

2009

MO HealthNet Managed
Care Program

External Quality Review

Report of Findings

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I.0 EXECUTIVE SUMMARY



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I.1 Introduction

The United States Department of Health and Human Services (DHHS), Centers for Medicare and Medicaid Services (CMS) requires an annual, independent external evaluation of State Medicaid Managed Care programs by an External Quality Review Organization (EQRO). External Quality Review is the analysis and evaluation by an approved EQRO of aggregate information on quality, timeliness, and access to health care services furnished by MO HealthNet MCHPs (MCHPs) and their contractors to participants of MO HealthNet Managed Care services. The Centers for Medicare and Medicaid Services (42 CFR §433 and §438; Medicaid Program, External Quality Review of Medicaid Managed Care Organizations) rule specifies the requirements for evaluation of Medicaid managed care programs.

The State of Missouri contracts with the following MO HealthNet MCHPs represented in this report:

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

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

I) Validating Performance Improvement Projects¹

Each MO HealthNet Managed Care Health Plan (MCHP) conducted performance improvement projects (PIPs) during the 12 months preceding the audit; two of these PIPs were validated through a combination of self-selection and EQRO review. The final selection of PIPs to be audited was determined by the State Medicaid Agency (SMA; Missouri Department of Social Services, MO HealthNet Division (MHD)).

¹ Department of Health and Human Services. Centers for Medicare and Medicaid Services (2002). Validating Performance Improvement Projects: A protocol for use in Conducting Medicaid External Quality Review Activities, Final Protocol, Version 1.0, May 1, 2002. Washington, D.C.: Author.

2) Validating Performance Measures²

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

3) Validating Encounter Data³ (optional activity)

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

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

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

² Department of Health and Human Services. Centers for Medicare and Medicaid Services (2002). Validating Performance Measures: A protocol for use in Conducting Medicaid External Quality Review Activities, Final Protocol, Version 1.0, May 1, 2002. Washington, D.C.: Author.

³ Department of Health and Human Services. Centers for Medicare and Medicaid Services (2002). Validating Encounter Data: A protocol for use in Conducting Medicaid External Quality Review Activities, Final Protocol, Version 1.0, May 1, 2002. Washington, D.C.: Author.

⁴ Department of Health and Human Services. Centers for Medicare and Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR §400, 430, et al., Final Protocol, Version 1.0, February 11, 2003. Washington, D.C.: Author.

I.2 Validation of Performance Improvement Projects

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

Below are the PIPs identified for validation at each Health Plan:

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

The focus of the PIPs is to study the effectiveness of clinical or non-clinical interventions. These projects should improve processes associated with healthcare outcomes, and/or the healthcare outcomes themselves. They are to be carried out over multiple re-measurement periods to measure: 1) improvement; 2) the need for continued improvement; or 3) stability in improvement as a result of an intervention. Under the State contract for MO HealthNet Managed Care, Health Plans are required to have two active PIPs, one of which is clinical in nature and one non-clinical.

Specific feedback and technical assistance was provided to each Health Plan by the EQRO during the site visits for improving study methods, data collection, and analysis.

ACCESS TO CARE

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

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

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

QUALITY OF CARE

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

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

TIMELINESS OF CARE

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

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

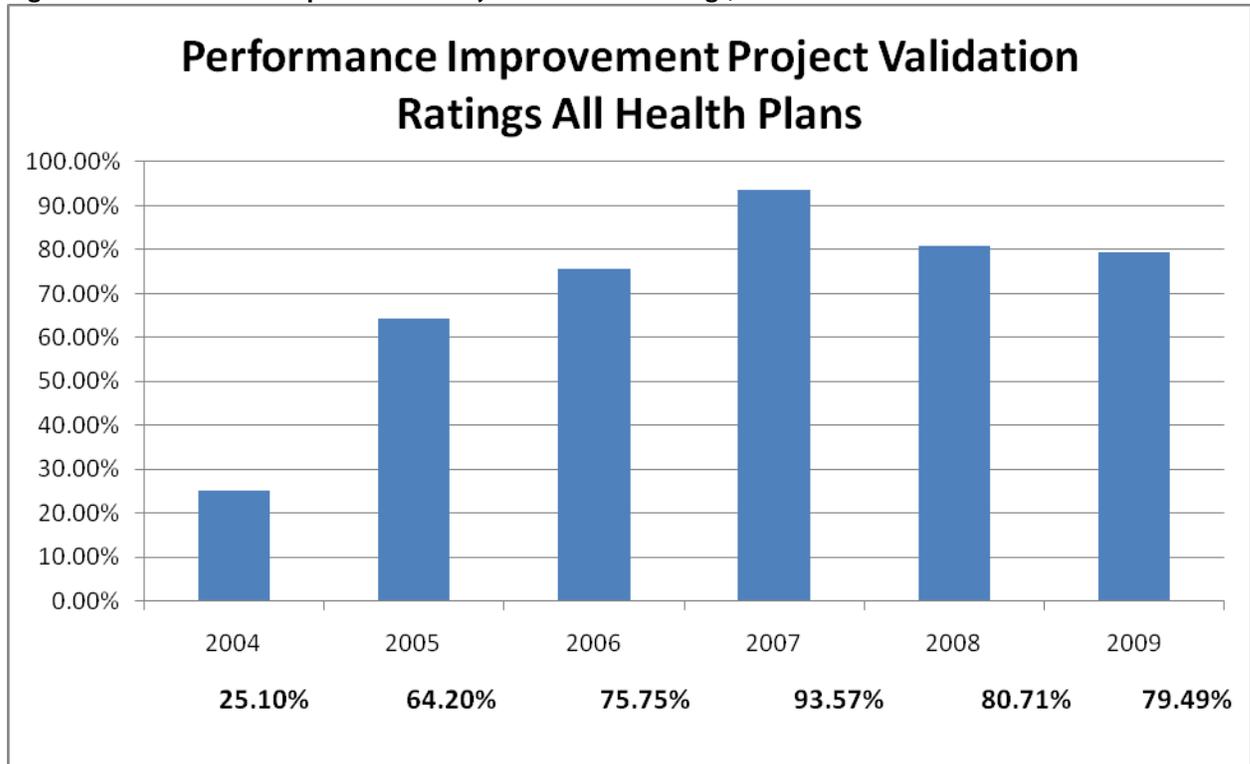
All addressed the need for timely access to preventive and primary health care services. The health plans all related their awareness of the need to provide not only quality, but timely services to members. Projects reflected this awareness in that they addressed internal processes and direct service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

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

CONCLUSIONS

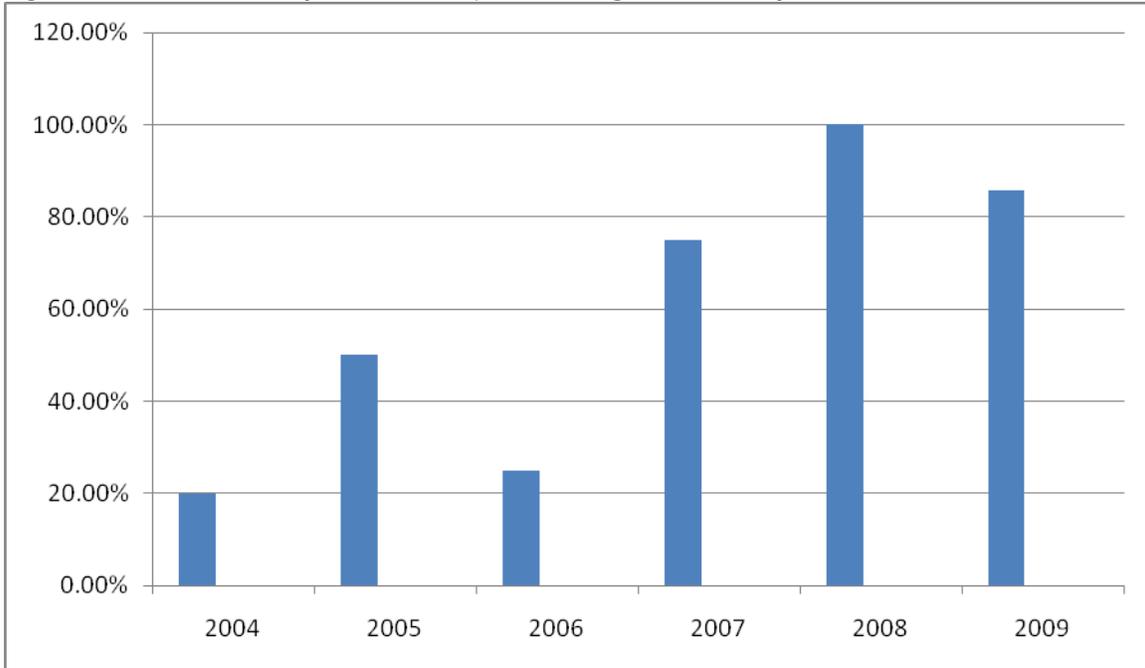
The Health Plans have made significant improvements in utilizing the PIP process since the current measurement process began in 2004. Figure I indicates the improvements the Health Plans have made in providing valid and reliable data for evaluation.

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



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

Figure 2 – Performance Improvement Projects Meeting Sustained Improvement



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

1.3 Validation of Performance Measures

The Validating Performance Measures Protocol requires the validation or calculation of three performance measures at each MO HealthNet MCHP by the EQRO. The measures selected for validation by the SMA are required to be submitted by each health plan on an annual basis. The measures were also submitted by the State Public Health Agency (SPHA; Missouri Department of Health and Senior Services; DHSS) for all Managed Care Organizations (MCOs) operating in the State of Missouri. For the HEDIS 2009 evaluation period, the three performance measures selected for validation were Annual Dental Visits (ADV), Adolescent Well-Care Visits (AWC), and Follow-Up After Hospitalization for Mental Illness (FUH). Detailed specifications for the calculation of these measures were developed by the National Committee for Quality Assurance (NCQA), a national accrediting organization for managed care organizations. The EQRO examined the information systems, detailed algorithms, health plan extract files, medical records, and data submissions provided to the SPHA to conduct the validation activities of this protocol. The data reported to the SPHA was based on MO HealthNet MCHP performance during 2008.

QUALITY OF CARE

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

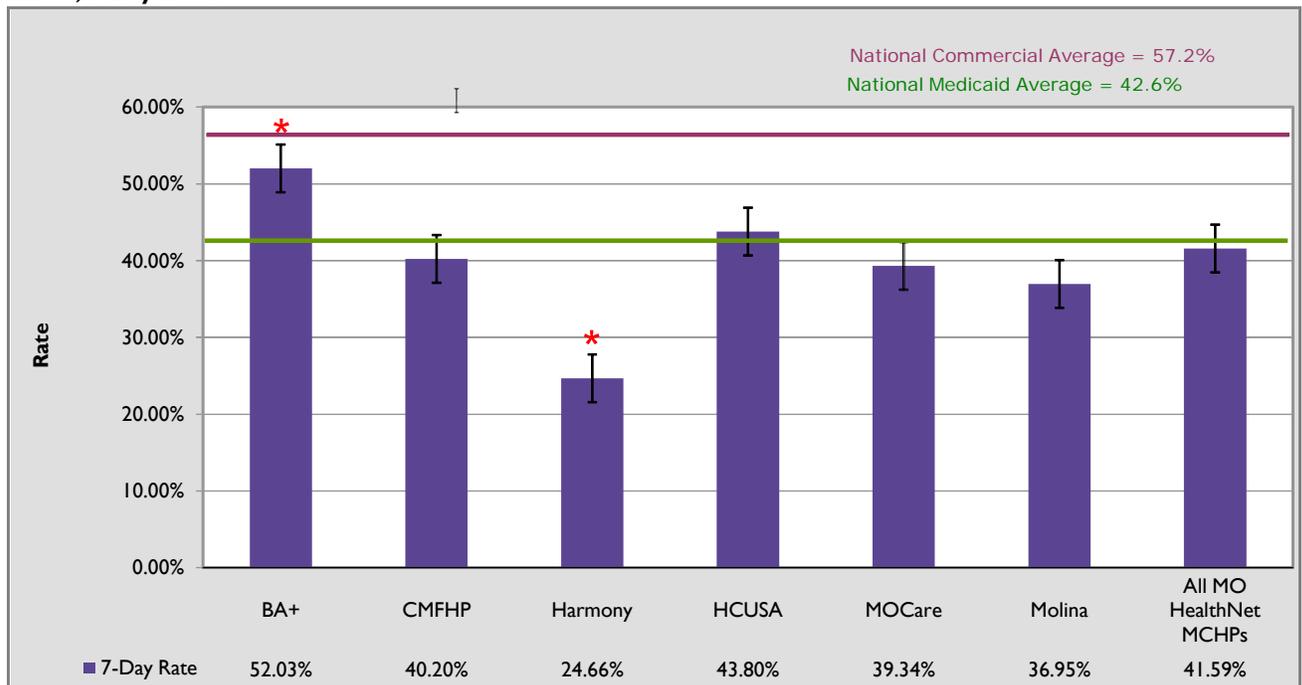
One MO HealthNet MCHP was Fully Compliant with the specifications for calculation of this measure. The five remaining MO HealthNet MCHPs were substantially compliant with the specifications for calculation of this measure.

