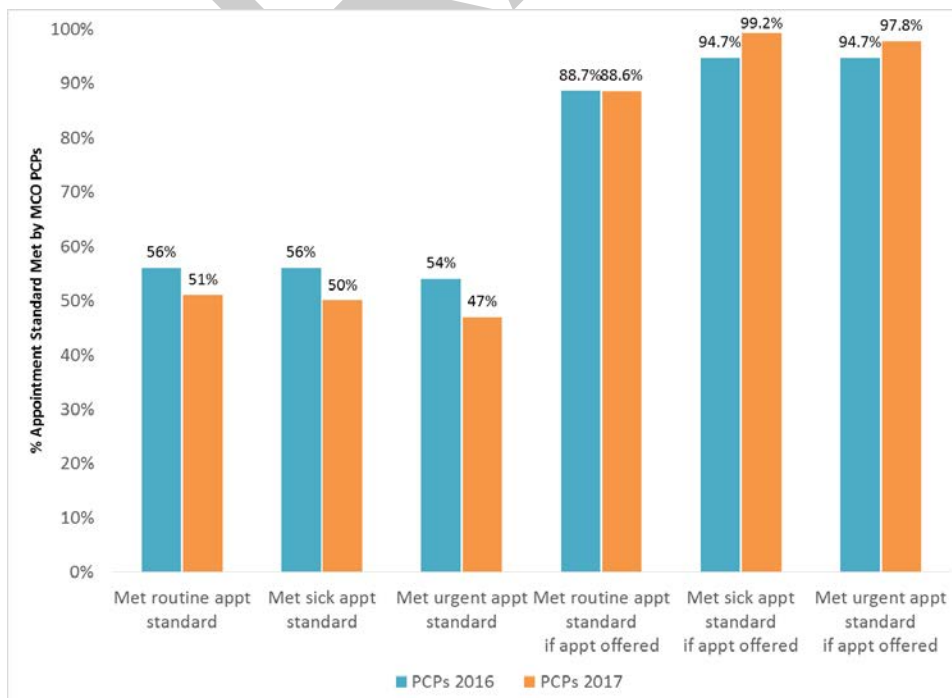


Figure 22: Appointment Standards (PCPs)

For psychiatrists, only 45.2% were offering appointments at all during the 2016 survey, and that declined to 37.4% in 2017. The percentage that was offering appointments within the standard was also lower. Only 25.6% of psychiatrists that were offering appointments in 2016 could offer one within two weeks. That decreased to 5.6% for 2017. The average wait time for a routine psychiatric appointment increased from 40.3 days in 2016 to 70.7 days in 2017 (see Figure 23).

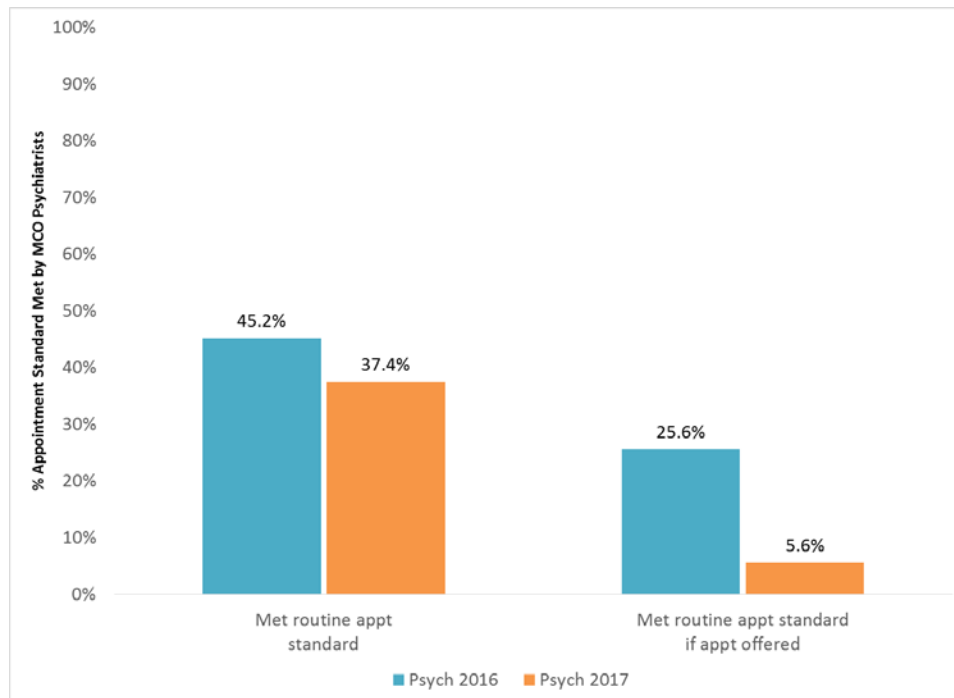


Figure 23: Appointment Standards (Psychiatry)

