MO HEALTHNET OVERSIGHT COMMITTEE
Follow-Up Information to
December 4, 2007 Meeting

As a result of requests made during the December 4, 2007 meeting, the following information was provided to Committee members and is included in this packet:

1. MC+ Managed Care Consumer Guide 2006
2. Managed Care Overview Presentation
3. MO HealthNet Rollout Presentation
4. HEDIS Definitions and Measures
5. CAPHS Consumer Satisfaction Survey
6. CyberAccess Description
7. Health Plan Survey Information and Profit/Not-for-Profit Status

2006 Consumer's Guide

MC+ Managed Care in Missouri

MC+ Managed Care

MC+ is the statewide medical assistance program for low-income families, pregnant women, children and uninsured parents. MC+ recipients get their care through either Fee-for-Service (FFS) or managed care depending on where the person lives in Missouri. MC+ managed care is in 37 Missouri counties. MC+ managed care members must choose a health plan and a primary care provider (PCP). A PCP directs a member's health care. The PCP will refer the member to other health care providers when needed. There are some services not in MC+ managed care that are covered by MC+ FFS.

Table of Contents

Know Your Rights

You have the right to:

- Be treated with respect and dignity
- Receive needed medical services
- Have privacy and confidentiality (including minors) subject to state and federal laws
- Select your own PCP
- Refuse care from a specific provider
- Receive information about your health care and treatment options
- Participate in decision-making about your health
- Have access to your medical records
- Have someone act on your behalf if you are unable to do so
- Receive information in a manner and format that can be easily understood
- Receive information on physician incentive plans, if any
- Be free of restraint or seclusion from a provider who wants to:
    1. Make you do something you should not
    2. Punish you
    3. Get back at you
    4. Make things easier for him or herself
- Be free to exercise these rights without retaliation

Know Your Responsibilities

Learn the rules of your MC+ managed care plan before you get medical care. You have a responsibility to:

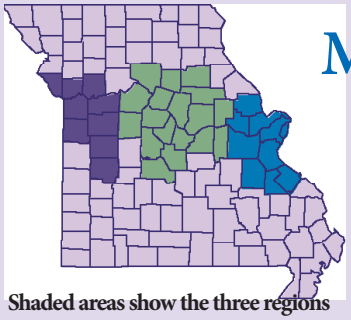
- Pick a primary care provider (PCP)
- Make and keep appointments, or call ahead to cancel
- Ask questions about your health care, talk to your PCP or managed care plan
- Call your PCP before you get care from another provider, or you may have to pay the bill
- Use urgent care facilities for urgent health care conditions that are not emergencies
- Eat right, exercise, get regular checkups, don't smoke and follow your PCP's instructions

To find out about your rights, phone:
1-800-392-2161
or write: Recipient Services
Missouri Division of Medical Services
P.O. Box 6500
Jefferson City, MO 65102.

Statewide Averages and Quality of Care Symbols Explained

The percent on the "Statewide Averages" line indicate the average percent of all plans for each indicator shown in the header of the column. The Quality of Care Ratings reflect a statistical comparison of the plan's percentage on the indicator (measure) and the statewide average percentage for all plans. An Average (◒) rating for a specific plan means the plan scored close to the Statewide Average for that indicator. A High (●) or Low (◯) rating means the plan scored much higher or much lower than the Statewide Average.

MC+ Managed Care Plan Performance



Shaded areas show the three regions where MC+ managed care plans offer coverage

Women's Health

	Chlamydia Screening For Sexually Transmitted Disease	Check-Ups For Cervical Cancer Pap Test	High Risk Pregnancy Education for all Plan Enrollees
Eastern Region			
Community Care Plus	●	○	YES
HealthCare USA of Missouri	●	●	YES
Mercy MC+	○	◒	none
Central Region			
HealthCare USA of Missouri	○	●	YES
Missouri Care Health Plan	○	●	none
Western Region			
Blue-Advantage Plus	○	◒	YES
Family Health Partners	◒	◒	YES
FirstGuard Health Plan	●	◒	YES
HealthCare USA of Missouri	◒	○	YES
Statewide Averages	**56%**	**66%**	

Female plan members (ages 16-20) who are sexually active and had at least one test for chlamydia (an STD) during the past year.

Women (ages 21-64) who had a pap test in the past two years.

Plan provides educational information to members who are at risk for High Risk Pregnancy.

This table compares health plans' performance on Women's Health Care measures to the statewide average, using the rating symbols below. The table also reports on which plans offer selected benefits and coverages.

Quality of Care Ratings*

● – High

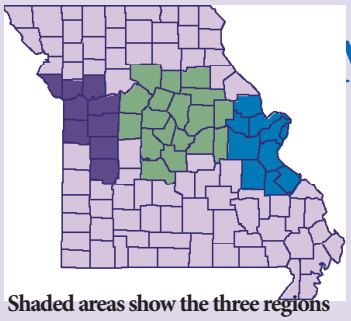
◒ – Average

○ – Low/Needs Improvement

NA – Numbers too small

NR – Not reported by plan

*Plan performance measures are compared to statewide averages



Shaded areas show the three regions where MC+ managed care plans offer coverage

MC+ Managed Care Plan Performance

Children's Health

	Use of Appropriate Medication for People with Asthma	Childhood Immunizations	Adolescent Immunizations	Adolescent Well-Care Visit	Obesity Education of All Plan Enrollees	Yearly Dental Visits
Eastern Region						
Community Care Plus	○	◒	◒	○	none	◒
HealthCare USA of Missouri	◒	◒	●	●	YES	◒
Mercy MC+	◒	○	◒	◒	none	○
Central Region						
HealthCare USA of Missouri	◒	●	○	●	YES	○
Missouri Care Health Plan	◒	●	◒	●	none	○
Western Region						
Blue-Advantage Plus	●	○	○	◒	none	●
Children's Mercy's Family Health Partners	●	●	●	◒	YES	●
FirstGuard Health Plan	◒	○	○	○	none	●
HealthCare USA of Missouri	NA	◒	○	○	YES	○
Statewide Averages	**88%**	**60%**	**28%**	**33%**		**29%**

Child members (ages 5-9) who have persistent asthma and are being given acceptable medications for long term control of asthma.

Children who turned 2 in the past year and received vaccinations.

Adolescents who turned 13 in the past year and received vaccinations.

Adolescents (ages 12-21) who had a well care visit during the past year.

Plan provides educational information for members about risks of obesity.

Children and young adults (ages 4-21) who had one or more dental visits during the past year.

Quality of Care Ratings*

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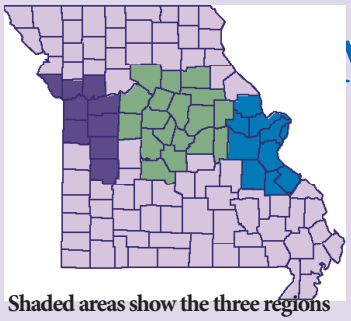
○ – Low/Needs Improvement

NA – Numbers too small

NR – Not reported by plan

*Plan performance measures are compared to statewide averages



Shaded areas show the three regions where MC+ managed care plans offer coverage

MC+ Managed Care Plan Performance

Member Satisfaction

	Customer Service (1)	Getting Care Quickly (2)	Getting Needed Care (3)	Rating of Doctor Seen Most Often (4)	Rating of Specialist Seen Most Often (5)	Overall Rating of Plan (6)
Eastern Region						
Community Care Plus	◒	◒	◒	◒	◒	◒
HealthCare USA of Missouri	◒	◒	◒	◒	◒	●
Mercy MC+	◒	●	◒	●	◒	◒
Central Region						
HealthCare USA of Missouri	◒	●	◒	◒	◒	◒
Missouri Care Health Plan	◒	◒	◒	◒	◒	○
Western Region						
Blue-Advantage Plus	◒	◒	◒	◒	◒	◒
Children's Mercy's Family Health Partners	◒	◒	◒	◒	◒	◒
FirstGuard Health Plan	◒	◒	◒	◒	◒	◒
HealthCare USA of Missouri	◒	◒	◒	◒	◒	◒
Statewide Averages	**75%**	**79%**	**80%**	**80%**	**77%**	**80%**

Response Descriptions for Satisfaction Catagories Above

(1) No problem with paperwork, written materials or help from customer service.
(2) No problem getting necessary care in a reasonable time.
(3) No problem getting good doctors and nurses, referrals, and necessary care.
(4) Overall rating of personal doctor seen most often.
(5) Overall rating of specialist seen most often.
(6) Overall rating of health plan.

Statewide Averages and Quality of Care Symbols are explained on page 5.

Quality of Care Ratings*

● – High
◒ – Average
○ – Low/Needs Improvement
NA – Numbers too small
NR – Not reported by plan
*Plan performance measures are compared to statewide averages

Member Services Telephone Numbers

MC+ Plan	Customer Service	Nurse Helpline
Blue Advantage Plus Blue Cross Blue Shield KC	816-395-2119	
Community Care Plus	800-875-0679	800-875-0679
Family Health Partners	800-347-9363	800-347-9363
FirstGuard Health Plan	888-828-5698	888-828-5698
HealthCare USA	800-566-6444	800-475-1142
Mercy MC+	800-796-0056	800-811-1187
Missouri Care	800-322-6027	888-884-2401

You may contact the following State agency about MC+ managed care plan problems.

Division of Medical Services

1-800-392-2161

http://dss.missouri.gov/dms/

For further information about this Consumer's Guide, contact:
Missouri Dept. of Health and Senior Services
P.O. Box 570, Jefferson City, MO 65102-0570
(573) 751-6272

The Missouri Department of Health and Senior Services has attempted to publish accurate information based upon common definitions. The data reported are based on plan performance during 2005. Managed care plans were given an opportunity to review and correct the data presented. Other corrections or suggestions should be forwarded to the Center for Health Information Management and Evaluation (CHIME), Missouri Department of Health and Senior Services, PO Box 570, Jefferson City, MO 65102. Our telephone number is (573) 751-6272.