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

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

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

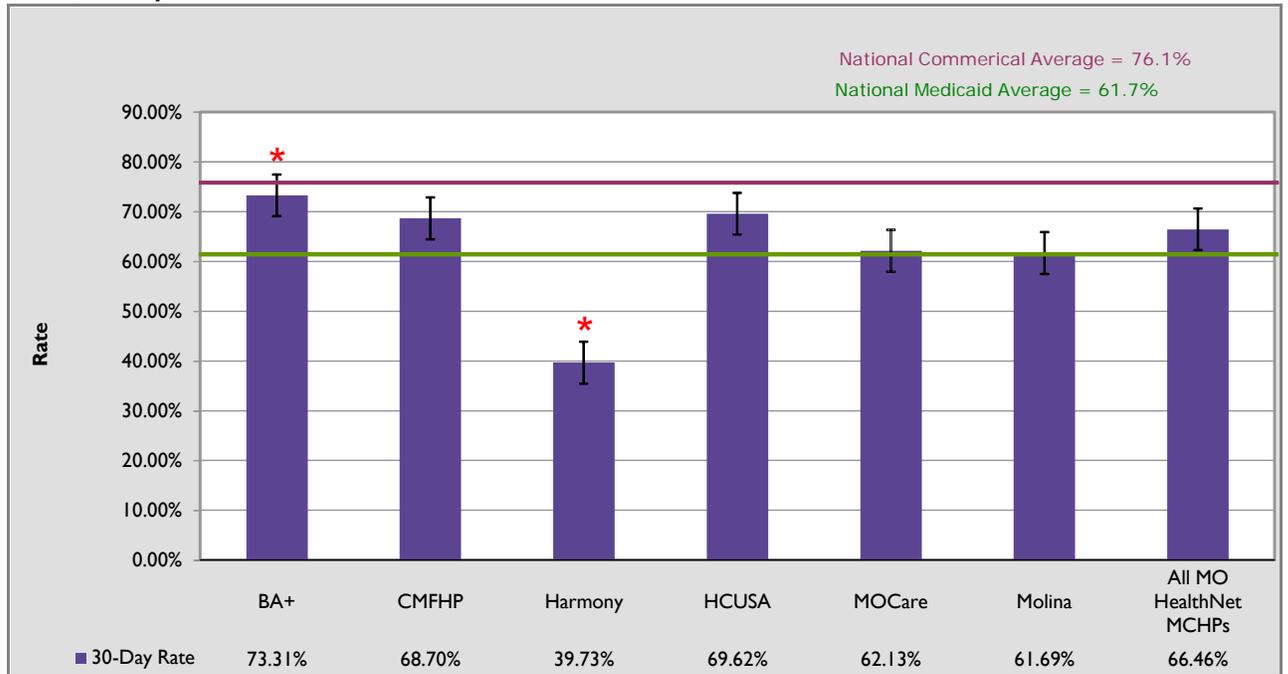
Figure 3 - MO HealthNet Managed Care Program HEDIS 2009 Follow-Up After Hospitalization for Mental Illness, 7-Day Rates



Note: Error bars on the y-axis represent 95% confidence intervals; * indicates values are significantly lower or higher than the MOHealthNet average at the 95% level of significance.

Sources: MO HealthNet MCHP HEDIS 2009 DST; National Committee for Quality Assurance (NCQA).

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

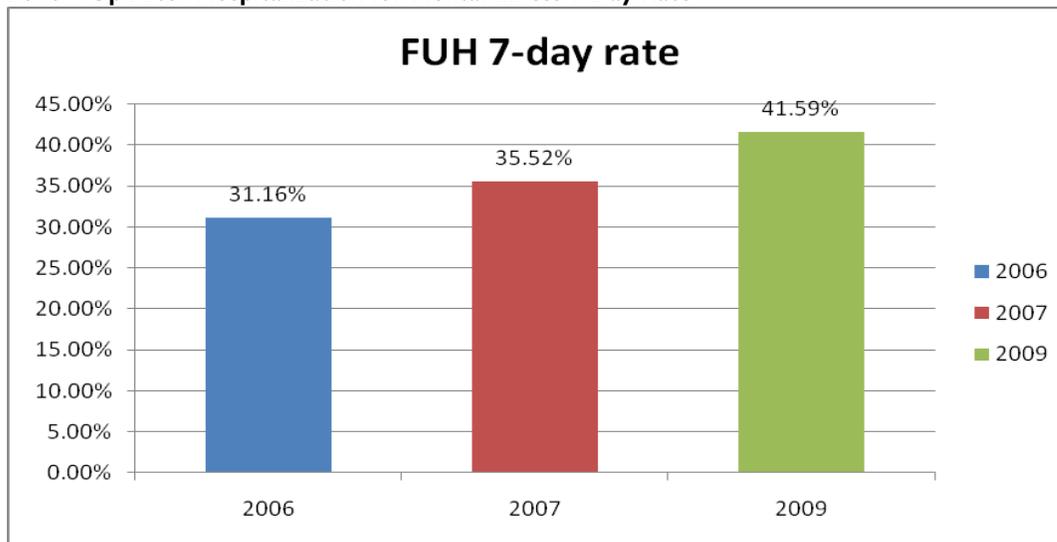


Note: Error bars on the y-axis represent 95% confidence intervals.

Sources: MO HealthNet MCHP HEDIS 2009 DST; National Committee for Quality Assurance (NCQA)

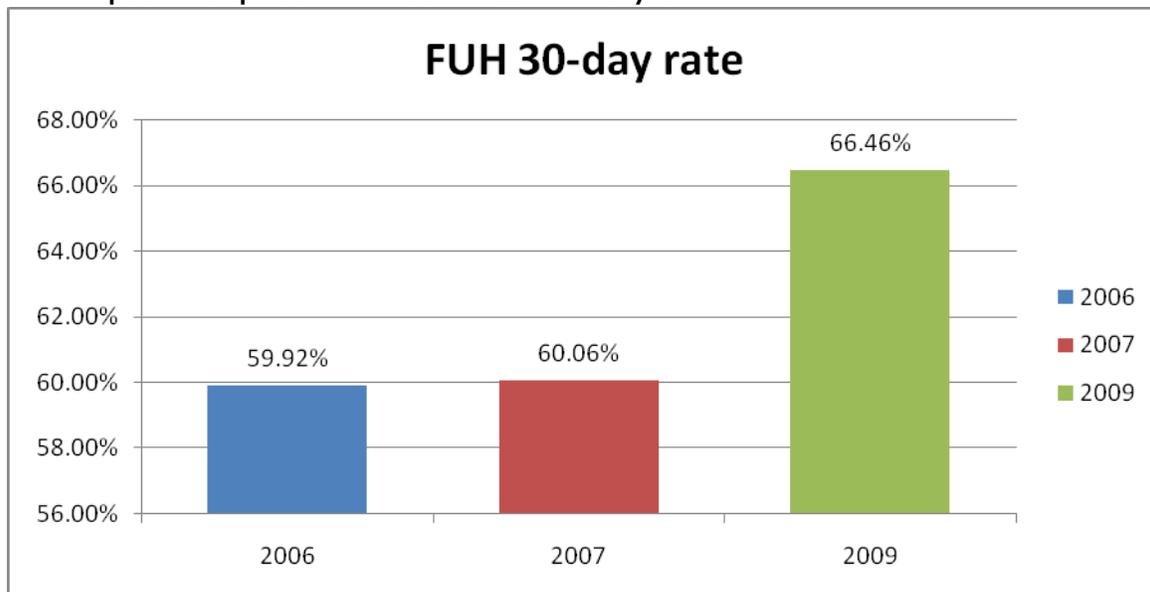
This measure was previously audited by the EQRO in audit years 2006 and 2007 (See Figure 5). The 7-Day reported rate for all MO HealthNet MCHPs in 2009 (41.59%) was a 10.43% increase overall since the rate reported in 2006 (31.16%); it is 6.07% higher than the rate reported in 2007 (35.52%).

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



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

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



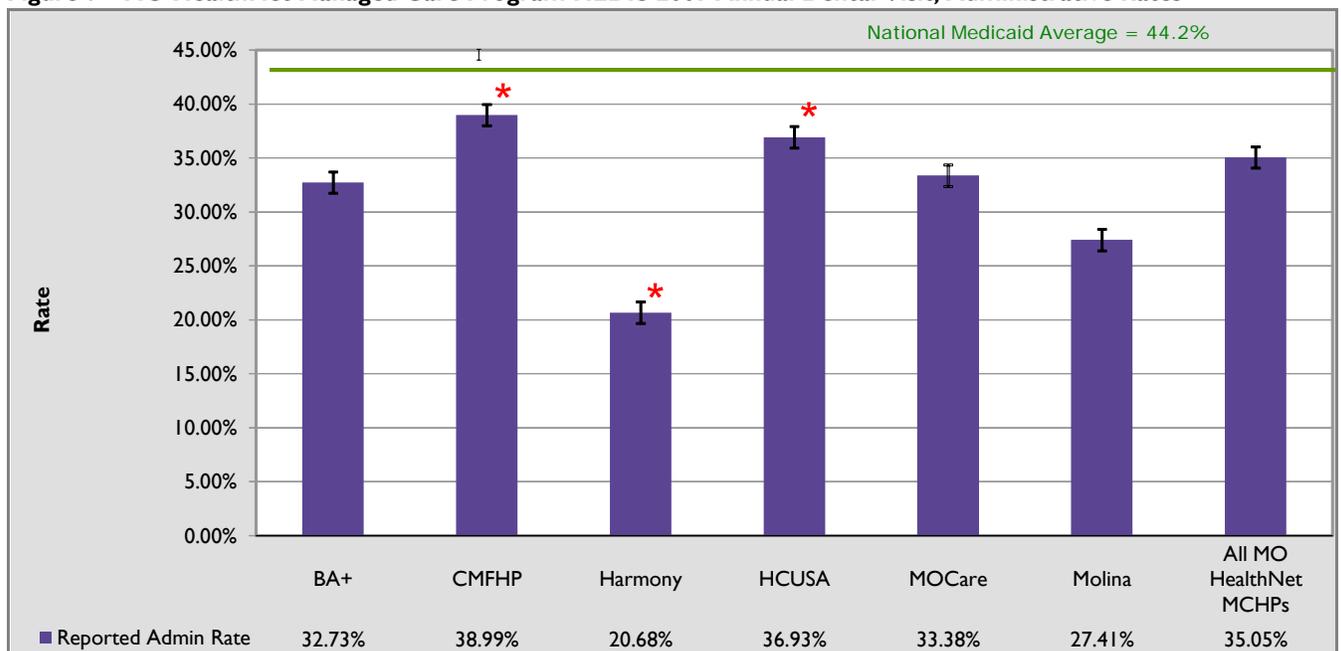
ACCESS TO CARE



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

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

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

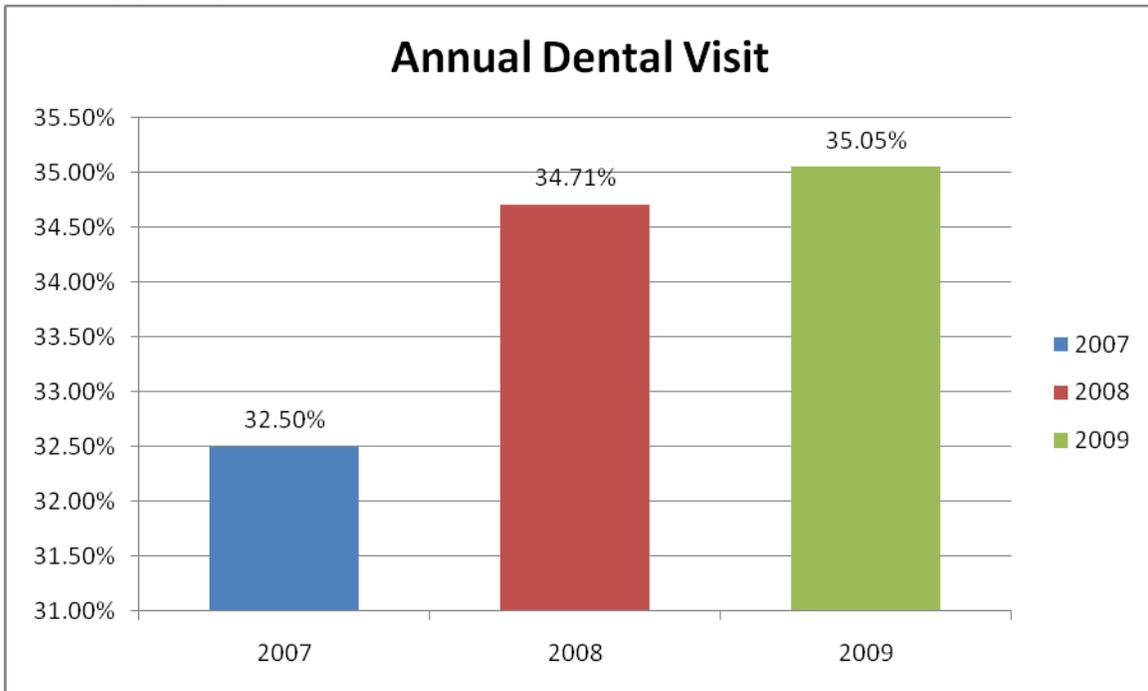


Note: Error bars on the y-axis represent 95% confidence intervals; * indicates values are significantly lower or higher than the MOHealthNet average at the 95% level of significance.