Other metrics of access to care related to early morning, evening and weekend appointments and being seen within thirty minutes of scheduled outpatient appointment were not incorporated into the Secret Shopper Survey due to methodological challenges.

Data on the number of MCO members receiving care management, as reported by the MCOs on a quarterly log, has been available since 2015 (see Figure 24). The overall counts have fallen each year, from a high of 4,663 members in 2015 to 2,755 members in 2017, a decrease of 40%. Two MCOs showed the same downward progression, while one plan increased in 2017 to their highest count of the three years reviewed. These differences are likely to be due to issues with care management reporting. The MHD is currently collaborating with the MCOs to improve the process of creating and submitting the care management log.

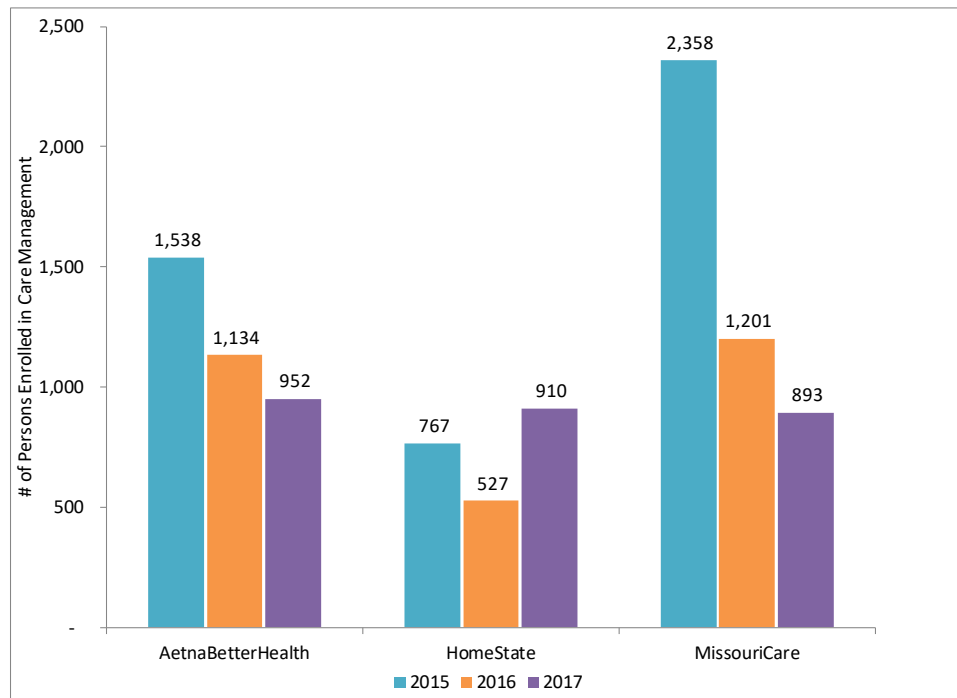


Figure 24: MCO Members Receiving Care Management Services

Goal 4: Promote member satisfaction with the experience of care.

A review of data from 2014-2016 for the Care Management Satisfaction Survey shows very high levels of satisfaction for all eight survey questions (see Figure 25-26). For all years, average ratings for each question are between 4.19 and 4.64 on a 5-point scale, with 5 being “Very Satisfied.” However, this survey is conducted over the telephone, and participation rates over the years have been low. Missouri is considering requiring the health plans to use a mailed survey with the intent of improving response rates.