MO HealthNet Managed Care

December 4, 2007

Legal Authority

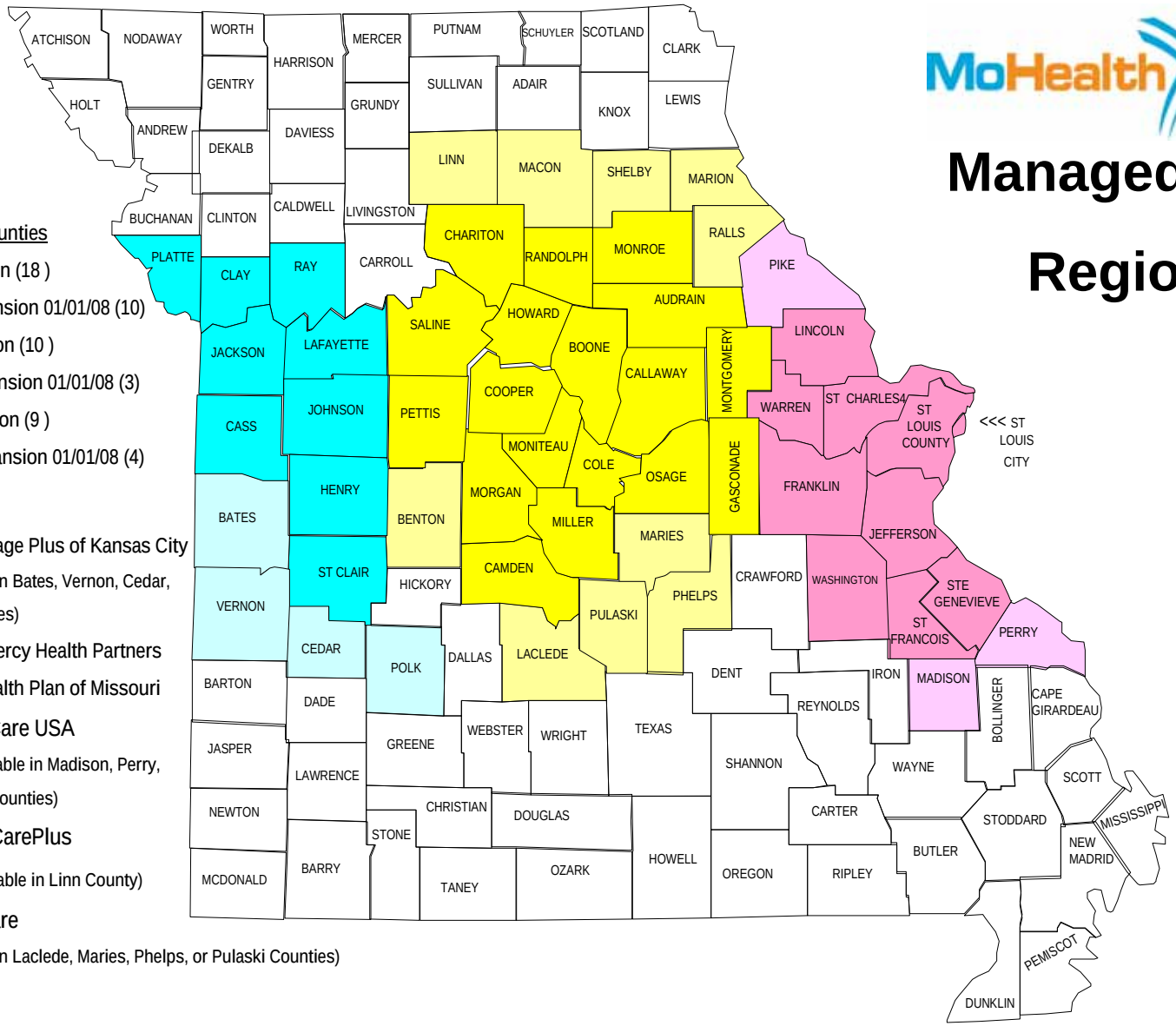
- State Statute: RSMo. 208.166 This section provides authority to purchase medical services from health plans;
- Federal Law:
  - 1903(m) This section specifies the conditions under which CMS may make payment to States for Medicaid managed care services.
  - 1915(b) States are permitted to waive statewideness, comparability of services, and freedom of choice.
  - 1932 Among other things, this section permits States to require most groups to enroll in managed care arrangements; requires specified information to enrollees; added increased consumer protections; requires quality assessment and improvement strategies; and provides for external, independent review.
- Federal Regulations: 42 CFR 438 This rule implements the provisions of the BBA of 1997

Participants in Managed Care

- There are 3 primary population groupings:
  - Parents/Caretakers, Children, Pregnant Women;
  - Foster Care Children; and
  - Children in SCHIP.
- 342,279 - Total Enrollment as of 11/30/2007

MoHealthNet

Managed Care Regions



Number of Counties

- Central Region (18)
- Central Expansion 01/01/08 (10)
- Eastern Region (10)
- Eastern Expansion 01/01/08 (3)
- Western Region (9)
- Western Expansion 01/01/08 (4)

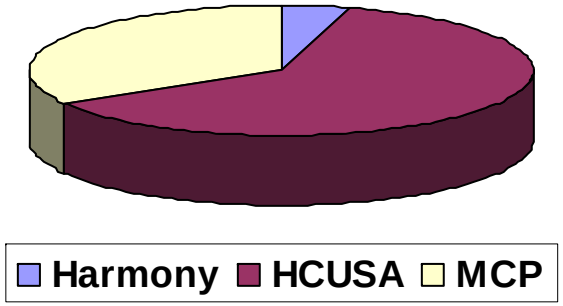
Health Plans

- Blue-Advantage Plus of Kansas City
  (not available in Bates, Vernon, Cedar, or Polk Counties)
- Children's Mercy Health Partners
- Harmony Health Plan of Missouri
- HealthCare USA
  (not available in Madison, Perry, or Polk Counties)
- Mercy CarePlus
  (not available in Linn County)
- Missouri Care
  (not available in Laclede, Maries, Phelps, or Pulaski Counties)

East Region

185,041 enrollees as of 11/30/2007

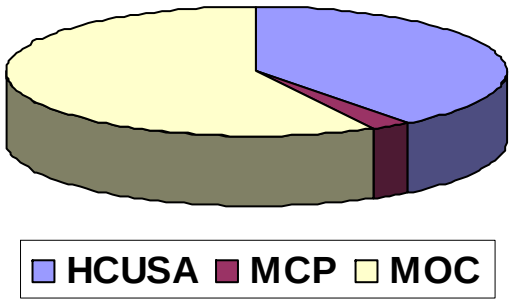
- *Harmony Health Plan of Missouri*
  - *8,176 enrollees*
- *HealthCare USA*
  - *115,188 enrollees*
- *Mercy CarePlus*
  - *61,677 enrollees*



Central Region

47,853 enrollees as of 11/30/2007

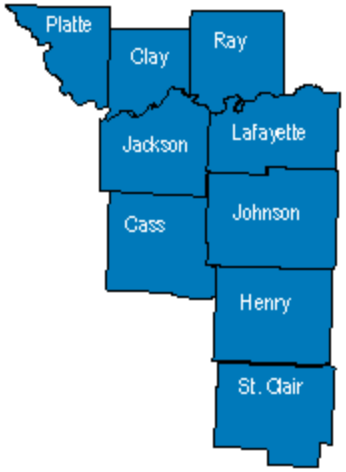
- *HealthCare USA*
  - *18,995 enrollees*
- *Mercy CarePlus*
  - *1,214 enrollees*
- *Missouri Care*
  - *27,644 enrollees*

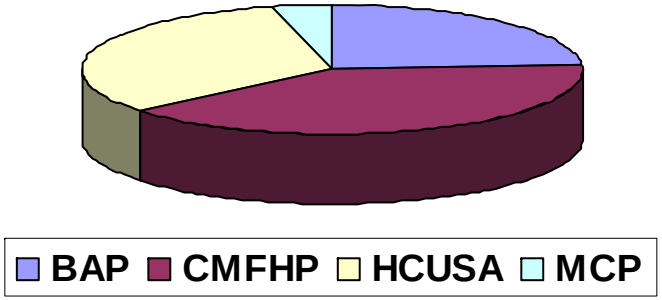


West Region

109,385 enrollees as of 11/30/2007

- *Blue-Advantage Plus of Kansas City*
  - *26,257 enrollees*
- *Children's Mercy Family Health Partners*
  - *43,532 enrollees*
- *HealthCare USA*
  - *35,217 enrollees*
- *Mercy CarePlus*
  - *4,380 enrollees*





Benefits Summary

- Primary and Specialty Physician Care
- Maternity
- Inpatient and Outpatient Hospital
- Mental Health
- Pharmacy
- Home Health
- Laboratory and Diagnostic
- Durable medical equipment (DME)
- And other services listed in contracts.

Quality Provisions

- Service Accessibility Standards
  - Travel Distance
  - Appointment Standards
  - Prior Authorization Standards
- Performance Standards
  - EPSDT
  - HEDIS
- Performance Improvement Projects

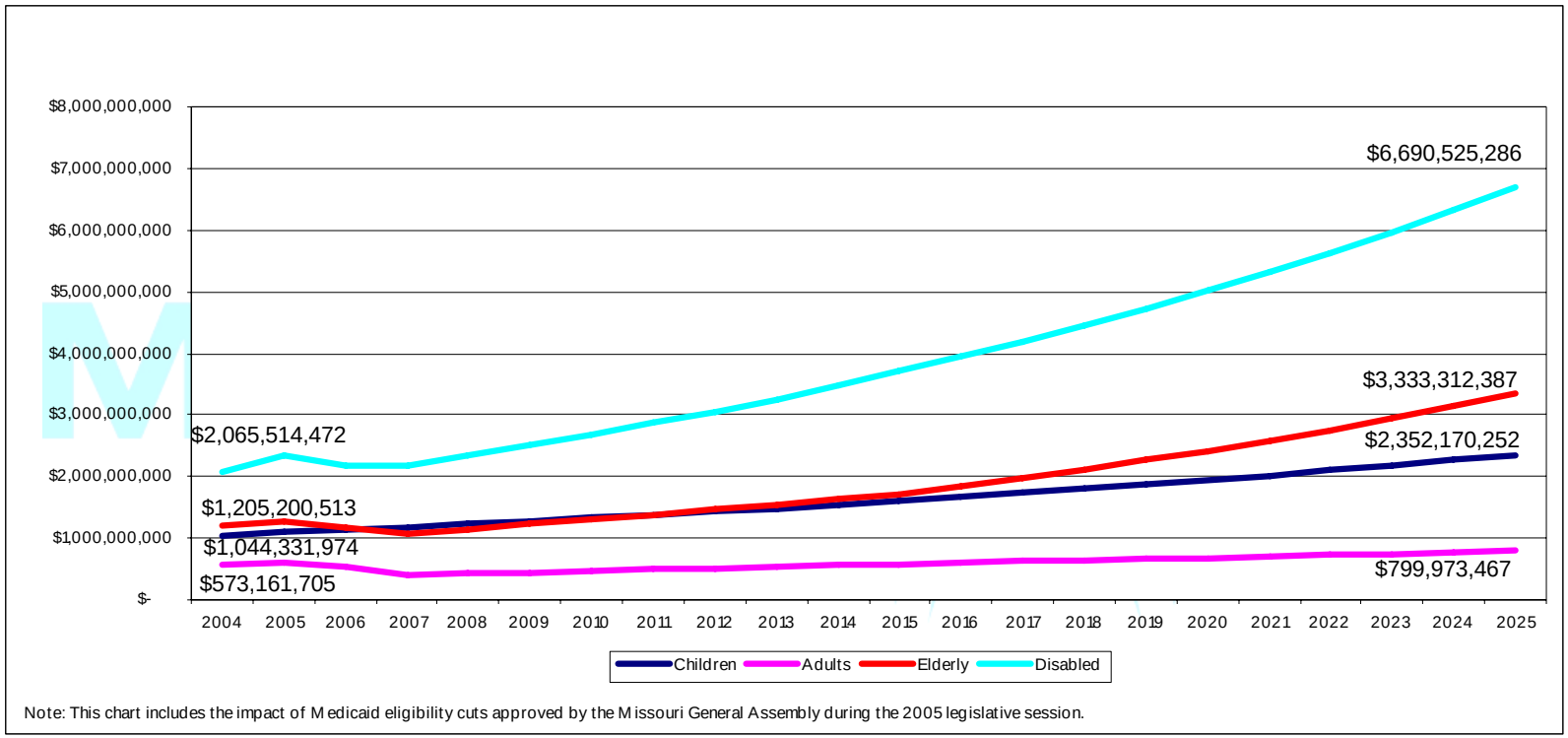
MO HealthNet
Beginning the Rollout

MO HealthNet Oversight Committee

December 4, 2007

George L. Oestreich, Pharm.D., MPA
Deputy Division Director, Clinical Services
MO HealthNet Division

Projected Future Medicaid Spending by Eligibility Group, 2004-2025



Note: This chart includes the impact of Medicaid eligibility cuts approved by the Missouri General Assembly during the 2005 legislative session.