Sources: MO HealthNet MCHP HEDIS 2009 Data Submission Tool (DST); National Committee for Quality Assurance (NCQA).

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

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



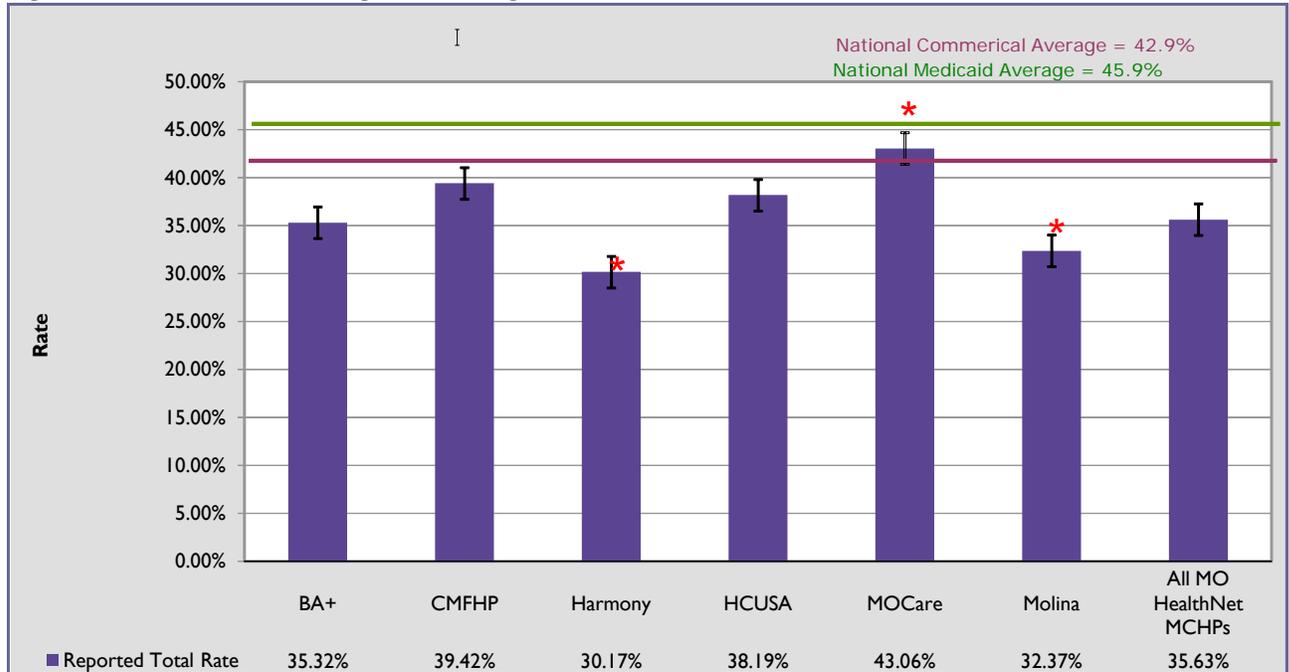
This trend shows an increased level of dental care received in Missouri by MO HealthNet members, illustrating an increased access to care for these services for the HEDIS 2009 measurement year.

TIMELINESS OF CARE

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

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

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

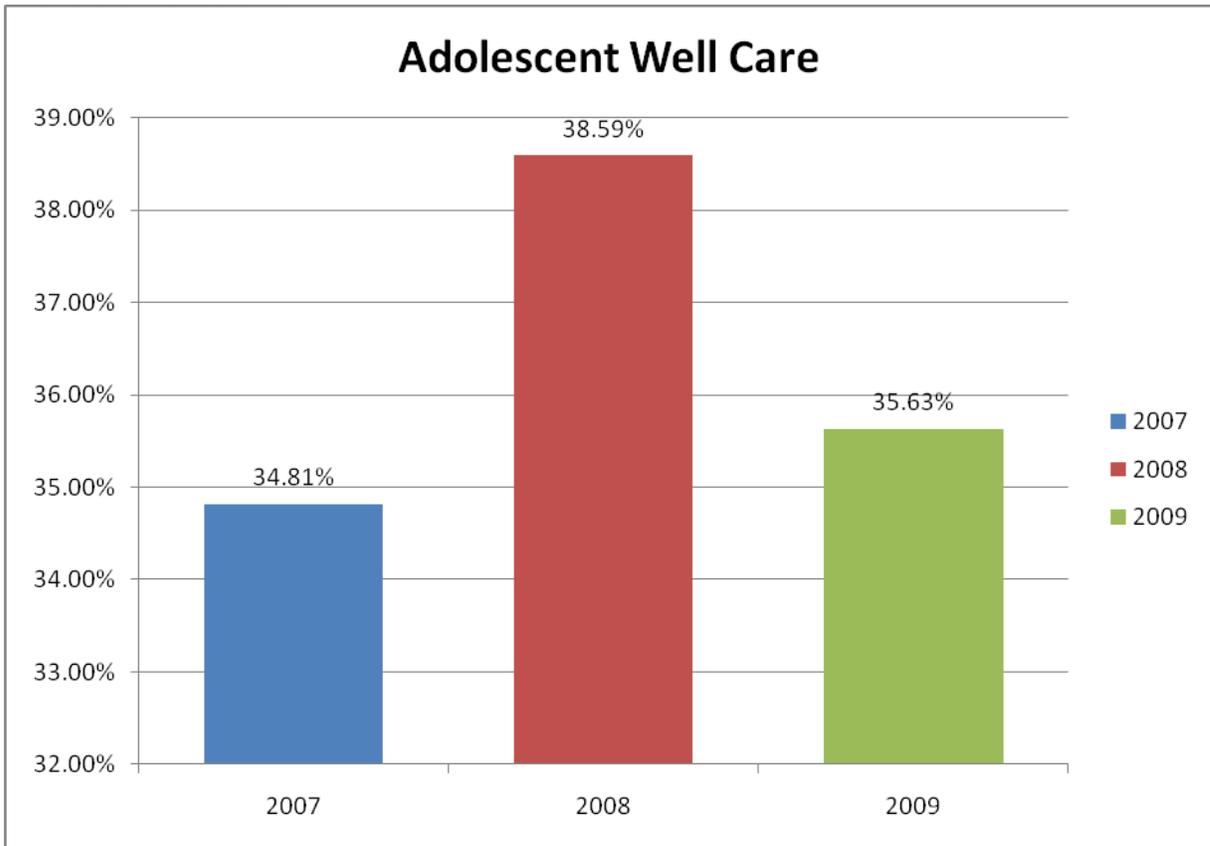


Note: Error bars on the y-axis represent 95% confidence intervals; * indicates values are significantly lower or higher than the MOHealthNet average at the 95% level of significance.

Sources: MO HealthNet MCHP HEDIS 2009 Data Submission Tool (DST); National Committee for Quality Assurance (NCQA).

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

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

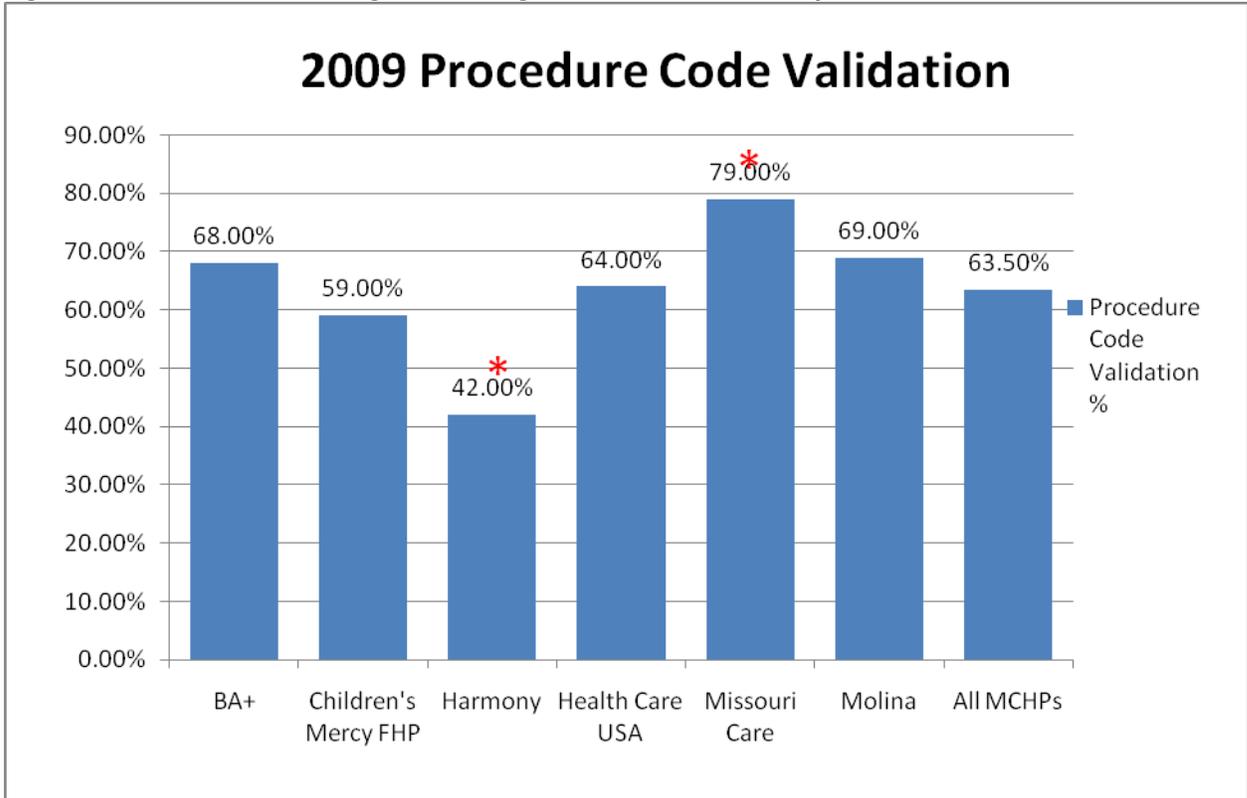


I.4 Encounter Data Validation

Encounter claims data are used by SMAs to conduct rate setting and quality improvement evaluation. Before SMA encounter claims data can be used, it is necessary to establish the extent to which the data for critical fields (e.g., diagnosis and procedure codes, units and dates of service, member and provider identifiers) are complete (each field contains information), accurate (the information contained in each field is of the right size and type), and valid (the information represents actual dates or procedure and diagnosis codes). Several critical fields for each of six claim types (Medical, Dental, Home Health, Inpatient, Outpatient Hospital, and Pharmacy) were identified by the SMA and examined by the EQRO for completeness, accuracy, and validity using an extract file from SMA paid encounter claims. To examine the extent to which the SMA encounter claims database was complete (the extent to which SMA encounter claims database represents all claims paid by MO HealthNet MCHPs); the level and consistency of services was evaluated by examining the rate of each of six claim types. Additionally, the representativeness (or completeness) of the SMA encounter claims database was examined by comparing data in the SMA encounter claims database to the medical records of members.

A random sample of medical records was used to compare the: 1) diagnosis codes and descriptions and 2) the procedure codes and descriptions in the SMA encounter claims database with documentation in MO HealthNet member medical records.