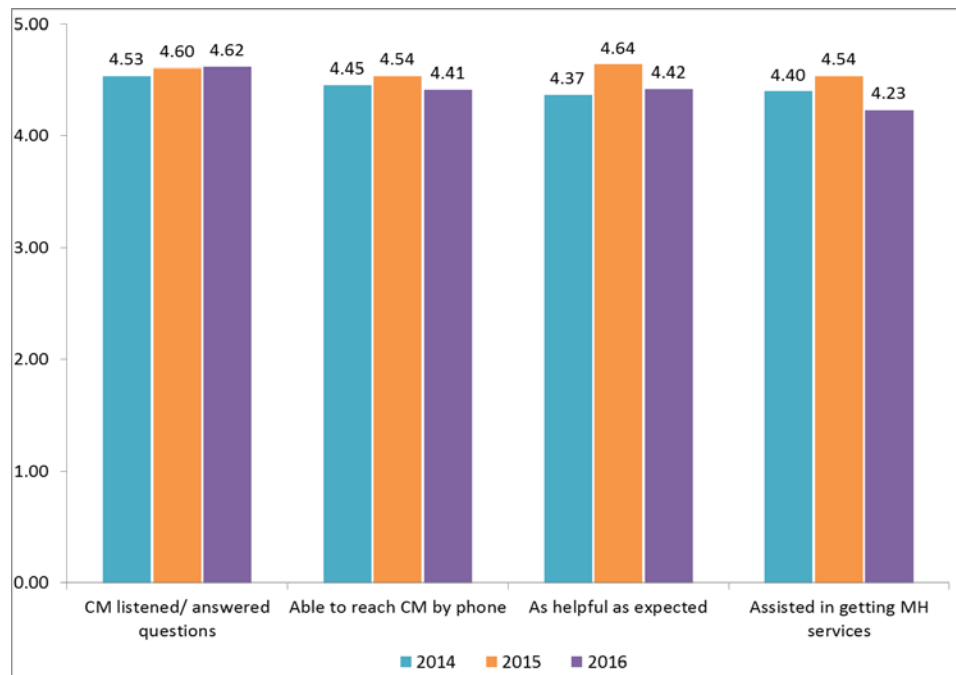


Figure 25: Member Satisfaction with Care Management Services

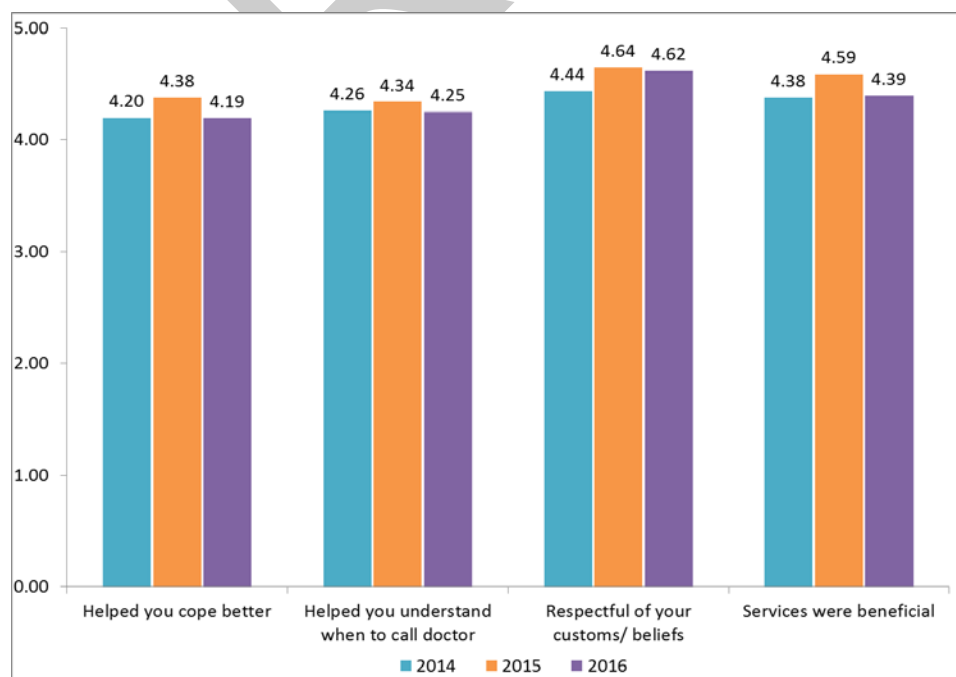


Figure 26: Member Satisfaction with Care Management Services (cont.)