Missouri Change in Philosophy

- From: Social Service Role
  - Passive Claims Payment
  - Enrollment
  - Safety Net
- To: Healthcare Consumer and Payer Role
  - Care Management Programs
  - E.H.R. to engage and inform Providers
  - Define Standards and Identify and Resolve Treatment Gaps
  - Consumer Directed

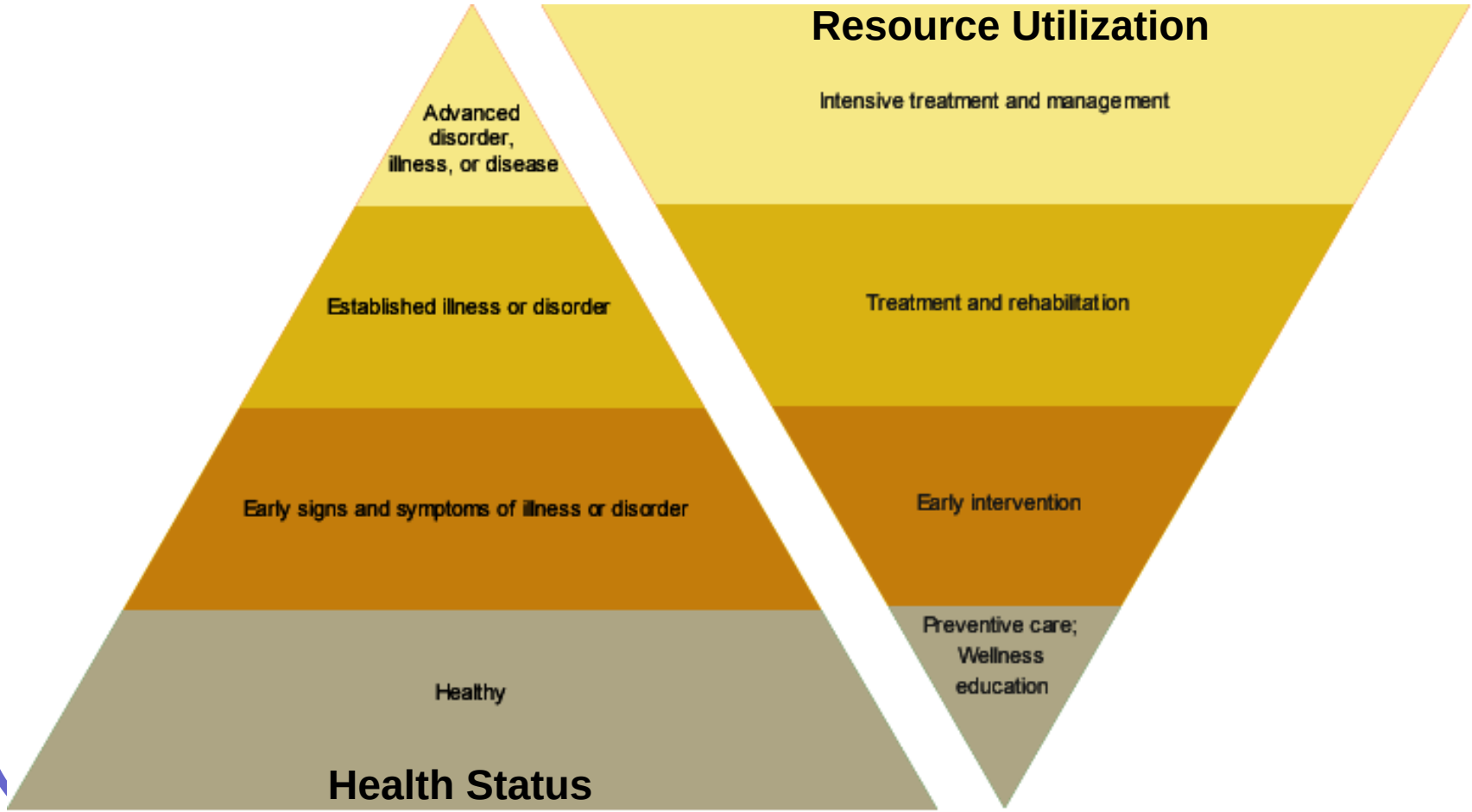
The Tenets of MO HealthNet

- Make decisions on medical evidence and best practices not intuition or expenditures
- Provide management that is as transparent to patients and providers as possible
- Produce outcomes reports for all programs
- Review and insure quality assurance for program policy
- Don’t punish the many for the sins of a few

Medicaid Transformation

Current System	Missouri Transformed System
Provider-centered	Individual-centered
Price-driven	Values-driven
Hidden price and quality information	Transparent price and quality information
Knowledge-disconnected	Knowledge-intense
Slow diffusion of innovation	Rapid diffusion of innovation
Disease-focused	Prevention and health-focused
Paper-based	Electronically-based
Process-focused government	Outcomes-focused government
Limited choice	Increased choice
Quantity and price measured	Quality of care and quality of life

This reflects a philosophical shift in healthcare delivery from a system in which beneficiaries are entitled to buffet (everything), to a system of individualized services based on health need.



Disease Prevalence MHN FFS vs. Private Sector

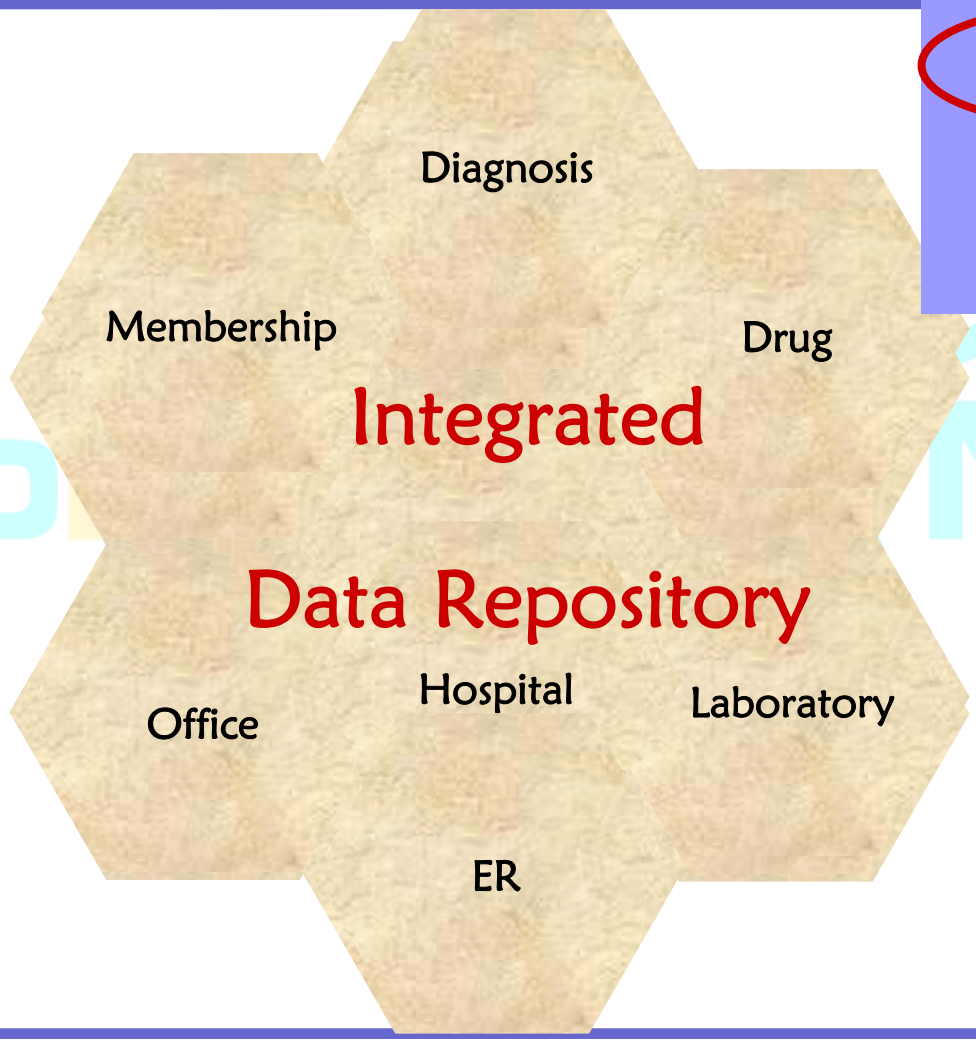
Measures	Actual	Benchmark	% Difference
Patients Per 1000 Anxiety Disorder	23.86	12.22	95.2%
Patients Per 1000 Asthma	37.49	29.65	26.5%
Patients Per 1000 Bipolar Disorder	33.31	4.51	638.7%
Patients Per 1000 Coronary Art Dis	39.47	14.58	170.6%
Patients Per 1000 CHF	28.61	2.51	1,040.6%
Patients Per 1000 COPD	50.05	7.16	599.4%
Patients Per 1000 Depression	71.07	31.18	127.9%
Patients Per 1000 Diabetes	77.25	35.76	116.0%
Patients Per 1000 HIV Infection	2.87	.60	376.1%
Patients Per 1000 Hypertension	101.70	75.08	35.4%
Patients Per 1000 Osteoarthritis	60.96	29.24	108.5%
Patients Per 1000 Rheum Arthritis	5.10	3.25	56.7%