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



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

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

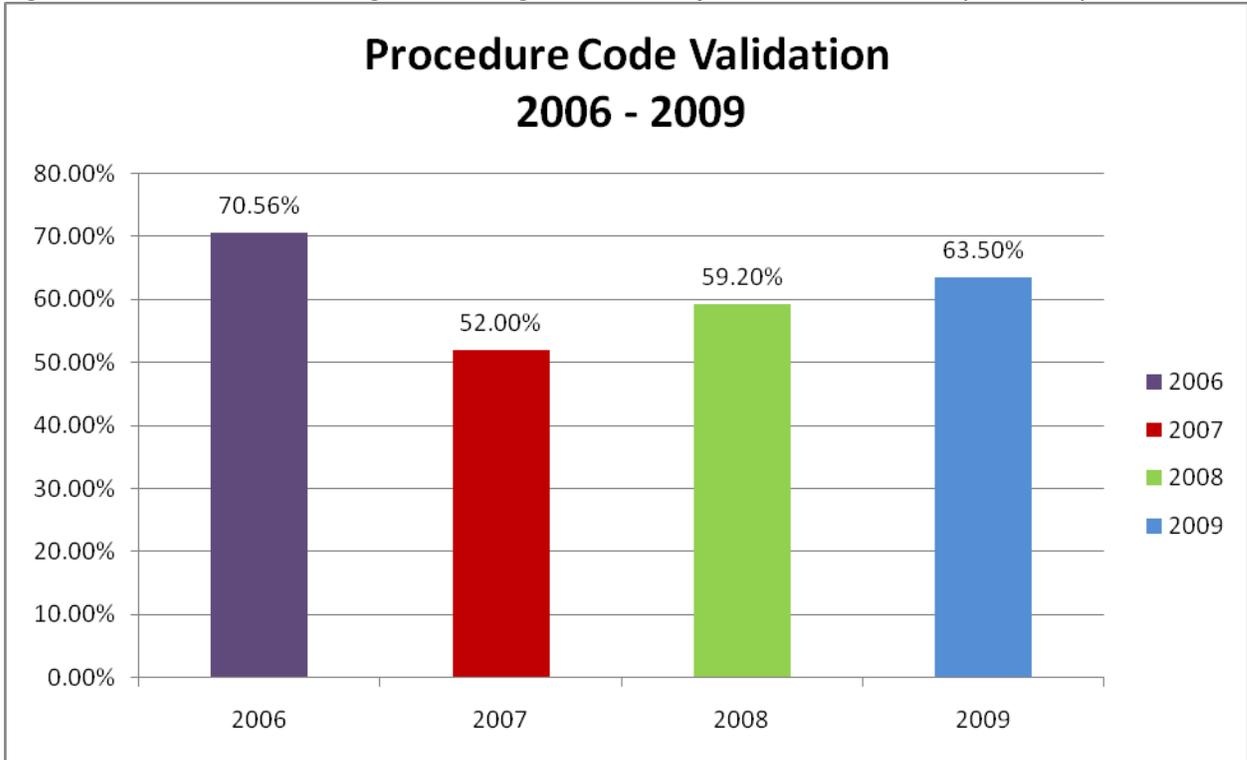
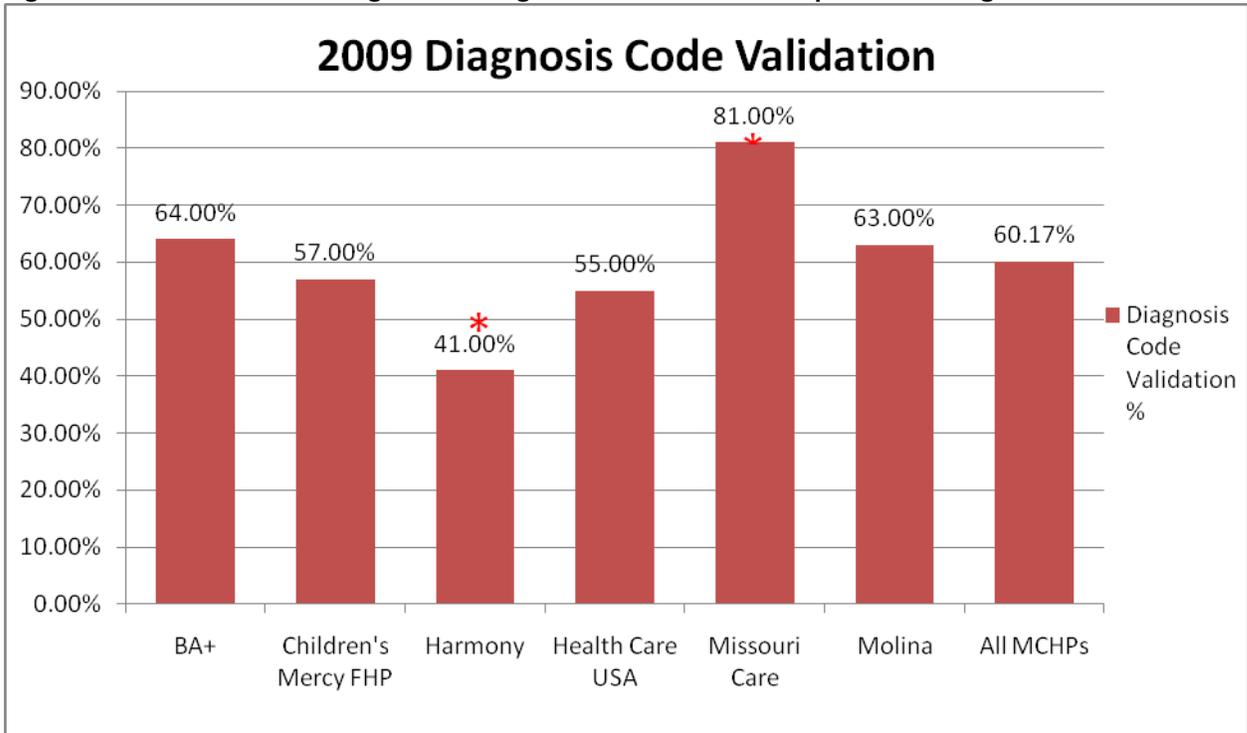
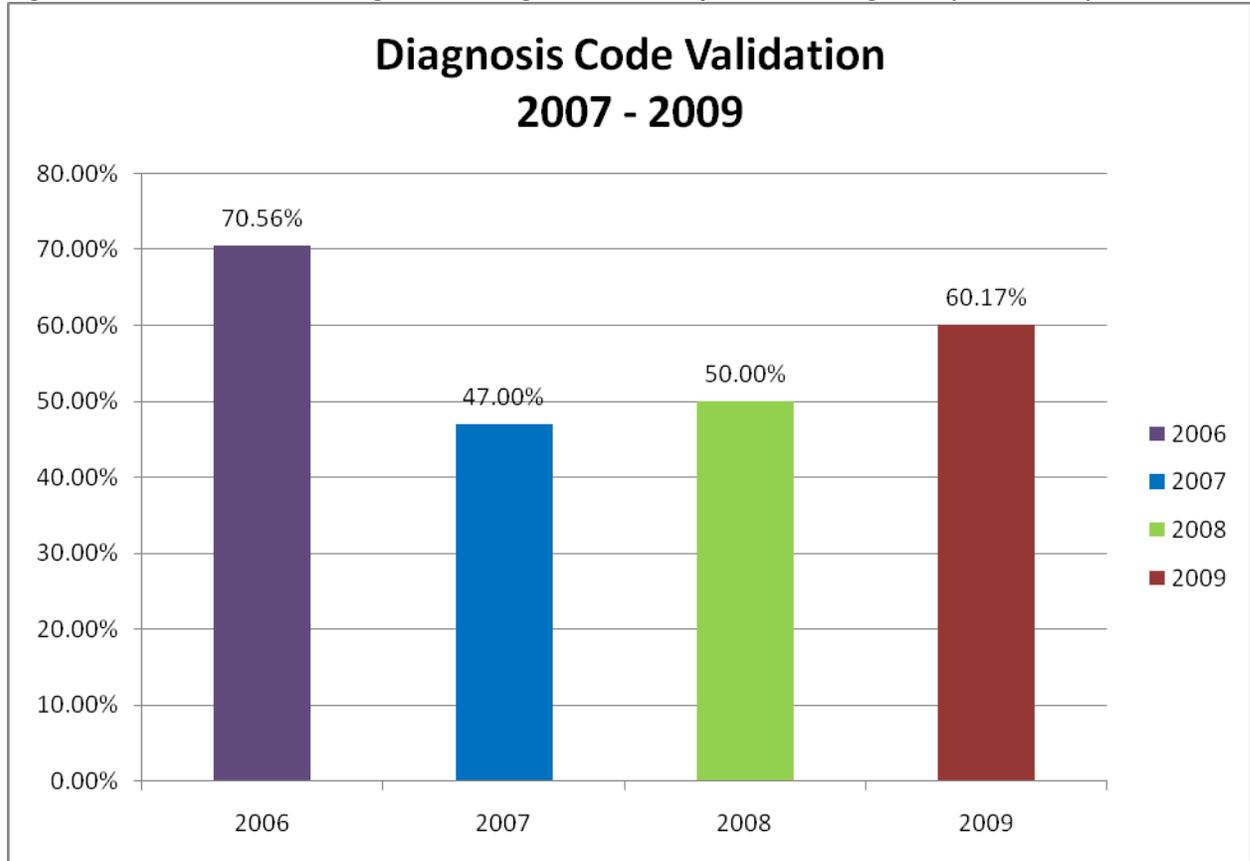


Figure 13 – MO HealthNet Managed Care Program Statewide Rate Comparison for Diagnoses



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

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



The findings of these comparisons were used to determine the completeness of the SMA encounter claims database in regards to the medical records of members. The completeness of the SMA paid encounter claims was then compared with MO HealthNet MCHP records of paid and unpaid claims. All six MO HealthNet MCHPs provided data in the format necessary to make the comparisons. The results obtained are detailed in the results of the Aggregate Encounter Data Validation section of this report.

STRENGTHS

1. All Dental and Pharmacy claim type fields examined were 100.00% complete, accurate and valid for all MO HealthNet MCHPMCHPs. The SMA encounter claims data critical fields examined for accepted and paid claims of this type are valid for analysis.
2. All MO HealthNet MCHPMCHPs submitted data in the format requested, and the EQRO was able to perform the analysis of paid and unpaid claims contained in the SMA database.
3. The examination of the level, volume, and consistency of services found significant variability between MO HealthNet MCHPMCHPs in the rate of each type of claim (Medical, Dental, Inpatient, Outpatient Hospital, Home Health, and Pharmacy), however, no patterns of variation were noted by Region or type of MO HealthNet MCHPMCHP.
4. There were no unmatched “paid” encounters within all claim types (Inpatient, Outpatient, and Pharmacy) for all MCHPs.
5. Unpaid claims represented less than .0001% of all claims submitted to the SMA during the period July 1, 2009 through September 30, 2009.

AREAS FOR IMPROVEMENT

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

I.5 MO HealthNet MCHP Compliance with Managed Care Regulations

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

The policy and practice in the operation of each Health Plan was evaluated against the seventy (70) regulations related to operating a Medicaid managed care program. The regulations were grouped into three main categories: Enrollee Rights and Protections, Quality Assessment and Improvement, and Grievance Systems. The category of Quality Assessment and Improvement was subdivided into three subcategories: Access Standards, Structure and Operation Standards, and Measurement and Improvement. Initially, the SMA reviewed each MO HealthNet MCHP's policy to determine compliance with the requirements of the MO HealthNet Managed Care Contract. These determinations and their application to the requirements of the federal regulations were assessed by the EQRO.

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

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

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

regulations. Next, interview questions were prepared, based on the need to investigate if practice existed in areas where approved policy was or was not available, and if local policy and procedures were in use when approved policy was not complete. The interview responses and additional documentation obtained on-site were then analyzed to evaluate how they contributed to each health plan's compliance. All information gathered was assessed, re-reviewed and translated into recommended compliance ratings for each regulatory provision.

QUALITY OF CARE

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

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

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

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

ACCESS TO CARE

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

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

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

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

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

TIMELINESS OF CARE

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

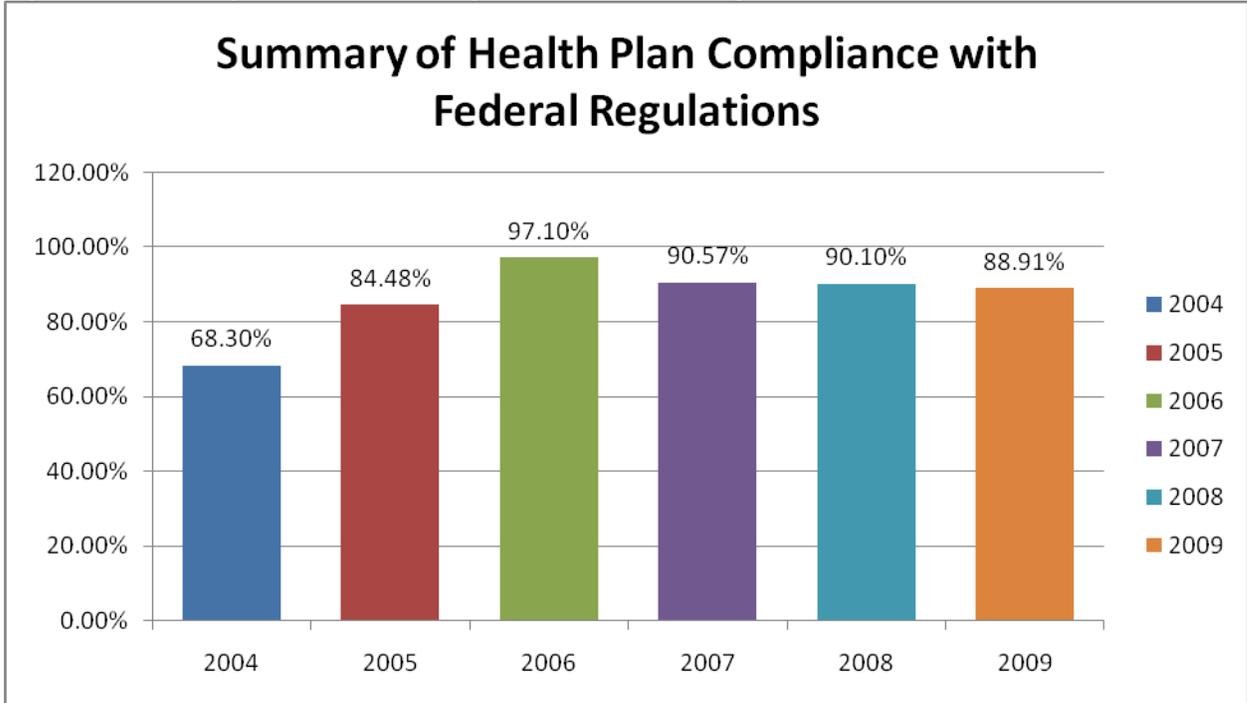
- All six Health Plans adopted, disseminated and applied practice guidelines to ensure sound and timely healthcare services for members.
- The Health Plans used their health information systems to examine the appropriate utilization of care using national standard guidelines for utilization management.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

CONCLUSIONS

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

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

Figure 15 – Summary of Health Plan Compliance with Federal Regulations



1.7 MO HealthNet MCHP Best Practices

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

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

BLUE ADVANTAGE PLUS

Emergency Room Interventions

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

2007

➤ Intervention I: Well Aware - Ongoing

The Blue-Advantage Plus Well Aware member newsletter has adopted a strong focus on educating the member on how to access appropriate care, where to get appropriate care and transportation options. The newsletter is sent to all Blue-Advantage Plus member households each quarter. The following articles have been included in Well Aware.