CAHPS data similarly show high rates of satisfaction with the nine composite and rating items for calendar years 2014-2016. Scores are above 2.5 on a 3-point scale, with a few exceptions (see Figure 27-28). However, scores are generally high nationally for these measures, and so it is helpful to look at national percentile ranks. Most of our MCO scores are above the national median. “Customer Service” is at the 50th percentile for 2016, lower than prior years. “Rating of Specialist” has improved from below the median to the 4th quartile in 2016. Interestingly, ratings are generally above the mean for most measures, while the “Rating of Health Plan” score has been below the median for the 2014-2016 time periods, and is presently below the 25th percentile.

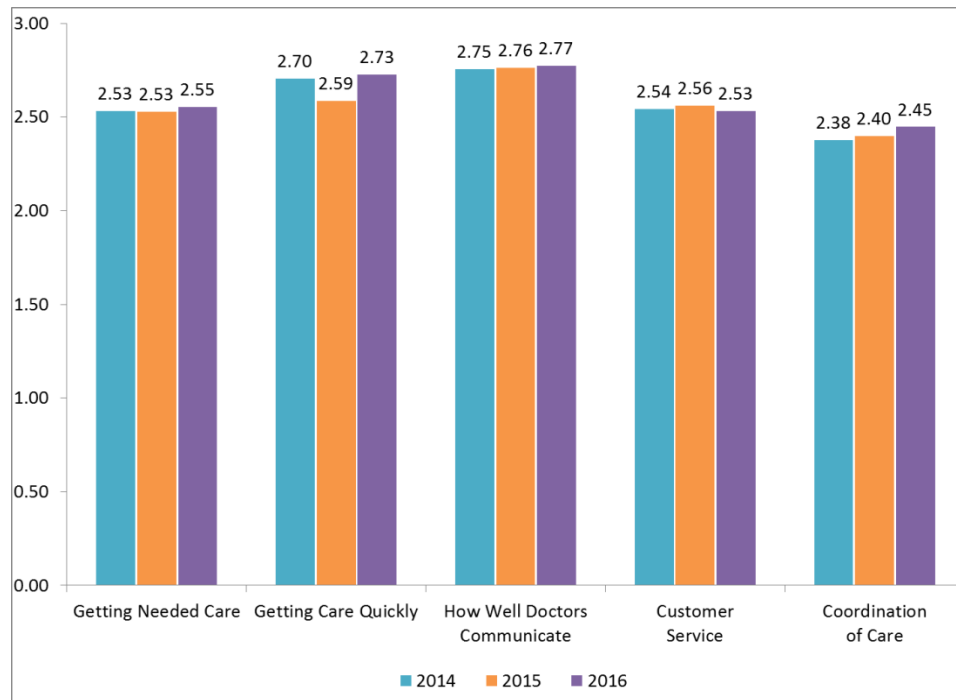


Figure 27: Member Satisfaction with MCO Services (CAHPS)