Disease Prevalence in MHN MCO vs. Private Sector

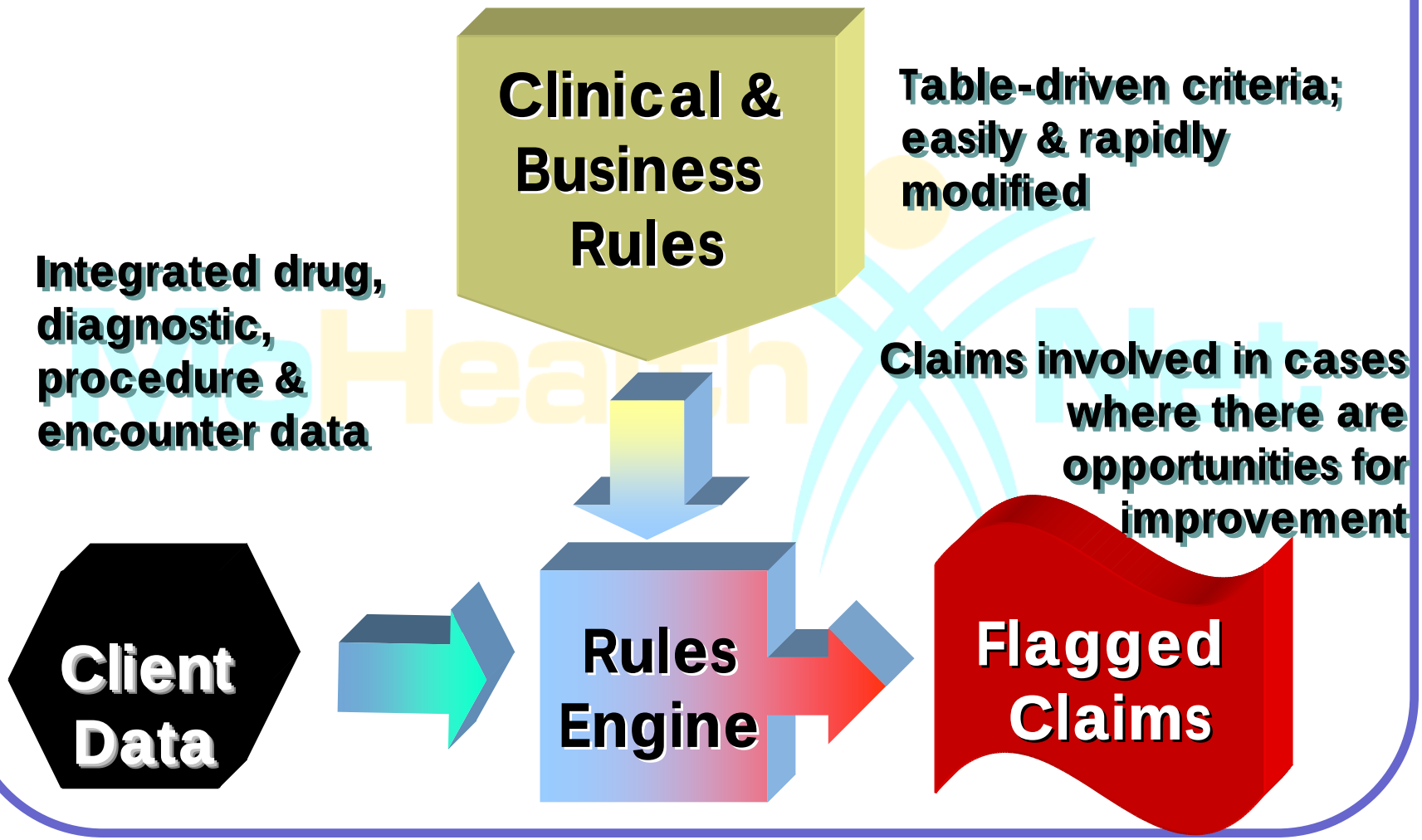
Measures	Actual	Benchmark	% Difference
Patients Per 1000 Anxiety Disorder	7.93	7.93	-0.1%
Patients Per 1000 Asthma	41.39	36.44	13.6%
Patients Per 1000 Bipolar Disorder	13.21	2.91	353.4%
Patients Per 1000 Coronary Art Dis	1.04	.81	28.1%
Patients Per 1000 CHF	.50	.28	82.5%
Patients Per 1000 COPD	1.83	1.90	-3.5%
Patients Per 1000 Depression	30.32	20.34	49.1%
Patients Per 1000 Diabetes	6.82	5.85	16.5%
Patients Per 1000 HIV Infection	.49	.16	210.6%
Patients Per 1000 Hypertension	8.58	7.88	8.8%
Patients Per 1000 Osteoarthritis	4.08	3.63	12.4%
Patients Per 1000 Rheum Arthritis	.45	.88	-48.2%

Mapping & Data Integration

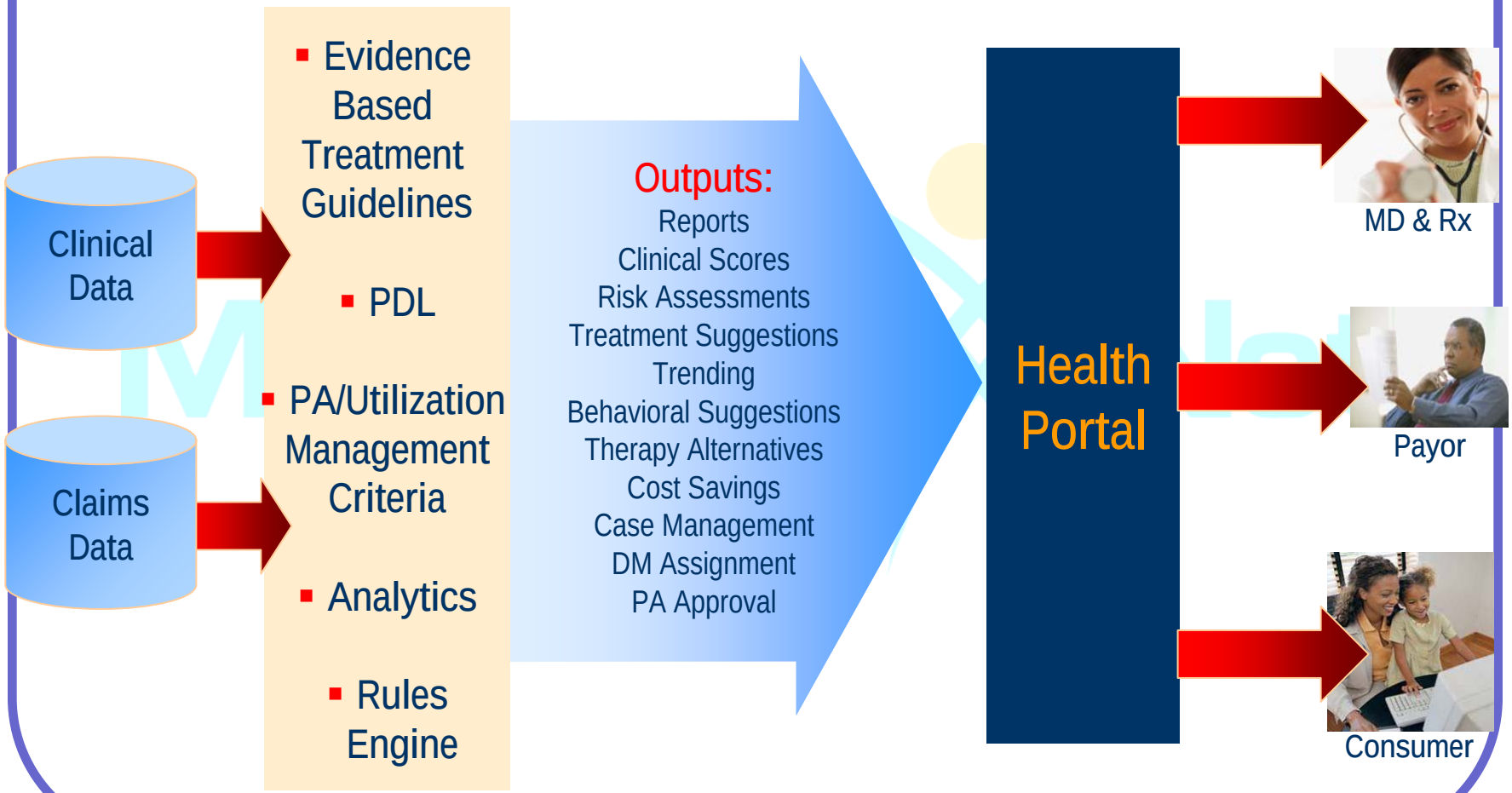
- Pharmacy Claims
- Medical Claims
- Reference Data



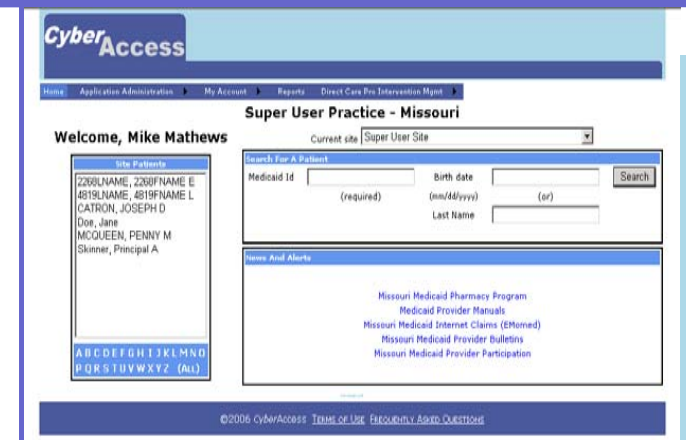
Clinical Rules System

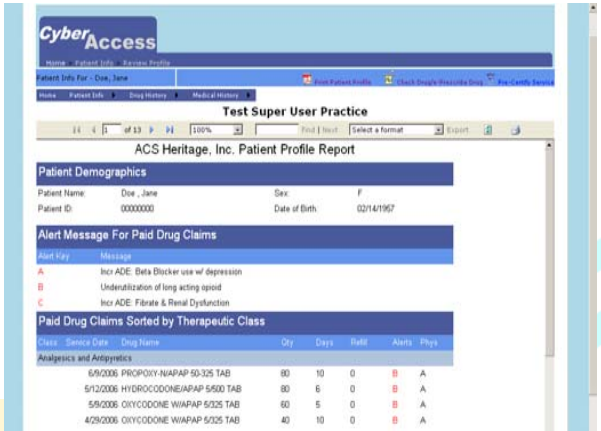


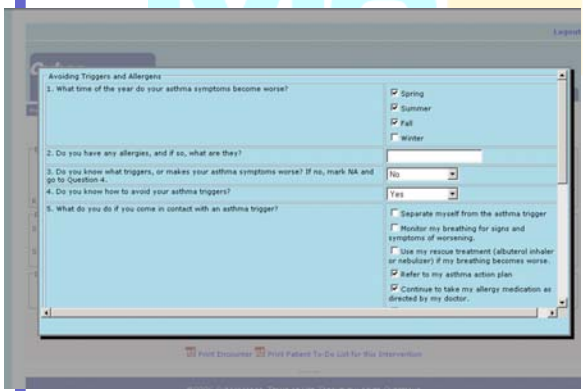
Self-Service Model

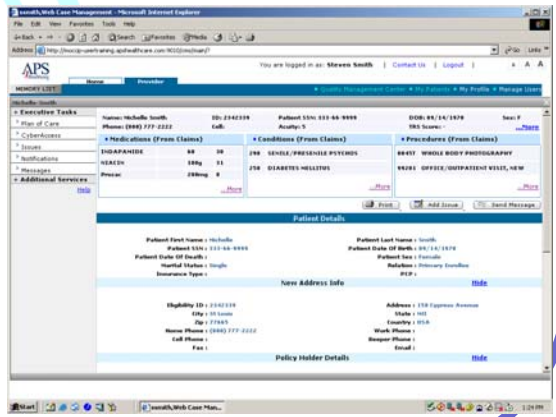


Driving Change Through Technology









Next Steps SFY 2008-2013

- Complete integration of imaging pre-certifications
- Continue pre-certification of durable medical equipment
- Integration of new delivery models with Medicaid reform legislation
- Statewide patient health record
- Insure Missouri initiative
- Long-term care insurance integration
- Integrate home and community based waiver services and evaluation
- Additional services added into program (if funded)
  - Optometric
  - Dental