- Well Aware (Spring 2007, Spring 2009) – When to Go to the ER
- Well Aware (Winter 2007, Fall 2007, Winter 2008, Winter 2009, Winter 2010) - When It’s Not Quite An Emergency
- Well Aware (Winter 2008, Winter 2009) – How to Know When It’s An Emergency
- Well Aware (Summer 2008, Summer 2009) – Where Should You Go For Care?
- Well Aware (Fall 2008) – Urgent Care
- Well Aware (Winter 2009) – A Medical Emergency: Are You Ready?
- Well Aware (Fall 2009) – Is It Really An Emergency?

2008

➤ Intervention 2: Transportation - Ongoing

One of the findings associated with barriers to appropriate ER utilization was members did not know the details of their transportation benefit. To remove the transportation barrier, Blue-Advantage Plus began to include articles on transportation in Well Aware. By including articles on transportation in Well Aware, Blue-Advantage Plus is educating and informing members of their transportation benefits. The following articles have been included in Well Aware.

- Well Aware (Spring 2008) – We'll Pick You Up
- Well Aware (Summer 2008, Winter 2008, Winter 2009) – Take the Bus
- Well Aware (Winter 2010) – Get Paid for Gasoline

➤ Intervention 3: Urgent Care Centers - Ongoing

In 2008, Blue-Advantage Plus developed a member-friendly list of urgent care centers (see attachment A) and included it in all information packets that were mailed to members (i.e., new member letters, Self-Care Guide packets, vaccination packets, and lead packets).

➤ Intervention 4: Welcome Call Script - Ongoing

In 2008, the Blue-Advantage Plus Welcome Call Script was modified to include a paragraph educating new members about the importance of their PCP. In addition, information is provided on how to obtain medical help for no-emergent or emergent situation. Members are also informed to contact the customer service line if they are having trouble making an appointment.

➤ Intervention 5: Nurse Advice Line – Ongoing

It was discovered on analysis of the Nurse Advice Line's regular reports that they were not referring members to any urgent care centers. Upon investigation, it was discovered that Nurse Advice Line did not have an urgent care center option in their decision algorithm when referring a member to a treatment setting. State Programs sent Nurse Advice Line detailed information of the Blue-Advantage Plus urgent care center network and requested that Nurse Advice Line incorporate this information in the decision algorithm when referring a member to treatment. As a result of this recommendation, Nurse Advice Line acted promptly in updating their decision algorithm, and conducted 130 hours of training to the nurse advice line staff on urgent care center options for treatment.

➤ Intervention 6: Case Management Outreach – Ongoing

State Programs runs a report on a weekly basis to identify members who went to an ER within the last week and a member who went to the ER four or more times in the previous year. A Blue-Advantage Plus of Kansas City nurse case manager reviews the report and makes outreach calls to the parent or guardian of 0-6 year old members who appear on the report. The case manager conducts a biopsychosocial assessment and offers education to the member on alternative treatment settings and encourages contact with the PCP. In addition, the nurse case manager provides education about transportation, self-care, and the Nurse Advice Line. In 2009, BA+ began offering to send a Self-Care Guide to members who received Case Management Outreach. Results for 2008 and 2009 are listed below

2009

➤ Intervention 7: Blue-Advantage Plus ER Magnet Mailer - Ongoing

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

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

➤ **Intervention 8: Blue-Advantage Plus Website - Ongoing**

On October 1, 2009, Blue-Advantage Plus launched a new website (www.bapluskc.com) dedicated to Blue-Advantage Plus members. The website contains information on the benefits of the urgent care center and a list of urgent care centers that are in the Blue-Advantage Plus provider network. Blue-Advantage Plus members are able to visit the Blue-Advantage Plus website and quickly locate an urgent care center if they need to seek treatment.

➤ **Intervention 9: PCP Collaborative Outreach – Ongoing**

In 2008, Blue-Advantage Plus set out to collaborate with high-volume PCP groups to partner with them to encourage members to use the PCP as their “medical home.” By providing PCPs with our report of members who visit the ER, on a weekly and timely basis, PCPs can conduct their own outreach and intervention with these members. Ideally, Blue-Advantage Plus would like to see the PCPs provide active coordination of the care of these members across all settings of care. Due to time constraints and staffing issues with the PCP groups, Blue-Advantage Plus was unable to engage any high volume PCP offices for collaborative outreach efforts.

In 2009, Blue-Advantage Plus revised the PCP collaborative intervention. Blue-Advantage Plus identified eight members who belonged to a high volume PCP group and utilized the ER excessively for non-emergent reasons in 1Q09. Throughout 2009, Blue-Advantage Plus offered all in-house interventions and monitored ER utilization.

ER utilization for the eight members continued to rise and an ER report was developed and presented to the BCBSKC Director, Provider Relations for possible referral to the PCP’s at Swope Health Services to determine if any outreach by the PCP’s could be provided.

2010

➤ **Intervention 10: ER Magnet Mailer – Ongoing**

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

Measurable Results

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

Case Management Outreach - 2008

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

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

Case Management Outreach - 2009

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

ER Magnet Mailer Intervention - 2009

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

CHILDREN'S MERCY FAMILY HEALTH PARTNERS

Customer Service Best Practices

Customer Service Availability

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

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

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

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

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

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

Improvements in Providing Customer Relations

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

Skills Based Routing

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

Customer Service Call Back

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

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

Post Call Satisfaction Survey

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

Post Call Evaluations

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

HARMONY HEALTH PLAN OF MISSOURI

Case Management Information System

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

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

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

Goals:

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

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

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

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

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

Enhancement to EMMA in 2009**October 2009**

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

July 2009

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

May 2009

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

HEALTHCARE USA

Neonatal Intensive Care Unit (NICU) Project

According to the 2001 Nationwide Inpatient Sample from the Healthcare Cost and Utilization Project, 10% of U.S. newborns are admitted to neonatal intensive care units (NICUs).

Approximately 8% of all admissions in the first year of life included a diagnosis of preterm birth/low birth weight. NICU stays for preterm and low birth weight infants contribute to 50% of all infant hospitalization costs in the first year of life. NICU admissions account for 25% of national health care costs for ALL children, demonstrating an enormously disproportionate share of healthcare dollars spent on these conditions.

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

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

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

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

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

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

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

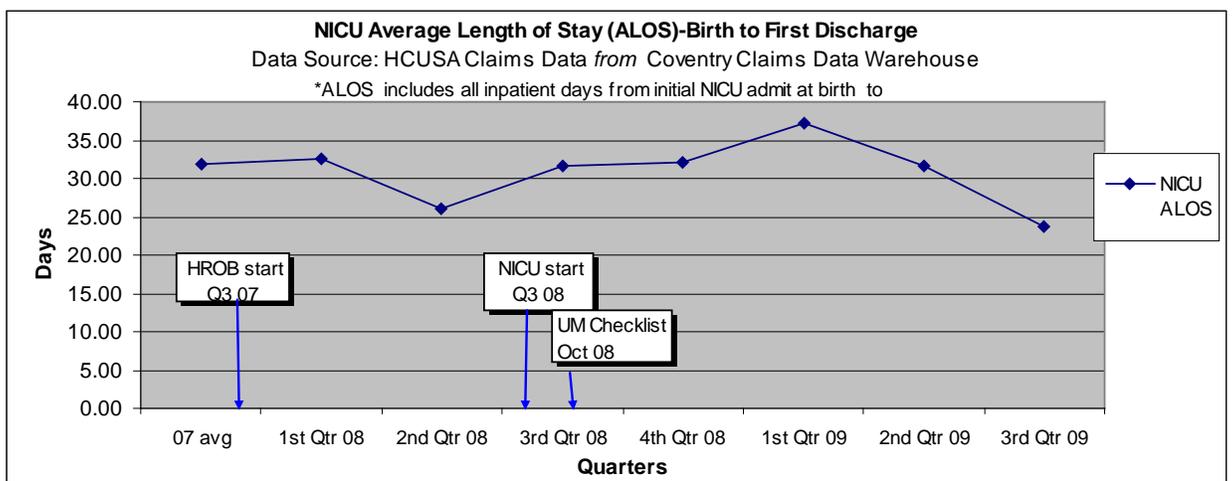
The primary role of the NICU nurse is to establish a positive, trusting relationship with the parent/caregivers, the NICU team and the primary care provider to identify and resolve real and perceived barriers to parents/caregivers successful self-management in caring for their NICU baby.

In year 1, there were 58 continuously enrolled. Results for these 58 participants include:

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

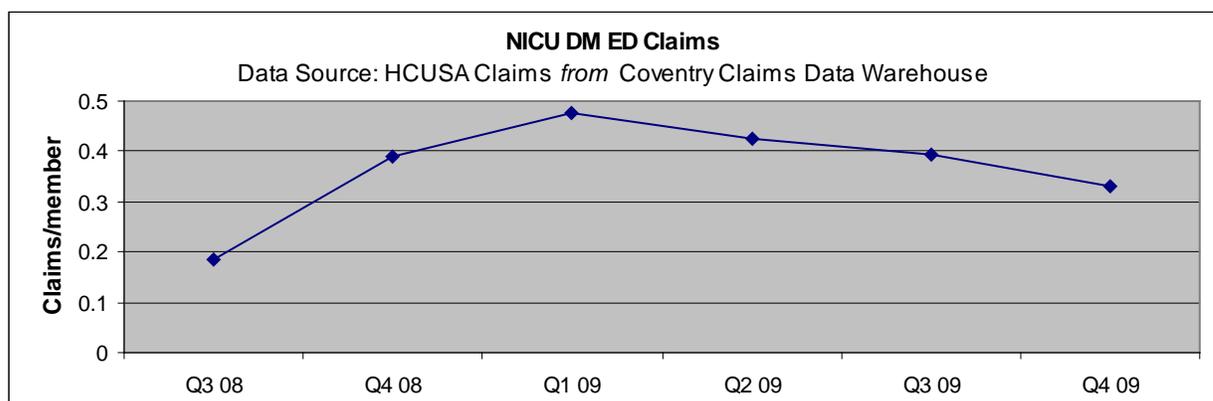
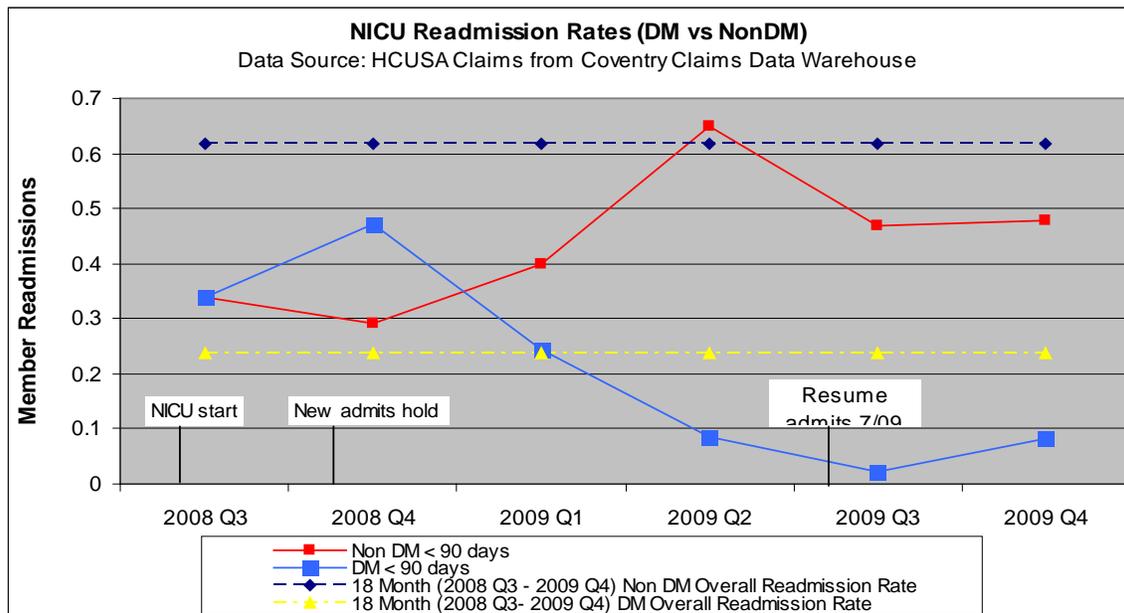
Outcome metrics for the program participants as compared the 425 NICU graduates identified as the baseline data and non-program participants includes the following:

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



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

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



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

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

MISSOURI CARE HEALTH PLAN

Dental Outreach Initiatives

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

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

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

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

MOLINA HEALTHCARE OF MISSOURI

Cesarean Section Wound Infection

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

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

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

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

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

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

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

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

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

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

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



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2.0 VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS (PIPs)

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2.1 Definition

A Performance Improvement Project (PIP) is defined by the Centers for Medicare and Medicaid Services (CMS) as “a project designed to assess and improve processes, and outcomes of care...that is designed, conducted and reported in a methodologically sound manner.” The Validating Performance Improvement Projects Protocol specifies that the EQRO conduct three activities in the validation of two PIPs at each health plan that have been initiated, are underway, were completed during the reporting year, or some combination of these three stages. The State Medicaid Agency (SMA: the Department of Social Services, MO HealthNet Division) elected to examine projects that were underway during the preceding calendar year 2009. All of the health plans submitted continued non-clinical projects regarding Adolescent Well Care Visits, which was originally initiated as a Statewide PIP. The aggregate report was evaluated, and each individual health plan’s response and interventions were examined. Criteria for identification of a PIP as outlined in the CMS protocols include the following:

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

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

Performance Improvement Projects: The health plan shall conduct PIPs that are designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and nonclinical care areas that are expected to have a favorable effect on health outcomes and member satisfaction. As requested, the health plan shall report the status and results of each PIP to the state agency, which must include state and/or health plan designated PIPs... The PIPs must involve the following:

- Measurement of performance using objective quality indicators.
- Implementation of system interventions to achieve improvement in quality.
- Evaluation of the effectiveness of the interventions.
- Planning and initiation of activities for increasing or sustaining improvement.