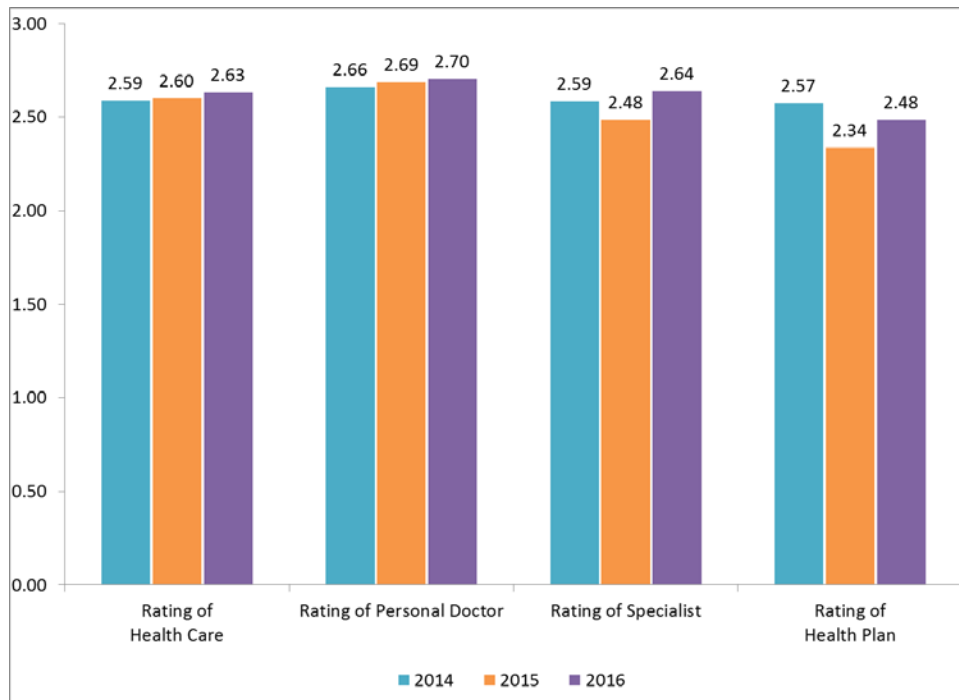


Figure 28: Member Satisfaction with MCO Services (CAHPS) (cont.)

Discussion

Missouri's ongoing evaluation of QIS processes and associated data metrics has revealed metrics that we wish to strengthen or expand, discontinue, and those that did not perform as expected. A series of changes to the 2018 QIS processes and measures has resulted from these periodic reviews.

A small number of metrics dealing with well-care visits, outpatient/ambulatory care, and reporting of body-mass index were found to be duplicated across goals, with slight wording variations. The duplication will be eliminated in the new QIS, and reporting of results above placed the data within the most appropriate goal.

A couple of planned measures were discontinued shortly after the 2013 QIS was finalized, such as member self-selection of a PCP. Additionally, measures of MCO provider FTEs were replaced with broader measures of network adequacy and our Secret Shopper Survey. The planned scope of the Secret Shopper Survey was limited by methodological challenges, including developing a valid method of determining how quickly a member is seen after arriving for a scheduled appointment. Questions about weekend and early/late appointment availability will be added in this year's survey.

Several measures that were proposed in the QIS could not be collected. A HEDIS measure of body-mass index was abandoned because the specific claims codes needed for that measure are not required to be submitted, and thus are infrequently reported by providers. The resulting rates are extremely low and, based on other data that we have available, are simply incorrect.

Similarly, the rate of tobacco usage among members was to be collected through the CAHPS, but the resulting reports from vendors' aggregate individual questions into larger classes or domains, and the detail of the tobacco usage questions was lost. The Department of Health and Senior Services has some information on statewide tobacco usage, but does not have data specific to the Medicaid program. Alternative methods to collect reliable data on tobacco usage in our population are being considered.

HEDIS measures that look at medication adherence in major depression and schizophrenia were selected, but these are not collected or reported by the MCOs. Instead, these rates were calculated in-house using encounter claims. Furthermore, by grouping all MCO members together for these measures rather than evaluating by individual plan, the continuous eligibility requirement to "managed care" was applied broadly, instead of to a particular plan. This has the added benefit of resulting in a slightly larger denominator than would have been possible with separate analyses by plan.

Many of the measures selected for the QIS did not perform as expected, and the specific performance goals were fully met for only approximately one-quarter of the measures. Approximately one-half of measures fluctuated, with improvements seen in some years but not all. The last one-quarter of measures showed decreased performance across all three years of the review period.

The annual EQRO review of MCOs is summarized with a "report card" that considers PIPs, performance measure validation, meeting compliance standards, and case management performance. The EQRO report card is consistent with these findings, showing variable success with performance improvement projects, and large decreases in performance measure validation for this review period. The EQRO's review of care management showed improvement, but the overall MCO score on the EQRO "report card" fell from B+ (87%) in 2014 to C+ (77%) in 2016 (see Figure 29). For more information about individual MCO scores and methodology for EQRO reports, please visit <https://dss.mo.gov/mhd/mc/pages/eqro.htm>.