Mo HealthNet Oversight Committee

- Mo HealthNet Oversight Committee
  - Eighteen Members
    - Four from the General Assembly
    - One consumer
    - Two primary care physicians
    - Two physicians not primary care
    - One representative of the state hospital association
    - One non-physician appointed by Director of Insurance
    - One Dentist
    - Two patient advocates
    - One public member
    - Directors or their designees from DHSS, DMH, and DSS (exofficio)
  - Meet at least four times annually
  - Advise and approve plans, review operations, compare plans
  - Establish subcommittee on single point of entry (21 members)

Additional Committees

- Joint Committee on HealthNet
  - Ten members of the General Assembly
  - Study 5 year rolling budget
  - Make recommendation to the General Assembly annually
- Professional Services Payment Committee
  - Eighteen members
  - Develop and oversee pay-for-performance program guidelines
  - Includes nine physicians, two patients advocates, Attorney General or his/her designee, hospital administration, nursing home administration, dentistry, and pharmaceuticals

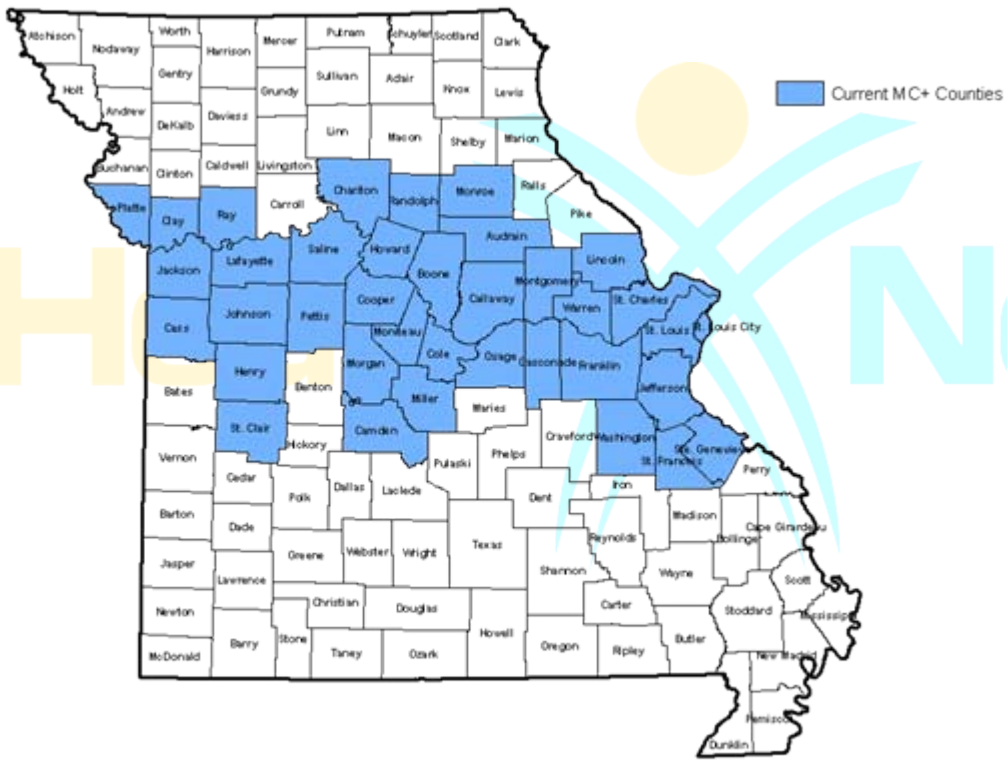
Disease Management Program Outcomes (2002-2008)

Parameter	SFY2004 – Enrolled % change vs.. Control % change	SFY2005 – Enrolled % change vs. Control % change	SFY2006 – Enrolled % change vs. Control % change
Hospitalizations	- 2% vs.. + 11%	+ 0% vs. + 62%	+ 33% vs. + 45%
ER Visits	- 25% vs. + - 16%	+ 25% vs. + 46%	+ 3% vs. + 28%
# Drug Related Problems	+ 7% vs. – 5%	+ 0% vs. + 4%	- 21% vs. + 129%

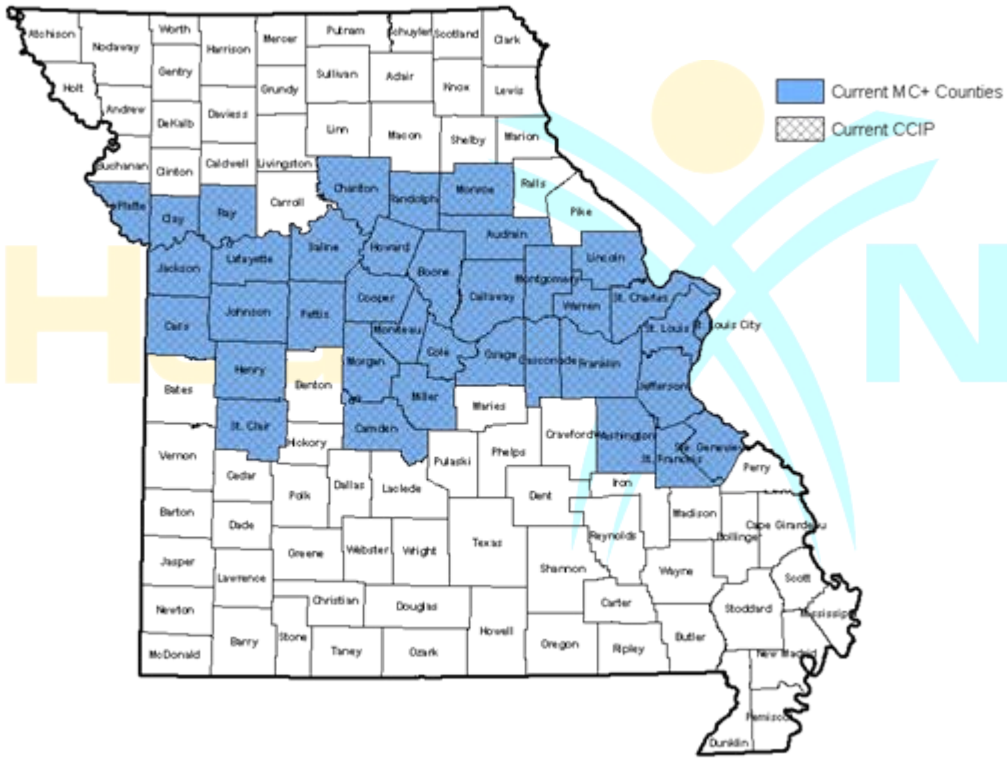
Disease Management Program Savings (2002-2008)

Year	PMPM Savings	% Increase Savings from Prior Year	% Increase Savings from Year One of Program
SFY2004	$191.00		
SFY2005	$305.00	60%	60%
SFY2006	$428.76	41%	124%

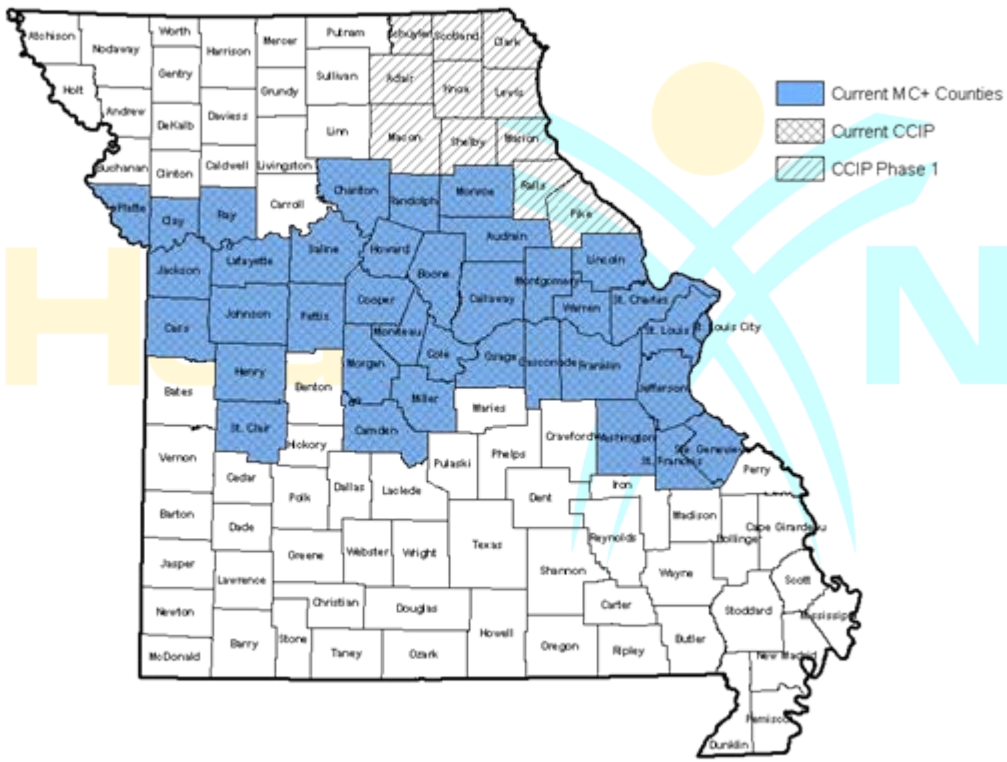
Current Managed Care Counties



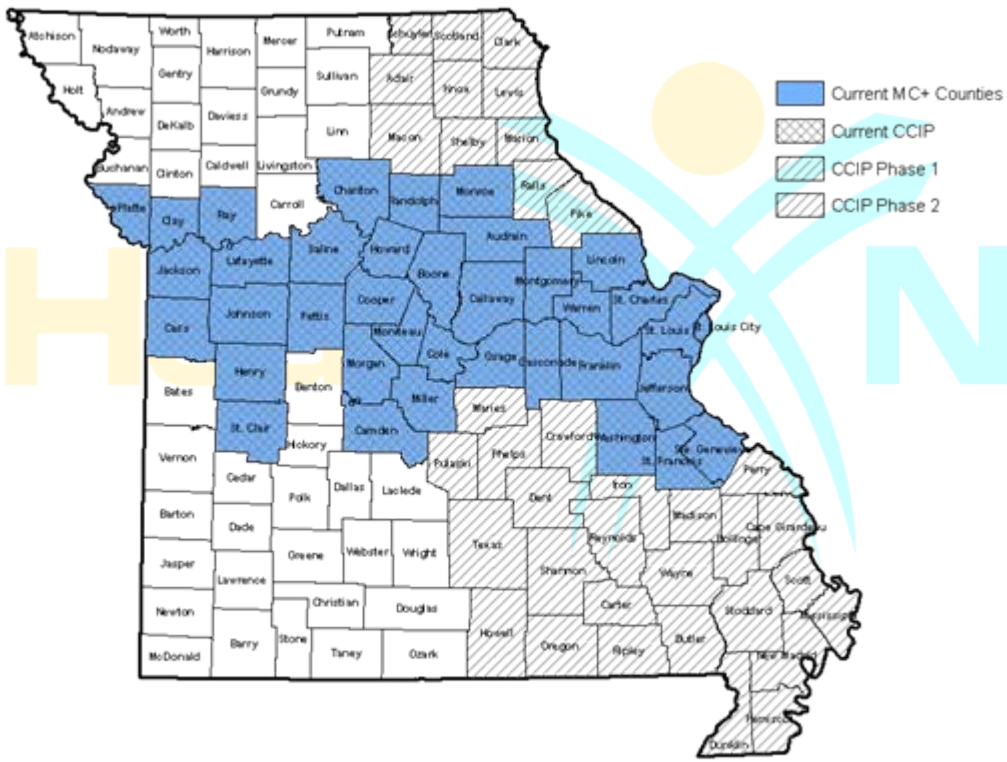
Current Chronic Care Improvement Program