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

2.2 Purpose and Objectives

The purpose and objectives of the present review were to evaluate the soundness and results of PIPs implemented by health plans during the calendar year 2009. The MO HealthNet MCHPs were to have two active PIPs in place, one clinical and one non-clinical. The validation process examines the stability and variability in change over multiple years. The evaluation in 2009 included the initial and ongoing methods utilized in the Statewide PIP, which was the non-clinical PIP evaluated for each health plan for the second or follow-up year. Each health plan committed to implementing individualized interventions to create improved outcomes for their members. These PIPs were evaluated as the nonclinical PIP for each health plan.

2.3 Findings

Below are the PIPs identified for validation at each MCHP:

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

STEP 1: SELECTED STUDY TOPICS

Study topics were selected through data collection and the analysis of comprehensive aspects of member needs, care, and services; and to address a broad spectrum of key aspects of member care and services. In all cases they included all enrolled populations pertinent to the study topic without excluding certain members. Two of the clinical PIPs addressed follow-up care after discharge from hospitalization from mental illness; one addressed members at risk of cesarean wound infection; one addressed lead screening; one addressed dental utilization; and one focused on improving the rates of Chlamydia screening for women. All six non-clinical projects addressed improving adolescent well care through health plan specific interventions, as extensions of the Statewide PIP.

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

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

Table 1 – Performance Improvement Project Validation Findings by Health Plan

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

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

STEP 2: STUDY QUESTIONS

Study questions are statements in the form of a question that describe the potential relationship between the intervention, the intended outcome, and the data to be obtained and analyzed. They should be specific enough to suggest the study methods and the outcome measures. The MO HealthNet MCHPs made a concerted effort to ensure that statements were provided in the form of a question, and in most cases the questions were directly related to the hypotheses and topic selected. Ten (83.33%) of the PIPs included clearly stated study questions (Step 2.1). The study purposes identified were consistent with the remainder of the PIP (the target population, interventions, measures, or methods) in most instances. One health plan (HCUSA) did not include a study question for its clinical PIP and in the non-clinical did not indicate any new or updated interventions. This study question was not updated from the health plan's 2008 submission to the 2009 project.

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

Step	Item	All MOHealthNet MCHPs				Total Number Applicable	Rate Met
		Number Met	Number Partially Met	Number Not Met			
Step 1: Selected Study Topics	1.1	12	0	0	12	100.00%	
	1.2	12	0	0	12	100.00%	
	1.3	12	0	0	12	100.00%	
Step 2: Study Questions	2.1	10	1	1	12	83.33%	
Step 3: Study Indicators	3.1	11	1	0	12	91.67%	
	3.2	11	0	1	12	91.67%	
Step 4: Study Populations	4.1	11	1	0	12	91.67%	
	4.2	11	0	1	12	91.67%	
Step 5: Sampling Methods	5.1	0	0	0	0	n/a	
	5.2	0	0	0	0	n/a	
	5.3	0	0	0	0	n/a	
Step 6: Data Collection Procedures	6.1	11	0	1	12	91.67%	
	6.2	11	1	0	12	91.67%	
	6.3	11	0	1	12	91.67%	
	6.4	11	0	1	12	91.67%	
	6.5	9	2	1	12	75.00%	
	6.6	10	1	1	12	83.33%	
Step 7: Improvement Strategies	7.1	7	5	0	12	58.33%	
Step 8: Analysis and Interpretation of Study Results	8.1	8	3	1	12	66.67%	
	8.2	6	6	0	12	50.00%	
	8.3	6	6	0	12	50.00%	
	8.4	7	5	0	12	58.33%	
Step 9: Validity of Improvement	9.1	7	3	1	11	63.63%	
	9.2	7	2	0	9	77.77%	
	9.3	6	3	0	9	66.66%	
	9.4	5	4	0	9	55.55%	
Step 10: Sustained Improvement	10.1	6	0	1	7	85.71%	
Number Met		217	45	11	273	79.49%	

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

Source: BHC, Inc., 2009 External Quality Review Performance Improvement Project Validation

STEP 3: STUDY INDICATORS

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

STEP 4: STUDY POPULATIONS

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

STEP 5: SAMPLING METHODS

None of these PIPs employed true sampling techniques. The type of sample (e.g., convenience, random) or sampling methods (e.g., simple, cluster, stratified) should be described if utilized. It should be noted that for the six (6) PIPs concerning Adolescent Well Care results were based on the HEDIS technical specifications, which are an actual sample. However, this was accepted by all health plans and an assessment of this sampling technique was audited in the Performance Measure section of this report.

STEP 6: DATA COLLECTION PROCEDURES

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

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

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

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

STEP 7: IMPROVEMENT STRATEGIES

Seven of the 12 (58.33%) PIPs identified reasonable interventions to address the barriers identified through data analysis and quality improvement processes undertaken. Five of the PIPs were Partially Met in this requirement. The nature of identification of the barriers, a description of barriers, and a plan for addressing barriers should be described.

STEP 8: DATA ANALYSIS AND INTERPRETATION OF STUDY RESULTS

All twelve PIPs were mature enough to have data to analyze. The MO HealthNet MCHPs conducted the analyses according to the data analysis plan (Step 8.1) in eight of the PIPs (66.67%). In 6 of the 12 (50.0%) there was a complete and thorough analysis of the data presented. These six PIPs presented baseline or re-measurement data, and all numerical findings accurately and clearly (Step 8.2). In some instances, data were presented in formats different from those described in the calculation of measures (e.g., presenting percentages in graphic format while the description of the calculation of measures indicated rates per 1,000). The remaining six PIPs Partially Met this criteria. Axis labels and units of measurement should be reported in Tables and in Figure legends and this information should be made clearly identifiable to the reader. In one case the baseline data was in table form and the re-measurement was in a graphic form. This creates difficulty in evaluation of the data presented.

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

STEP 9: VALIDITY OF IMPROVEMENT

Seven of the eleven PIPs (63.63%) with re-measurement points used the same method at re-measurement as the baseline measurement (Step 9.1). Whenever possible the baseline measure should be recalculated consistent with the re-measurement method to ensure validity of reported improvement and comparability of measurement over time. The same source of measures should also be used at re-measurement points. Seven of nine PIPs (77.77%) that were mature enough to include data analysis employed statistical significance testing to document quantitative improvements in care (Step 9.2). They were able to show significant improvement over multiple re-measurement points; however, this improvement was not always statistically significant. Six of nine (66.66%) PIPs reporting improvements had face validity, meaning that the reported improvement was judged to have been related to the intervention applied (Step 9.3). These PIPs provided some discussion or interpretation of findings by health plans. Additional narrative in this area would ensure proper evaluation of all data and information provided. After reporting findings, there should be some interpretation as to whether the intervention or other factors may have accounted for improvement, decline, or lack of change. Five of the nine PIPs (55.55%) that had reached a level of maturity to include this data did provide statistical evidence that the observed improvement was true improvement (Step 9.4). Then, barriers should be identified and addressed for the next cycle of the PIP, or reasons for discontinuing the PIP should be described.

STEP 10: SUSTAINED IMPROVEMENT

Of the seven PIPs examining multiple measurement points over time, six (85.71%) PIPs used statistical significance testing to demonstrate improvement. The PIPs reaching this level of maturity provided arguments for continuing the improvement efforts leading to success, and their reasoning for maintaining sustainability.

2.4 Conclusions

Across all MO HealthNet MCHPs, the range in proportion of criteria that were "Met" for each PIP validated was 12.5% through 100% (see Table I). Across all PIPs validated statewide, 79.49% of criteria were met. All sources of available data were used to develop the ratings for the PIP items. The EQRO comments were developed based on the written documentation and presentation of findings. In all cases, there was enough information provided to validate the PIPs. On-site interviews and subsequent information provided revealed in-depth knowledge of the PIPs and detailed outcomes.

Generally the PIPs presented included thoughtful and complex information. In some of the PIPs, enhanced information obtained at the on-site review, made it clear that the health plans intended to use this process to improve organizational functions and the quality of services available or delivered to members. In several cases the PIP had already been incorporated into health plan daily operations. PIPs are to be ongoing, with periodic re-measurement points. At least quarterly re-measurement is recommended to provide timely feedback to the health plan regarding the need to address barriers to implementation. Health plan personnel involved in PIPs had experience in clinical service delivery, quality improvement, and monitoring activities. It was clear that they had made a significant improvement and investment in designing valid evaluation studies using sound data collection and analysis methods. This requires technical expertise in health services research and/or program evaluation design.

Based on the PIP validation process, at least four health plans (CMFHP, BA+, Molinaand MO Care) had active and ongoing PIPs as part of their quality improvement programs. One health plan (Harmony) submitted PIPs for review for the second time, and the results indicated some improvement to their commitment to the PIP process. They have a stated commitment to develop quality programming although their projects reflect areas that need improvement. One health plan (HCUSA) has historically utilized the PIP process as an essential component of their quality improvement program. They, as were all of the health plans, were encouraged to submit updated information on the PIP submissions at the time of the on-site review. They chose not to submit additional information or analysis. An improved commitment to the quality improvement process was observed during the on-site review at all health plans.

Table 3 - Validity and Reliability of Performance Improvement Project Results

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

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

Source: BHC, Inc., 2010 External Quality Review Performance Improvement Project Validation.

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

ACCESS TO CARE

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

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

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

QUALITY OF CARE

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

TIMELINESS OF CARE

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

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

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

RECOMMENDATIONS

1. It is recommended that health plans continue to refine their skills in the development and implementation of the Performance Improvement Projects. Improved training, assistance and expertise for the design, statistical analysis, and interpretation of PIP findings are available.
2. In the design of PIPs, health plans need to use generally accepted practices for program evaluation to conduct PIPs. In addition to training on the development of PIPs and on-site technical assistance, references to the CMS protocol, “Conducting Performance Improvement Projects” were recommended by the EQRO at each health plan as a guideline to frame the development, reporting and analysis of the PIP.
3. PIPs should be conducted on an ongoing basis, with at least quarterly measurement of some indices to provide data about the need for changes in implementation, data collection, or interventions. Ongoing PIPs should include new and refined interventions.
4. PIPs that are not yet complete should include narrative reflecting next steps and the plan for how the PIP will be maintained and enhanced for future years.
5. Efforts to continue to improve outcomes related to the Statewide PIP topic should be continued. Several health plans provided results indicating some improvement in their HEDIS measure has occurred. A number of innovative approaches were used to impact this issue. The health plans should continue with their individualized interventions and their individual approaches to obtaining positive outcomes when working on a statewide topic.
6. It appears that most of the health plans conduct PIPs on an ongoing basis as part of their quality improvement program. Continuing to utilize these PIPs as tools to improve the organizations ability to serve members is beneficial.

3.0 VALIDATION OF PERFORMANCE MEASURES

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3.1 Purpose and Objectives

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

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

3.2 Findings

MO HealthNet MCHPs conduct the calculation of performance measures in collaboration with a variety of vendors and use a number of different management information systems to extract data for the calculation of measures. They are also required to undergo annual audits by NCQA-certified auditing firms that provide MO HealthNet MCHPs with recommendations for reporting or not reporting findings of specific measures to the NCQA. Regardless of the NCQA audit rating or rotation, the health plans are required to report the performance measures validated to the SMA and SPHA. Table 4 summarizes the names of HEDIS-certified software used, medical record vendors, and HEDIS auditors for each of the MO HealthNet MCHPs.