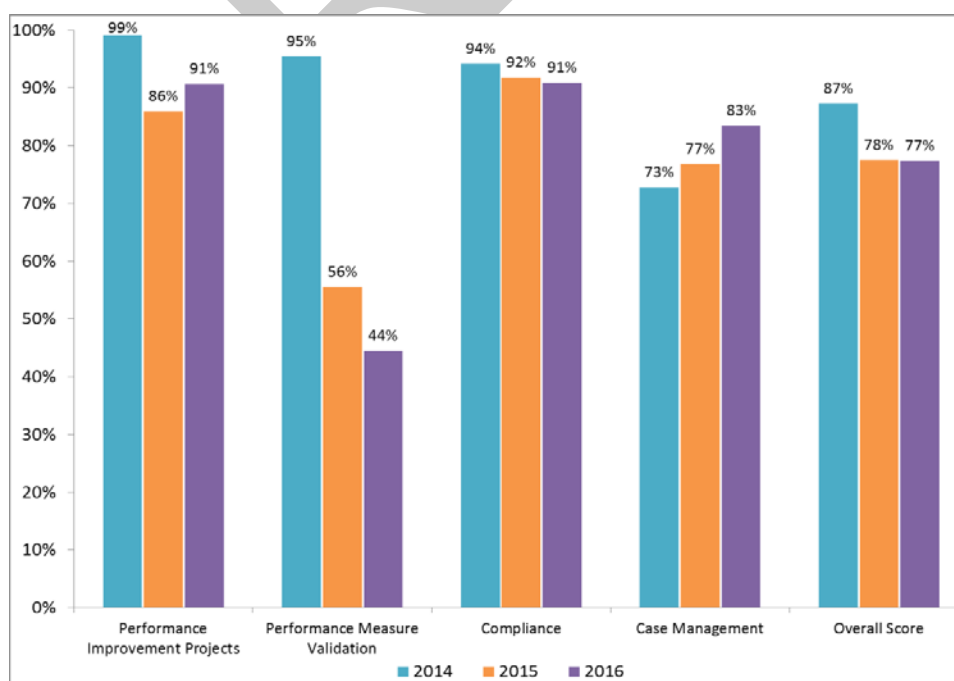


Figure 29: EQRO 'Report Card' for MCOs

MHD had the same three MCOs during this 3-year review period, and believed this stability would have yielded better results and regular, even if small, annual improvements. Several reasons for this apparent lack of progress are suspected.

There was confusion regarding the specifications for some of the quarterly and annual measures that MHD requires, and in assuring uniformity in their application across different MCOs. However, formal HEDIS data provided by the MCOs should not suffer from this confusion as such measures are calculated by NCQA-certified HEDIS vendors. This certification and associated training help assure uniformity in the application of HEDIS specifications even across different vendors. While there remain challenges with certain HEDIS measures due to only partial reporting of services (e.g., childhood immunizations that are provided free of charge at health fairs or other functions and which do not generate a corresponding claim), the impact of such challenges is thought to be uniform across the review period. Thus, while they would certainly depress the overall rate to a degree, the impact should be similar across all years, and should not obscure year-to-year performance trends. It is more likely that decreasing rates on formal HEDIS measures reflect actual declines in performance.

As we have proceeded with implementation of our QIS, we have discovered that we had included too many measures with too much variety. As a result, it was challenging to effectively monitor all of them, difficult to develop interventions for so many, and hard for the MCOs to spread their focus and resources across so many disparate metrics.

This valuable lesson informed the development of the 2018 QIS, which features a smaller number of measures that better express the MHD's current priorities. A number of processes were introduced and/or revised during this review period to help improve Missouri's ability to actively monitor and positively impact outcomes. A review of these processes follows.

Performance Withhold Program

A performance withhold program was started with the MCOs in 2015 to improve performance on selected metrics. Specifically, the program addresses five categories of performance indicators, with individual measures that focus on:

- Encounter data completeness/accuracy;
- Provider panel directory completeness/accuracy;
- EPSDT screenings;
- Case management for pregnant women and children with elevated lead levels;
- Member and provider incentive programs; and
- Creation of and enrollment in a Local Community Care Coordination Program (LCCCP).

The attention to encounter claims has been helpful, and the MCOs are now more consistent in their reporting of certain claims elements, which serves Missouri's need for accurate rate-setting as well as calculation of quality metrics and other quality data analytics. In addition, new data have been added to the encounter claims, in particular information regarding the performing provider for rendered services. Previously, that field was occupied with the MCO's ID, which rendered the data useless for identifying individual providers or running analyses based on associated provider characteristics, such as specialty, office location, etc. The inclusion of this field permits such analysis, as well as the combining of MCO data and FFS data to gain a broader picture of provider activities across both service models.