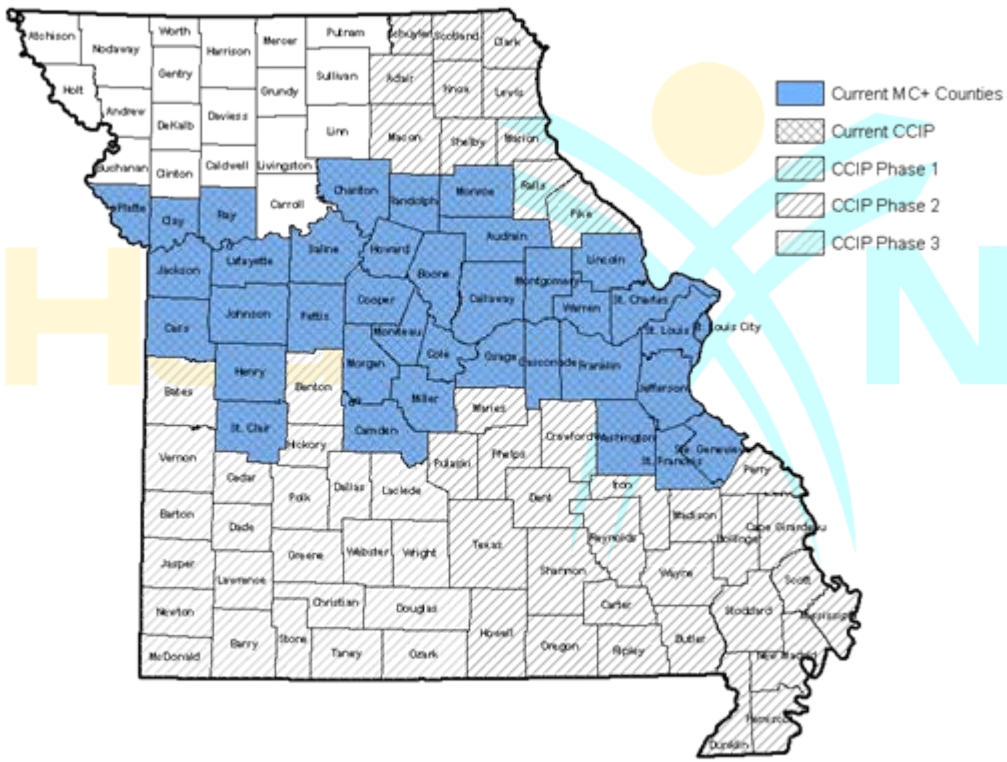
Continued CCIP Deployment NE



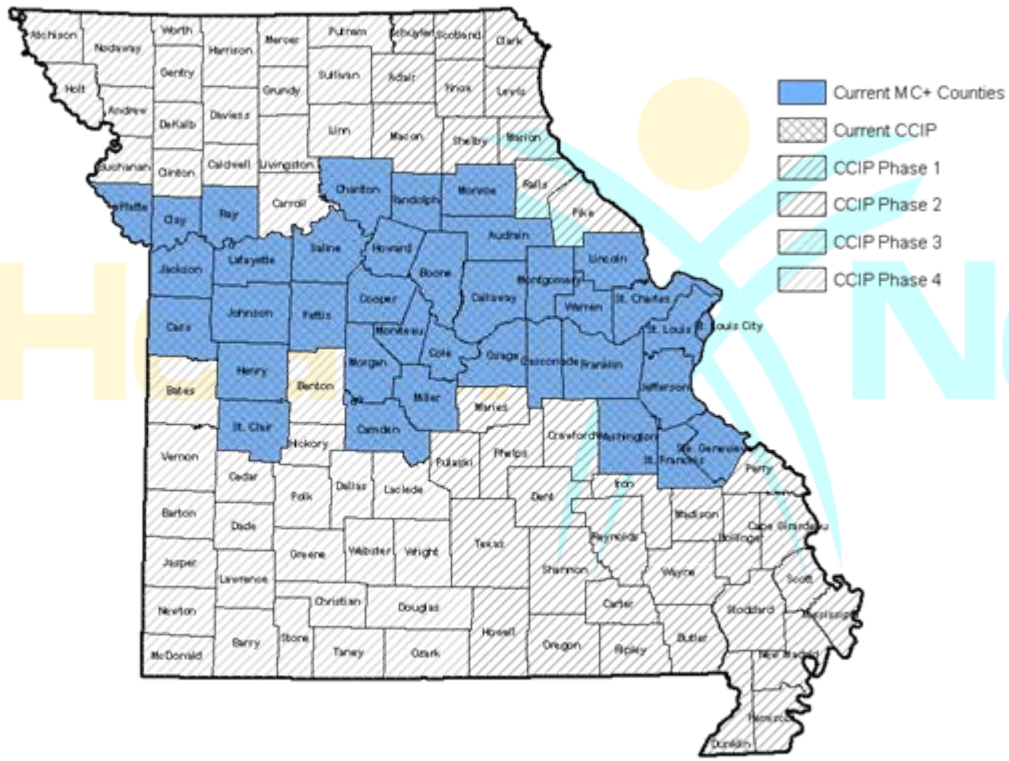
Continued CCIP Deployment SE



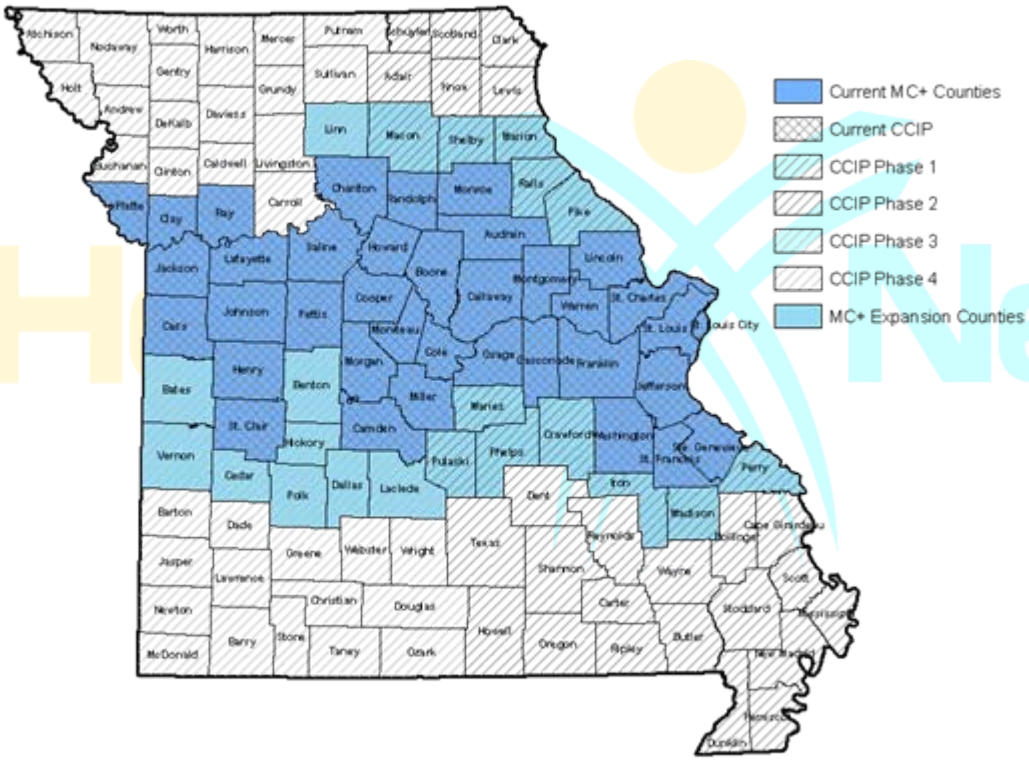
Continued CCIP Deployment SW



Continued CCIP Deployment NW



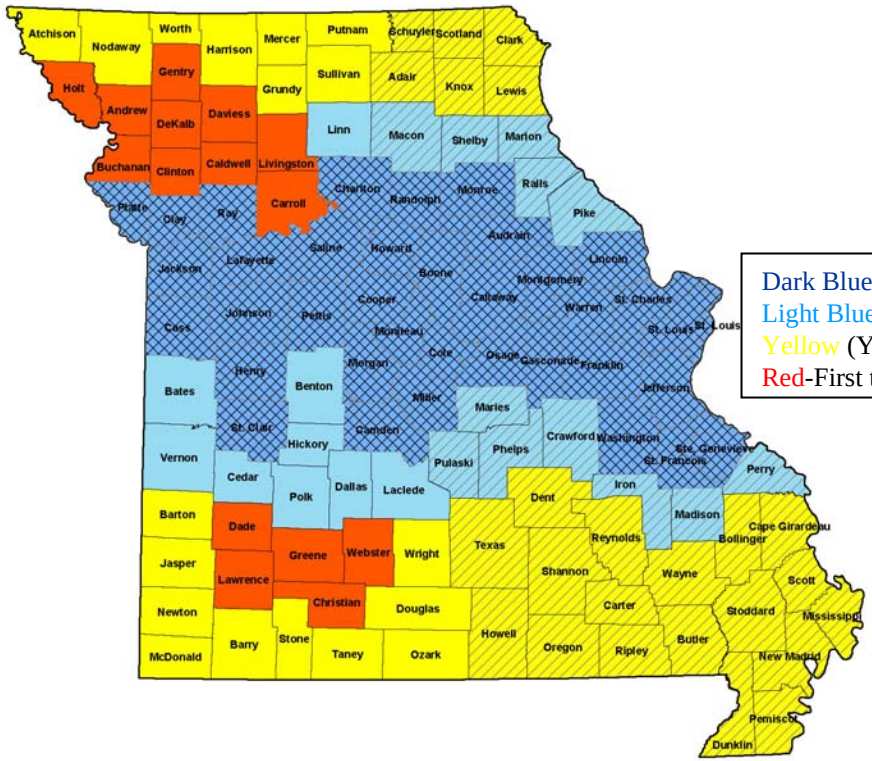
Expanded MCO Contiguous Counties



MHN Roll Out

- Continue the statewide rollout of CCIP (Chronic Care Improvement Program) [except in Springfield and St. Joseph]
- Do a request for proposal (RFP) for ASO models in the Springfield and St. Joseph catchment areas for all populations (including the chronically ill)
- Use the current CCIP vendor to identify the balance of the fee for service population and do a first level electronic risk assessment
- The Division will help them identify a healthcare home
- Work toward an incremental phase in of ASO management of all populations (including the chronically ill) in the fee for service counties of the state over the next two years.
- The current CCIP contract will expire as the chronically ill are included in ASO management for all populations within a given geographic area.