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

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

Note: * NCQA-certified

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

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

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

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

HEDIS 2009 ANNUAL DENTAL VISIT

Data Integration and Control

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

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

Item	Audit Elements	MO HealthNet MCHP						All MO HealthNet MCHPs				
		BA+	CMFHP	Harmony	HCUSA	MOCare	Molina	Number Met	Number Partially Met	Number Not Met	Number Applicable	Rate Met
5.1	MCHP/PIHP processes accurately and completely transfer data from the transaction files (e.g., membership, provider, encounter/claims) into the repository used to keep the data until the calculations of the performance measures have been completed and validated.	2	2	2	2	2	2	6	0	0	6	100.0%
5.2	Samples of data from repository are complete and accurate.	2	2	2	2	2	2	6	0	0	6	100.0%
5.3	MCHP's/PIHP's processes to consolidate diversified files, and to extract required information from the performance measure repository are appropriate.	2	2	2	2	2	2	6	0	0	6	100.0%
5.4	Actual results of file consolidations or extracts were consistent with those which should have resulted according to documented algorithms or specifications.	2	2	2	2	2	2	6	0	0	6	100.0%
5.5	Procedures for coordinating the activities of multiple subcontractors ensure the accurate, timely, and complete integration of data into the performance measure database.	2	2	2	2	2	2	6	0	0	6	100.0%
5.6	Computer program reports or documentation reflect vendor coordination activities, and no data necessary to performance measure reporting are lost or inappropriately modified during transfer.	2	2	2	2	2	2	6	0	0	6	100.0%
5.7	The repository's design, program flow charts, and source codes enable analyses and reports.	2	2	2	2	2	2	6	0	0	6	100.0%
5.8	Proper linkage mechanisms have been employed to join data from all necessary sources (e.g., identifying a member with a given disease/condition).	2	2	2	2	2	2	6	0	0	6	100.0%
5.9	Examine and assess the adequacy of the documentation governing the production process, including MCHP/PIHP production activity logs, and MCHP/PIHP staff review of report runs.	2	2	2	2	2	2	6	0	0	6	100.0%
5.10	Prescribed data cutoff dates were followed.	2	2	2	2	2	2	6	0	0	6	100.0%
5.11	The MCHP/PIHP has retained copies of files or databases used for performance measure reporting, in the event that results need to be reproduced.	2	2	2	2	2	2	6	0	0	6	100.0%
5.12	Review documentation standards to determine the extent to which the reporting software program is properly documented with respect to every aspect of the performance measurement reporting repository, including building, maintaining, managing, testing, and report production.	2	2	2	2	2	2	6	0	0	6	100.0%
5.13	Review the MCHP's/PIHP's processes and documentation to determine the extent to which they comply with the MCHP/PIHP standards associated with reporting program specifications, code review, and testing.	2	2	2	2	2	2	6	0	0	6	100.0%
	Number Met	13	13	13	13	13	13	78	0	0	78	100.0%
	Number Partially Met	0	0	0	0	0	0					
	Number Not Met	0	0	0	0	0	0					
	Number Applicable	13	13	13	13	13	13					
	Rate Met	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%					

Note: A = Administrative; H = Hybrid; NA = Not Applicable to the method employed by the MO HealthNet MCHP; Administrative Method was used by the MO HealthNet MCHP and the item relates to the Hybrid Method; 2 = Met and validated through HEDIS software certification process and proper explanation in documentation or proper explanation in documentation. 1 = Partially Met; 0 = Not Met, validated through HEDIS software certification process, but no proper explanation of the process in documentation or no or insufficient explanation in documentation. * Item is not applicable to the measure being validated. Rate Met = Number Met / Number Applicable. **Source:** BHC, Inc. 2009 External Quality Review Performance Measure Validation.



Documentation of Data and Processes

The objectives of this activity were to assess the documentation of data collection; the process of integrating data into a performance measure set; the procedures used to query the data set for sampling numerators and denominators; and the ability to apply proper algorithms. The findings of Attachment VI (Data and Processes Used to Calculate and Report Performance Measures) of the CMS Protocol are summarized in Table 7. Items 7.2, 7.3, 7.5, 7.7, 7.9, and 7.10 did not apply to this measure. All MO HealthNet MCHPs (100.0%) met the criteria for applying appropriate data and processes for the calculation of the HEDIS 2009 Annual Dental Visit measure.

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

Item	Audit Elements	MO HealthNet MCHP						All MO HealthNet MCHPs				
		BA+	CMFHP	Harmony	HCUSA	MOCare	Molina	Number Met	Number Partially Met	Number Not Met	Number Applicable	Rate Met
7.1	Data file and field definitions used for each measure. Maps to standard coding if not used in original data collection.	2	2	2	2	2	2	6	0	0	6	100.0%
7.2	Statistical testing of results and any corrections or adjustments made after processing.	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
7.3	All data sources, including external data (whether from a vendor, public registry, or other outside source), and any prior years' data (if applicable).	2	2	2	2	2	2	6	0	0	6	100.0%
7.4	Detailed medical record review methods and practices, including the qualifications of medical record review supervisor and staff; reviewer training materials; audit tools used, including completed copies of each record-level reviewer determination; all case-level critical performance measure data elements used to determine a positive or negative event or exclude a case from same; and inter-rater reliability testing procedures and results.	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
7.5	Detailed computer queries, programming logic, or source code used to identify the population or sample for the denominator and/or numerator.	2	2	2	2	2	2	6	0	0	6	100.0%
7.6	If sampling used, description of sampling techniques, and documentation that assures the reviewer that samples used for baseline and repeat measurements of the performance measures were chosen using the same sampling frame and methodology.	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
7.7	Documentation of calculation for changes in performance from previous periods (if applicable), including statistical tests of significance.	2	2	2	2	2	2	6	0	0	6	100.0%
7.8	Data that are related from measure to measure are consistent (e.g., membership counts, provider totals, number of pregnancies and births).	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
7.9	Appropriate statistical functions are used to determine confidence intervals when sampling is used in the measure.	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
7.10	When determining improvement in performance between measurement periods, appropriate statistical methodology is applied to determine levels of significance of changes.	2	2	2	2	2	2	6	0	0	6	100.0%
7.11	Number Met	5	5	5	5	5	5	30	0	0	30	100.0%
	Number Partially Met	0	0	0	0	0	0					
	Number Not Met	0	0	0	0	0	0					
	Number Applicable	5	5	5	5	5	5					
	Rate Met	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%					

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

Source: BHC, Inc. 2009 External Quality Review Performance Measure Validation



Processes Used to Produce Denominators

The objective of this activity was to determine the extent to which all eligible members were included in the denominator, evaluate the programming and logic source codes, and evaluate the specifications for calculating each measure. Table 8 summarizes the findings of Attachment X (Denominator Validation Findings) of the CMS Protocol. Items 10.5 (Identification of gender of the member), 10.6 (Calculation of member months or years), and 10.10 (Systems for estimating populations when they are unable to accurately be counted) were not applicable to this measure. All six of the MO HealthNet MCHPs reviewed met 100% of the criteria for producing denominators according to specifications.

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

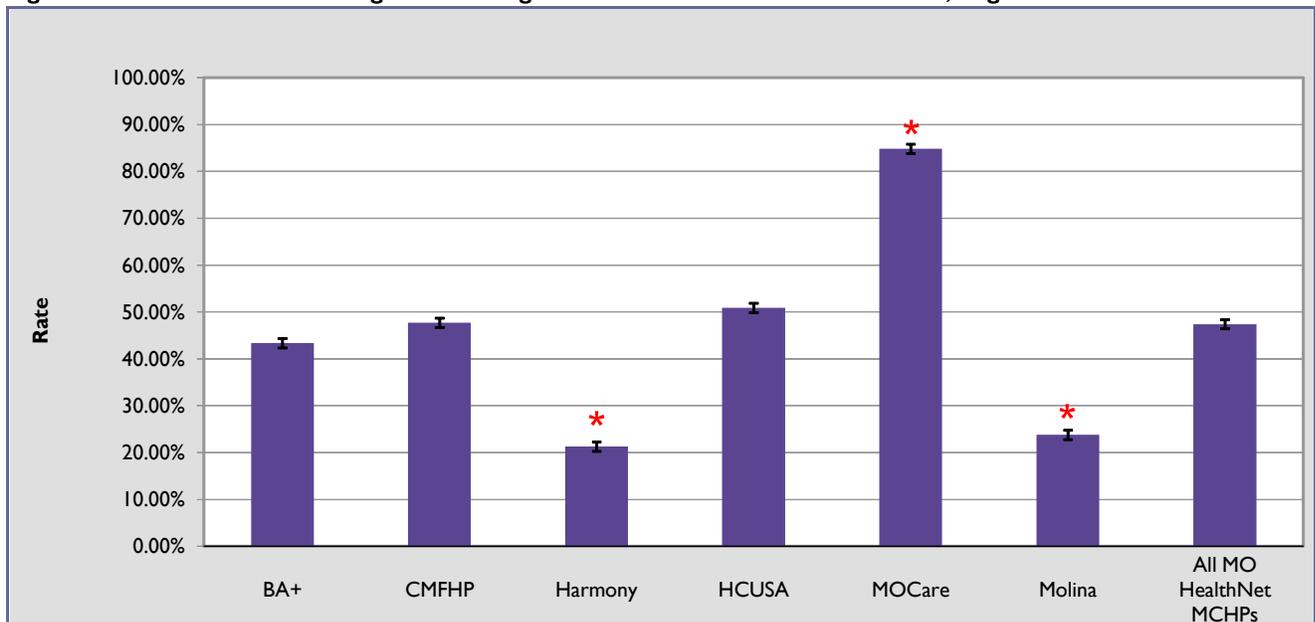
Item	Audit Elements	MO HealthNet MCHP						All MO HealthNet MCHPs				
		BA+	CMFHP	Harmony	HCUSA	MOCare	Molina	Number Met	Number Partially Met	Number Not Met	Number Applicable	Rate Met
10.1	All members who were eligible to receive the specified services were included in the initial population from which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

Note: A = Administrative; H = Hybrid; NA = Not Applicable to the method employed by the MO HealthNet MCHP; Administrative Method was used by the MO HealthNet MCHP and the item relates to the Hybrid Method; 2 = Met and validated through HEDIS software certification process and proper explanation in documentation or proper explanation in documentation. I =Partially Met; 0 = Not Met, validated through HEDIS software certification process, but no proper explanation of the process in documentation or no or insufficient explanation in documentation. * Item is not applicable to the measure being validated. Rate Met = Number Met / Number Applicable. Source: BHC, Inc. 2009 External Quality Review Performance Measure Validation



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

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



Note: Error bars on the y-axis represent 95% confidence intervals; * indicates values are significantly lower or higher than the MOHealthNet average at the 95% level of significance. Enrollment as of the last week in December 2008 (the measurement year) was used to calculate the rate.

Sources: MO HealthNet MCHP HEDIS 2009 Data Submission Tool (DST); Missouri Department of Social Services, Division of Medical Services, State MPRI Session Screens, enrollment figures for all Waivers, December 26, 2008.

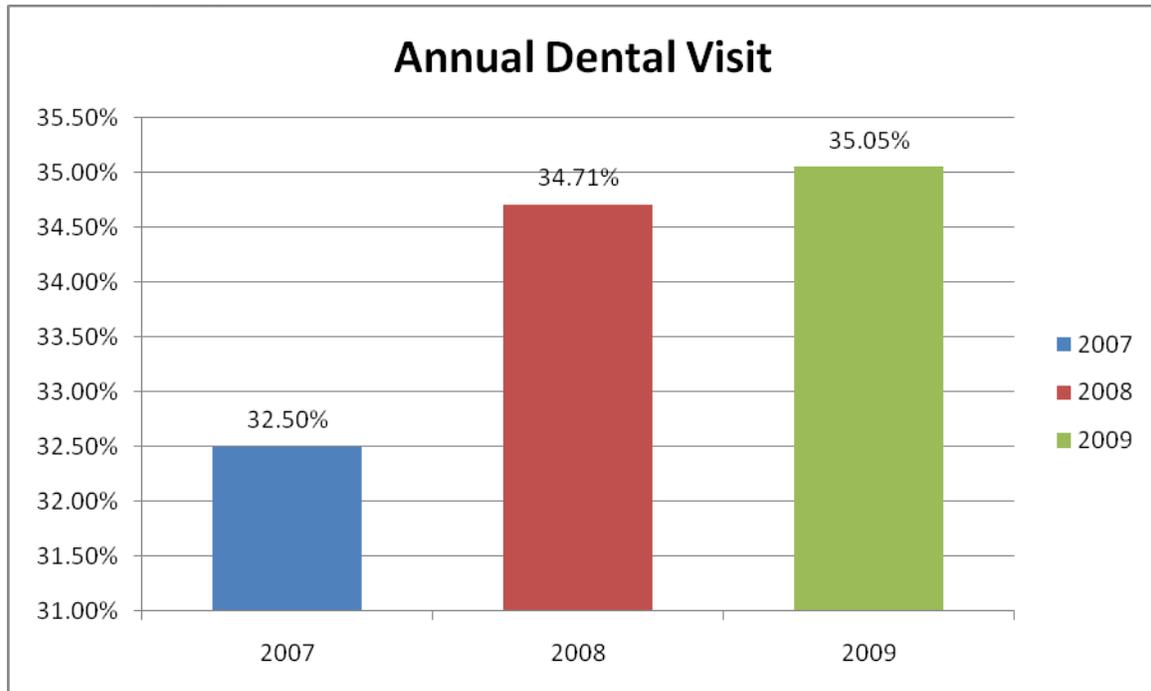
Processes Used to Produce Numerators

The objectives of this activity were to evaluate the MO HealthNet MCHPs' ability to accurately identify medical events, evaluate the ability to identify events from other sources, evaluate procedures for non-duplicate counting of multiple events, review time parameters and the use of non-standard code maps, and assess the processes and procedures for collecting and incorporating medical record review data. The Technical Specifications for the HEDIS 2009 Annual Dental Visit measure required the measure be calculated using the Administrative Method; the Hybrid Method procedures do not apply.