Reliability and validity in reporting, disagreements regarding metric definitions, performance targets calculation methods, and questions of whether MHD's requirements were attainable in the current environment were obstacles to making progress on quality performance. A series of collaborative discussions, meetings, clarifications, and revisions have led to improvements. The resulting modifications to the program are scheduled to be implemented on July 1, 2018, with a greater focus on performance vs. process measures, and on independently calculated measures (i.e., by a HEDIS vendor rather than through self-report or internally by MHD).

Measure Specifications and Calculations

Confusion and lack of clarity were addressed in the various measure specifications by providing increased detail and "draft" copies of specifications for review and comment by the MCOs. Additionally, two of the three MCOs collaborated with each other to have their shared HEDIS vendor do most of the annual calculations on their behalf, assuring a uniform methodology for these two plans. A review and validation process was implemented subsequent to data submission to allow the MCOs to examine their data within the context of all three plans. When data are presented in side-by-side graphs, the MCOs can easily spot outlier performance and determine whether it reflects actual performance differences or is, rather, an error in calculation. The MHD provides similar tables showing the year-to-year percentage change in values, so that the MCOs can easily target and inspect suspiciously large differences. Similarly, the quarterly data reporting process has seen significant improvements in validation processes, and while this often results in rejection of datasets from the MCOs, the quality of the data, once it passes all validation checks, is vastly improved.

Staffing Resources

Two new staff have been added to the MHD specifically to address managed care quality and compliance with State, Federal, and contract requirements. These individuals work closely with clinical staff on quality projects such as the Performance Withhold Program and EQRO.

MHD Monthly Quality Data Review Committee (QDR)

The QDR committee was recently formed to provide a consistently scheduled opportunity for managers and administrators to review the variety of quality data that are received, primarily in the quarterly data feeds, from the MCOs. While data are being collected and stored in databases, the MHD realized that not all of that data was being reviewed and acted upon as regularly as intended, due in part to competing priorities, staff turnover, etc. The committee was formed to address this issue, and a series of aggregate and management reports were developed for review by the committee. These are also disseminated to the MHD staff designated to review and intervene in the various programs monitored by these data, including member grievances and appeals, member call center activity, claims adjudication, prior authorizations, fraud/waste/abuse, care management, and disease management. The QDC meets monthly to review three to four of these reports each meeting, with the goal of reviewing all reports generated from the MCOs' quarterly data submissions over the course of that quarter. This allows for a review of trends, formulation of questions/follow-up for the MCOs, and development of interventions to address problematic or recalcitrant findings. Additionally, review of data from the annual reporting cycle will be incorporated into the QDR Committee as well.

QA&I Advisory Group

The QA&I group continues to make recommendations to ensure the focus remains on developing meaningful quality improvement ideas. Meetings take place two to three times per year to review quality data analysis and evaluation activities to determine if improvements or new opportunities need to be explored. In order to generate greater discussion surrounding quality improvement processes by the plans, and expectations by MHD, agendas are modified to keep the group innovative. The QA&I group will continue to establish separate task forces if specific areas of improvement are identified. The QA&I has been helpful in developing strategies that the MHD can implement to drive quality improvement.

EQRO

A new EQRO contract started in 2018, and we have a new vendor, Primaris, Inc. We are working with them at present to educate them about our program and our MCOs. We expect to expand the scope of the annual Secret Shopper Survey, and to make expanded use of “optional” EQRO activities, beyond those that are required by CMS.

Revised Selection of Performance Metrics

As part of the development of a new QIS, the MHD has reduced the number of performance measures to a more manageable number, attempting to avoid having multiple metrics that measure similar things, and to focus on areas that are of particular importance to MHD’s mission and goals, and align with our overall quality objectives.

Summary

The MHD is focused on continuous quality improvement in the Managed Care Program. Data summarized in this evaluation of the 2013 QIS has provided exceptional historical information, which will drive the 2018 QIS and the progress toward meeting new goals and objectives. The lessons learned in this process will help the MHD to focus its efforts on communicating expectations to the MCOs, improve data collection, and ensure the delivery of quality health care to MCO members. This effort will be conducted in collaboration with the MCOs, stakeholders, and members. The ultimate goal is to help meet the Department’s mission, to lead the nation in building the capacity of individuals, families, and communities to secure and sustain healthy, safe, and productive lives.