Graphic MHN Roll Out



Dark Blue-Current Managed Care
Light Blue-Managed Care Expansion
Yellow (Yellow)-CCIP to be ASO/ Coordinated FFS
Red-First to be Contracted ASO

A Healthcare Home

- A Healthcare Home is NOT:
  - A building, house or hospital
  - Directed by a specific type of provider

Tenets of a Healthcare Home

- A Healthcare Home IS:
  - A comprehensive primary healthcare delivery approach
  - Focusing on:
    - Comprehensive
    - Coordinated
    - Physical and Behavioral Healthcare

Characteristics of a Healthcare Home

- Accessible
- Continuously Available
- Comprehensive
- Family centered
- Coordinated
- Compassionate
- Culturally sensitive

Vision of a Healthcare Home

- Holistic Healthcare Partnership
  - Focus on Empowerment
    - Patient
    - Patient's family
    - Patient's caregiver
  - Meet Program Assurances
    - All medical
    - Behavioral
    - Psychosocial

Coordinator of a Healthcare Home

- Transparent with Regard to Provider
- Sensitive to Patient's Medical Needs
- Trained at Appropriate Level for Deliverables

Functions of a Healthcare Home

- Targets
  - Patient's predominant needs
  - Predominant diagnoses
    - Physical
    - Behavioral
  - Relative disease progression or morbidities in aggregate

Goals of a Healthcare Home

- Assist Patient, Family and Caregiver
  - Access primary care services
  - Coordinate referrals
  - Obtain specialty care
- Additional Goals
  - Supports health-based educational needs with related services
    - Out-of-home and in-home
    - Family support assistance from both private and public sector providers

Inclusions of a Healthcare Home

- Included but not limited to Periodic Updating and Implementing of:
  - A plan of care (POC) consistent with health risk assessment
  - A wellness plan
  - POC focusing upon maintaining patient's independence
  - Clinical care considerations
  - Expectations monitored, reasonable, relational to level of emergent need

Further Expectations of a Healthcare Home

- Inclusion of Routine Preventive Care
- Plan of Care (electronic preferred)
  - Integrated
  - Multidisciplinary
  - Inclusive
- Access to Emergent and Long-term Care
  - Consistent with overall clinical status
  - Evaluation by standard objective instrument

Further Expectations of a Healthcare Home

- Routine Patient Follow-up
- Perception of Healthcare Status
- Perception of Delivery System
  - Perception of services provided
  - Perception of providers

Overall Missouri Recipient Goals

- All Patient Will Have A Healthcare Home
  - Primary focus is the wellness of the patient
- Achieve Wellness and Length of Wellness
  - Education and resource coordination
    - Chronic care management
    - Consistent with disease severity and process
    - Focused on medically necessary level of care
- Encourage Personal Responsibility
- Balance Care with Wellness and Public-sector Investment

Overall Goals of Missouri Delivery System

- Appropriate Setting
- Appropriate Cost
- Targeted to Ensure Integrity of Pathway
- Empower Patient to Participate As Possible
- Focus of Access to Care and Payment
  - Best Practices
  - Medical Evidence
- Targeting of Guidelines to Assure
  - Necessity of Care
  - Diagnosis Based Treatment
  - Quality
  - Prudent Resource Allocation and Utilization

When Have You Achieved A Healthcare Home?

- Define in Context
  - of participants
  - of providers
  - of disease
- NCQA Point Standard
- Reporting of Access Standard
  - Wellness metrics
  - Claim filing

NCQA Process Overview

PCMH-PPC Proposed Content and Scoring

Standard 1: Access and Communication	Pts
A. Has written standards for patient access and patient communication**	**4**
B. Uses data to show it meets its standards for patient access and communication**	**5**
	9

Standard 2: Patient Tracking and Registry Functions	Pts
A. Uses data system for basic patient information (mostly non-clinical data)	2
B. Has clinical data system with clinical data in searchable data fields	3
C. Uses the clinical data system	3
D. Uses paper or electronic-based charting tools to organize clinical information**	**6**
E. Uses data to identify important diagnoses and conditions in practice**	**4**
F. Generates lists of patients and reminds patients and clinicians of services needed (population management)	3
	21

Standard 3: Care Management	Pts
A. Adopts and implements evidence-based guidelines for three conditions **	**3**
B. Generates reminders about preventive services for clinicians	4
C. Uses non-physician staff to manage patient care	3
D. Conducts care management, including care plans, assessing progress, addressing barriers	5
E. Coordinates care//follow-up for patients who receive care in inpatient and outpatient facilities	5
	20

Standard 4: Patient Self-Management Support	Pts
A. Assesses language preference and other communication barriers	2
B. Actively supports patient self-management**	**4**
	6

Standard 5: Electronic Prescribing	Pts
A. Uses electronic system to write prescriptions	3
B. Has electronic prescription writer with safety checks	3
C. Has electronic prescription writer with cost checks	2
	8

Standard 6: Test Tracking	Pts
A. Tracks tests and identifies abnormal results systematically**	**7**
B. Uses electronic systems to order and retrieve tests and flag duplicate tests	6
	13

Standard 7: Referral Tracking	PT
A. Tracks referrals using paper-based or electronic system**	**4**
	4

Standard 8: Performance Reporting and Improvement	Pts
A. Measures clinical and/or service performance by physician or across the practice**	**3**
B. Survey of patients' care experience	3
C. Reports performance across the practice or by physician **	**3**
D. Sets goals and takes action to improve performance	3
E. Produces reports using standardized measures	2
F. Transmits reports with standardized measures electronically to external entities	1
	15

Standard 9: Advanced Electronic Communications	Pts
A. Availability of Interactive Website	1
B. Electronic Patient Identification	2
C. Electronic Care Management Support	1
	4

** Proposed Core Elements

NCQA Measuring quality. Improving health care.

Regional Quality Improvement, August 7, 2007 11

Discussion

- Questions?

Thank you

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MO HEALTHNET MANAGED CARE PERFORMANCE MEASURES

Healthcare Effectiveness Data and Information Set (HEDIS) is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. Additional information regarding HEDIS can be accessed at the NCQA website: http://web.ncqa.org/tabid/59/Default.aspx

Following are the HEDIS measures collected by MO HealthNet Managed Care health plans and sent to Department of Health and Senior Services (DHSS). The measures with an * identify the DHSS required HEDIS measures per 19 CSR 10-5. 010.

EFFECTIVENESS OF CARE

1. (H) Childhood Immunization Status (CIS)*
2. (H) Adolescent Immunization Status (AIS)*
3. (H) Cervical Cancer Screening (CCS)*
4. (H) Chlamydia Screening in Women (CHL)*
5. (H) Follow-up After Hospitalization For Mental Health Disorders (FUH)
6. (H) Use of Appropriate Medications for People with Asthma (ASM)*

ACCESS/AVAILABILITY OF CARE

7. (H) Prenatal and Postpartum Care (PPC)
8. (H) Annual dental visit (ADV)*

SATISFACTION WITH THE EXPERIENCE OF CARE

9. (H) CAHPS 3.OH Child/Adult Survey*

USE OF SERVICES

10. (H) Well child Visits in the First 15 Months of Life (W15)
11. (H) Well Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life (W34)
12. (H) Adolescent Well-Care Visits (AWC)*
13. (H) Ambulatory Care (AMB)
14. (H) Mental Health Utilization – Percentage of Members Receiving Inpatient, Intermediate Care and Ambulatory Services (MPT)
15. (H) Identification of Alcohol and Other Drug Services (IAD)

(H) = HEDIS Measure
* DHSS required measure

Consumer Assessment of Healthcare Providers and Systems (CAHPS®[2]) surveys

The CAHPS surveys represent an effort to accurately and reliably capture information from consumers about their experiences with care in health plans in the past year for commercial plans and the past six months for Medicaid plans. Consumers, purchasers and health plans have a core survey instrument that reflects state-of-the-art research about key components of health care quality, about how to elicit from a broad range of consumers their experiences with those key components, and about how to report the information meaningfully to the public.

The CAHPS surveys were designed to collect data across populations—that is, there are versions for commercial and Medicaid populations, as appropriate.

A core group of questions makes up each of the CAHPS surveys. The questions in the surveys are worded to be understandable to a broad range of consumers and some questions combine to form composites about key areas of care and service. These composites provide summary results that are easier for consumers and purchasers to interpret. The questions chosen for the survey were those shown to discriminate best among health plans based on field tests. The Healthcare Effectiveness Data and Information Set (HEDIS)/CAHPS survey results provide comparable results across populations—Medicaid, commercial and Medicare.

Currently there are six HEDIS surveys, covering HMO, POS and PPO products:
1. CAHPS® 4.0H Adult Commercial
2. CAHPS® 3.0H Child Commercial
3. CAHPS® 3.0H Child Commercial with CCC (Children with Chronic Conditions)
4. CAHPS® 4.0H Adult Medicaid
5. CAHPS® 3.0H Child Medicaid
6. CAHPS® 3.0H Child Medicaid with CCC (Children with Chronic Conditions)

The CAHPS 3.0, Child Medicaid survey consist of 418 questions and is used by the MO HealthNet Managed Care Health Plans.

National Health IT Direction – Meeting Business and Technical Goals

ACS is a long standing innovator in Health IT Solutions and has been at the leading edge of e-Health Technology deployment. We are committed to providing a sustainable and interoperable health network that exceeds the goals of the CMS e-Health Initiative, President Bush's EHR Initiative and the MITA Maturity Model. The ACS CyberAccess system solution functions as a 3-tier, multi-payer, electronic health record solution and provider services solution with a Service-Oriented Architecture (SOA) that conforms to common industry standards and best practices. Its rules based logic and component design provide the appropriate framework for easily enabling improvements in the Medicaid Program that can be applied specifically to one or more system clients, or across all clients as needed.

Our high level goals and business models strive to:

- Improve or enhance medical care
- Improve patient involvement in their medical care and their overall satisfaction with the health care experience
- Streamline operations and business practices
- Control expenditures
- Prevent medical mishaps.

The CyberAccess Portal Solution meets Medicaid MITA Business and technical goals by:

- Being Fully Web-based and easily integrated into existing portals
- Being a portable solution. Consumers of the information need not purchase or install any additional software to have access to the EHR system
- By enabling customer-specific functionality. Each portal contains language and clinical output, plus additional e-health capability as appropriate to the target audience
- By being multi-client. The Portal allows customization for specific payers, while maintaining common code across clients.
- Enabling an EHR record including all members medical and pharmacy history for the past 24 months as provided by the Commonwealth or other payer or by providers or patients
- Enabling real-time prior authorization of drugs and medical services, cutting back provider time and facilitating services to recipients
- Enabling e-prescribing capabilities for the provider community

SOA Architecture

The solution is based on a service oriented architecture (SOA) platform to allow integration of community based systems and data contained in a centralized patient data hub (PDH) with expanded functionality. Web services interfaces are exposed to allow connectivity and transference of information across the enterprise service bus (ESB). We have patterned this capability to be fully Medicaid Information Technology Architecture (MITA) compliant. This will permit value-add capabilities and business functions, such as Care Management, a MITA level three capability, to be easily added to the completed SOA architecture. MITA provides a roadmap for Medicaid system functionality and architecture.

Cyber Access—A Physician EHR Portal

- CyberAccess[SM] provides treating physicians, nurses, physicians assistants, and care managers with:
  - Complete patient medical claims history
  - Succinct best practices recommendations
- CyberAccess[SM] uses a clinical rules engine, which:
  - Examines claims information real-time for all patients in the population
  - Identifies and alerts providers about care management issues and gaps-in-care as compared to nationally published guidelines for close to 40 different disease states, which may represent a serious potential risk for adverse health outcomes
  - Substitutes State adopted guidelines for selected disease states, as needed
- CyberAccess[SM] includes functionality, which:
  - Gives the provider a downloadable (and printable) patient history containing all claims data submitted for his/her patient over the past two years (drug claims, diagnosis codes, CPT codes, etc.)
  - Allows the physician to prospectively examine how specific formulary, medical and drug prior authorization (PA) requirements, and Pro-DUR criteria would affect the physician's decision to prescribe a certain drug or medical procedure to an individual and includes suggestions on prescribing alternatives and best-practices information. Using this information, the physician can determine if a prescription meets the payer's requirements and if a PA request is required
  - Includes E-prescribing capability allowing the provider to:
    - Determine if a patient meets the payer's guidelines for appropriate utilization and prior authorization (PA) and/or transmit a prescription electronically
    - Transmit a prescription electronically
- CyberAccess[SM] is being expanded to include:
  - Lab data
  - Information from provider patient record systems
  - Paper records translated to electronic format for inclusion in patient record

*Direct*CARE*Pro*[SM]*— Pharmacy Component of CyberAccess*

- *Direct*CARE*Pro*[SM] is a highly innovative point of service Web-based care enhancement model that assists pharmacists and other appropriate staff to:
  - Provide proper care for a recipient's multiple chronic diseases and co-morbidities by delivering nationally-recognized, evidence-based treatment standards onsite through the pharmacist's computer
  - Engage in face-to-face interaction with the patient, which adds value as compared to the traditional disease management approach of nurse call lines
  - Make the most efficient use of the most under-utilized sector of the health care community, namely, the pharmacist
- *Direct*CARE*Pro*[SM] features include:

- Auto assessment of enrollee risk, gaps in care, and intervention opportunities on a 24/7 basis using dozens of proprietary algorithms that scan claims and other data
- Focused interventions prompted by actionable Therapy or Treatment Standard Deviations (TSDs, also known as "gaps-in-care")
- Engagement of credentialed pharmacists to deliver interventions at the point of service with a client
- Web-based connection to participating pharmacists to access *Direct*CARE*Pro*SM with no disruption in claims administration and pharmacy operations
- Automatic adjustment of intervention intensity to fit the enrollee's risk and any Commonwealth medication therapy management (MTM) frequency requirements
- Documentation and billing of authorized services through a secure Internet site
- Provision of treatment standard deviations (TSDs) information to the physicians and nurses involved in directing the care of the enrollee
- Identification of TSDs and other gaps in care, and surveillance on the same data sources to monitor enrollee, pharmacist and physician response to evidenced-based interventions
- Provision of e-health data such as demographics, therapy profile, and diagnosis directly to the user

- *Direct*CARE*Pro*SM empowers pharmacists to:
  - Engage beneficiaries at the point of care to deliver effective, face-to-face interventions, providing numerous advantages and innovations beyond traditional care management models
  - Have a far greater opportunity for enrollment, outreach, and intervention than any other higher cost, traditional disease management models
- *Direct*CARE*Pro*SM provides another alternative response to the needs of persons receiving Medicaid services:
  - Provides the opportunity for individuals to directly interact with pharmacists as known, trusted providers
    - ACS data indicates that 80 percent of diabetics' claims are received from the same pharmacy
  - Provides individuals with on-going and regular communication with a healthcare professional regarding their particular health care needs
    - Anecdotal data indicates that diabetics see a pharmacist on average once a month—more than any other single provider in the health care system. On average, these individuals visited a prescriber less than twice annually and a pharmacy between 9 and 10 times annually

CyberAccess Network & Application Architecture –Protecting Data Security and Privacy

CyberAccess functions as a web portal to the provider community on the public Internet. As such, the application architecture is designed to protect the application and data while creating a stable platform for the application to reside.

The current implementation for the CyberAccess service is in a three-tier architecture. This implementation is for protecting data exposed on public-facing servers in which proprietary and confidential information is received or presented by a browser-based application. This type of

architecture is currently a best practice in the IT industry and provides layers of protections between the Web, Application and Database Server. Each layer is protected by a Layer 7 stateful firewall and is inspected by intrusion prevention systems. The equipment hosting the applications is configured for redundancy and load balancing to provide fault tolerance and continued customer service during high volume loads.

User can access the Web application in the Web zone using a standard Web browser that supports 128-bit SSL. All data retrieval calls are made to the Application layer via remote programming calls. The application layer will then retrieved the remotes call from the internal Database servers using stored SQL procedures.

Secure Application Access

CyberAccess functions as a thin-client web application. Users can access the application in the Web application zone using a standard Web browser that supports 128-bit SSL. The communication is securely transferred the internet from the client to the ACS Load Balancer for SSL offloading. SSL is the leading security protocol on the Internet. The protocol allows client/server applications to communicate in a way that is designed to prevent eavesdropping, tampering, or message forgery. When an SSL session is started, the browser sends its public key to the server so that the server can securely send a secret key to the browser. The browser and server exchange data via secret key encryption during that session.

CyberAccess conforms to HIPAA standards for security and privacy. All access to the different functionality of the application is Role based. No one user can have access to other client data that is outside of the assigned Site and Role. Users must know a Medicaid recipient ID or date of birth and last name to pull up individual records within the system. Access to specific functions with the system, such as e-prescribing, are also limited by role to prevent unauthorized users from writing prescriptions.

Within the application itself, the architecture is designed to protect the security of the data. The Web application layer uses forms based authentication. User data is stored in SQL Server 2005 databases, and all passwords are encrypted in the database. Authentication and Role verification is done through the middle tier application services

The middle tier applications are .Net Remoting services. The applications serve up .Net Business Objects remotely. This is where all of the Business Logic and Data Access is done. All data is accessed from SQL Server 2005 databases via Store Procedure calls. The middle tier applications are load balanced allowing scalability and fault tolerance.

ACS Clinical Rules Engine

The Clinical Rules Engine is the backbone of the ACS Web-based ***CyberAccess*** EHR solution having the ability to analyze integrated medical and pharmacy claims data using ACS' proprietary Clinical Rules Engine (CRE).

The Clinical Rules Engine:

- Accurately uncovers current cost drivers and clinical defects that will drive cost and compromise good health
- Provides a flexible table-driven software application with relational database file structures
- Provides a collection of clinical and business rules (comprehensive criteria) based on national or Commonwealth-specified criteria
    - 40 medical conditions and all prescription drugs

    - More than 7,000 defined clinical and economic rules ensure a robust analysis to identify care management issues
- Provides a rules engine that queries data obtained from the MMIS and other sources, including recipient eligibility, provider eligibility, and claims history
- Generates a collection of flagged claims, which are communicated through the EHR portals to providers, recipients, and the payer (s) in the form of health care recommendations
- Is an easy to use, table-driven - not "hard-coded" - platform
    - A non-programmer (e.g., a clinician, policy analyst or care manager) can easily make changes to the existing criteria to meet the changing needs of the Commonwealth.
    - Changes in clinical practice can be quickly and easily made to the clinical and business rules

Industry Nomenclature Standards

ACS utilizes all recommended industry standards in the development and deployment of its IT solutions. In fact, many ACS subject matter experts have been involved in organizational workgroups associated with the development of those standards. We employ all standard nomenclatures, taxonomies, and vocabularies recognized by the Health Insurance Portability and Accountability Act and the National Library of Medicine. These include:

- International Classification of Disease (ICD-9 CM Codes)
- Common Procedure Terminology (CPT/HCPCS Codes)
- Common Dental Terminology (CDT Codes)

Utilizing Industry Interconnectivity Standards

ACS utilizes applicable industry standards required to support its applications. These include:

- ASC X12 N Insurance Subcommittee Guideline for electronic data interchange
- NCPDP Standards for telecommunication and E-prescribing
- HL-7 Global healthcare messaging standard

CyberAcess Data – Enabling a Patient Data Hub

Overtime, the Patient Data Hub becomes a mosaic of patient demographic, clinical, and administrative data. The initial phase contains administrative and clinical information from the supply of the most readily available patient data, the claims data from the patient current health plan.

CyberAccess delivers the following data to its users:

- Recent medical history, including diagnosis, procedure code level information

- Patient demographics, including name, address, age, gender, phone number
- Recent medication history, including drug name, days supplied, refills left, prescription date, NDC
- Drug Alerts and information from our Rules Engine
- Provider System usage reports and administrative reports
- Provider Formulary File information
- Medical prior authorization requirements and real-time prior authorization creation
- Drug prior authorization requirements and real-time prior authorization creation
- FUTURE Addition - Lab results, type of lab test, date, place of service, doctor ordering results

Health Plan Survey Information and Profit/Not-for-Profit Status

Chart 1 indicates the type of providers MO HealthNet Managed Care Health Plans survey for satisfaction:

Chart 1.

MO HealthNet Managed Care Health Plan	Provider Survey	Provider Types Surveyed
HealthCare USA	Conducts annual survey. Last survey was conducted in 2007.	Primary Care and Specialist Providers
Children's Mercy Family Health Partners	Conducts survey every two Years. Last survey was conducted in 2005. Next scheduled survey is for first quarter 2008.	Primary Care, Specialist, and Hospital/Ancillary Providers
Blue-Advantage Plus of Kansas City	Conducts annual survey. Last survey was conducted in 2007.	Primary Care and Specialist Providers
Missouri Care	Conducts annual survey. Last survey was conducted in 2007.	Primary Care, Specialist, and Behavioral Health Providers
Mercy CarePlus	No survey conducted in 2006 or 2007. Consideration being given to conducting a survey in 2008.	Not Applicable
Harmony Health Plan of Missouri	Conducts annual survey. A formal survey was not done in 2006. Managed Care contract with Missouri began on 7/1/06.	Not Applicable

Chart 2 provides the response rates to the CAHPS survey by health plan:

Chart 2.

MO HealthNet Managed Care Health Plan	CAHPS Survey Reporting Year 2007 For CY2006 Data	Rate of Return
HealthCare USA	Yes	Eastern Region = 37.6% Central Region = 39.2% Western Region = 26.7%
Children's Mercy Family Health Partners	Yes	26.8%
Blue-Advantage Plus of Kansas City	Yes	30.2%
Missouri Care	Yes	25%
Mercy CarePlus	Yes	33.8%
Harmony Health Plan of Missouri	Not Applicable. Managed Care contract with Missouri began 7/1/06. First CAHPS due in June 2008.	Not Applicable

Chart 3 provides the profit versus not-for-profit status of the MO HealthNet Managed Care Health Plans.

Chart 3.

MO HealthNet Managed Care Health Plan	Holding Company	Status
Blue-Advantage Plus	Blue Cross and Blue Shield of Kansas City	Not-for-Profit
Children's Mercy Family Health Partners	Children's Mercy Hospital	Not-for-Profit
Harmony Health Plan of Missouri	Wellcare Health Plans, Inc.	For Profit
HealthCare USA of Missouri, LLC	Coventry Health Care, Inc.	For Profit
Mercy CarePlus	Molina HealthCare, Inc.	For Profit
Missouri Care, Inc.	Aetna Health Holdings, LLC	For Profit