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

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

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

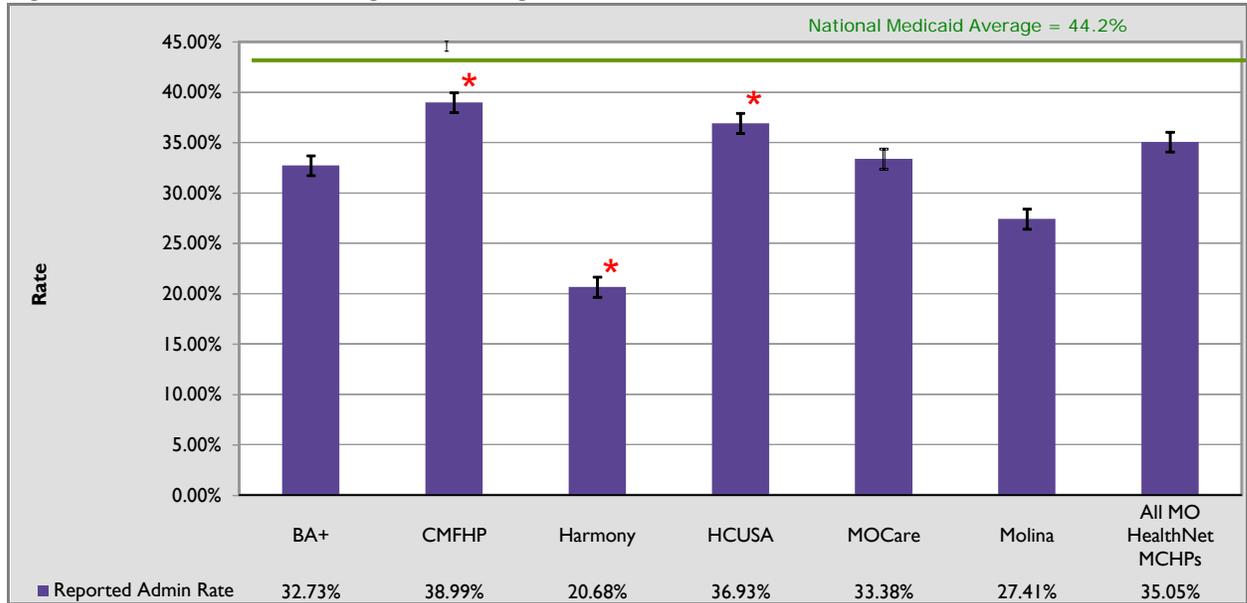
Figure 17 – MO HealthNet Managed Care Program Statewide Rate Comparison for HEDIS Measure: Annual Dental Visit**Table 9 - Data Submission and Final Validation for HEDIS 2009 Annual Dental Visit (combined rate)**

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

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

Source: MO HealthNet MCHPs' HEDIS 2009 Data Submission Tools (DST).

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



Note: Error bars on the y-axis represent 95% confidence intervals; * indicates values are significantly lower or higher than the MOHealthNet average at the 95% level of significance.

Sources: MO HealthNet MCHP HEDIS 2009 Data Submission Tool (DST); National Committee for Quality Assurance (NCQA).

Table 10 shows the validation of numerators based on the review of numerator extract files and the medical record review. Item 13.2 was not applicable to this measure, as the services reported could not easily be obtained outside the health plan. Item 13.6 also did not apply, as none of the MO HealthNet MCHPs used non-standard codes to determine the numerators. Items 13.8 through 13.13 relate to the Hybrid Method and were not applicable for the Annual Dental Visit measure. HCUSA did not provide correct dates of service in the numerator file submitted to the EQRO and therefore Item 13.7 was Not Met. Across all MO HealthNet MCHPs, 96.7% of the criteria for calculating the numerator were met.

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

Item	Audit Elements	MO HealthNet MCHP						All MO HealthNet MCHPs				
		BA+	CMFHP	Harmony	HCUSA	MOCare	Molina	Number Met	Number Partially Met	Number Not Met	Number Applicable	Rate Met
13.1	The MCHP/PIHP has used the appropriate data, including linked data from separate data sets, to identify the entire at-risk population.	2	2	2	2	2	2	6	0	0	6	100.0%
13.2	The MCHP/PIHP has in place and utilizes procedures to capture data for those performance indicators that could be easily under-reported due to the availability of services outside the MCHP/PIHP.	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
13.3	The MCHP's/PIHP's use of codes used to identify medical events are complete, accurate, and specific in correctly describing what has transpired and when.	2	2	2	2	2	2	6	0	0	6	100.0%
13.4	The MCHP/PIHP correctly evaluated medical event codes when classifying members for inclusion or exclusion in the numerator.	2	2	2	2	2	2	6	0	0	6	100.0%
13.5	The MCHP/PIHP has avoided or eliminated all double-counted members or numerator events.	2	2	2	2	2	2	6	0	0	6	100.0%
13.6	Any non-standard codes used in determining the numerator have been mapped to a standard coding scheme in a manner that is consistent, complete, and reproducible as evidenced by a review of the programming logic or a demonstration of the program.	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
13.7	Any time parameters required by the specifications of the performance measure are adhered to (i.e., that the measured event occurred during the time period specified or defined in the performance measure).	2	2	2	0	2	2	5	0	1	6	83.3%
13.8	Medical record reviews and abstractions have been carried out in a manner that facilitates the collection of complete, accurate, and valid data.	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
13.9	Record review staff have been properly trained and supervised for the task.	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
13.10	Record abstraction tools require the appropriate notation that the measured event occurred.	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
13.11	Record abstraction tools require notation of the results or findings of the measured event (if applicable).	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
13.12	Data included in the record extract files are consistent with data found in the medical records as evidenced by a review of a sample of medical record for applicable performance measures. (From Medical Record Review Validation Tools-Table 5, ATTACHMENT XII)	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
13.13	The process of integrating administrative data and medical record data for the purpose of determining the numerator is consistent and valid.	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
	Number Met	5	5	5	4	5	5	29	0	1	30	96.7%
	Number Partially Met	0	0	0	0	0	0					
	Number Not Met	0	0	0	1	0	0					
	Number Applicable	5	5	5	5	5	5					

Note: A = Administrative; H = Hybrid; NA = Not Applicable to the method employed by the MO HealthNet MCHP; Administrative Method was used by the MO HealthNet MCHP and the item relates to the Hybrid Method; 2 = Met and validated through HEDIS software certification process and proper explanation in documentation or proper explanation in documentation. 1 = Partially Met; 0 = Not Met, validated through HEDIS software certification process, but no proper explanation of the process in documentation or no or insufficient explanation in documentation. * Item is not applicable to the measure being validated. Rate Met = Number Met / Number Applicable. **Source:** BHC, Inc. 2009 External Quality Review Performance Measure Validation.



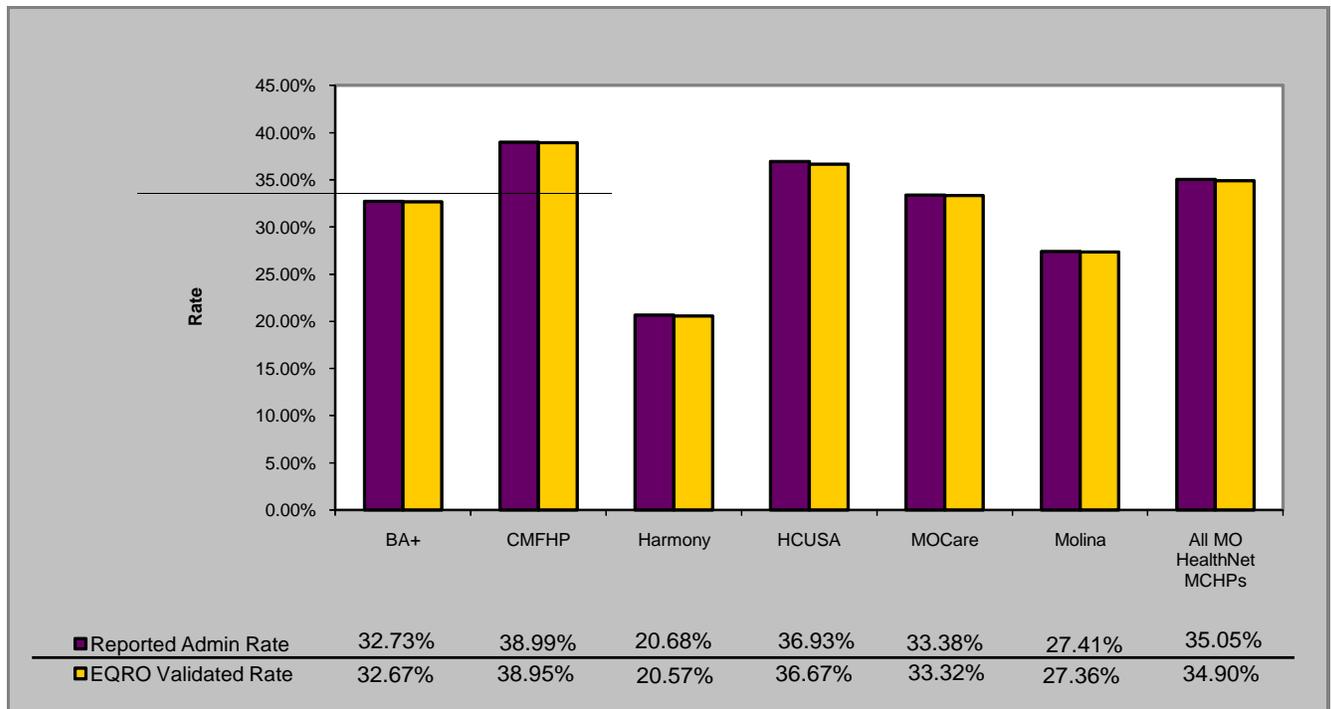
Submission of Measures to the State

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

Final Validation Findings

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

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



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

HEDIS 2009 ADOLESCENT WELL-CARE VISITS

Data Integration and Control

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

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

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

Item	Audit Elements	MO HealthNet MCHP								All MO HealthNet MCHPs			
		BA+	CMFHP	Harmony	HCUSA	MOCare	Molina	Number Met	Number Partially Met	Number Not Met	Number Applicable	Rate Met	
5.1	MCHP/PIHP processes accurately and completely transfer data from the transaction files (e.g., membership, provider, encounter/claims) into the repository used to keep the data until the calculations of the performance measures have been completed and validated.	2	2	2	2	2	2	6	0	0	6	100.0%	
5.2	Samples of data from repository are complete and accurate.	2	2	2	2	2	2	6	0	0	6	100.0%	
5.3	MCHP's/PIHP's processes to consolidate diversified files, and to extract required information from the performance measure repository are appropriate.	2	2	2	2	2	2	6	0	0	6	100.0%	
5.4	Actual results of file consolidations or extracts were consistent with those which should have resulted according to documented algorithms or specifications.	2	2	2	2	2	2	6	0	0	6	100.0%	
5.5	Procedures for coordinating the activities of multiple subcontractors ensure the accurate, timely, and complete integration of data into the performance measure database.	2	2	2	2	2	2	6	0	0	6	100.0%	
5.6	Computer program reports or documentation reflect vendor coordination activities, and no data necessary to performance measure reporting are lost or inappropriately modified during transfer.	2	2	2	2	2	2	6	0	0	6	100.0%	
5.7	The repository's design, program flow charts, and source codes enable analyses and reports.	2	2	2	2	2	2	6	0	0	6	100.0%	
5.8	Proper linkage mechanisms have been employed to join data from all necessary sources (e.g., identifying a member with a given disease/condition).	2	2	2	2	2	2	6	0	0	6	100.0%	
5.9	Examine and assess the adequacy of the documentation governing the production process, including MCHP/PIHP production activity logs, and MCHP/PIHP staff review of report runs.	2	2	2	2	2	2	6	0	0	6	100.0%	
5.10	Prescribed data cutoff dates were followed.	2	2	2	2	2	2	6	0	0	6	100.0%	
5.11	The MCHP/PIHP has retained copies of files or databases used for performance measure reporting, in the event that results need to be reproduced.	2	2	2	2	2	2	6	0	0	6	100.0%	
5.12	Review documentation standards to determine the extent to which the reporting software program is properly documented with respect to every aspect of the performance measurement reporting repository, including building, maintaining, managing, testing, and report production.	2	2	2	2	2	2	6	0	0	6	100.0%	
5.13	Review the MCHP's/PIHP's processes and documentation to determine the extent to which they comply with the MCHP/PIHP standards associated with reporting program specifications, code review, and testing.	2	2	2	2	2	2	6	0	0	6	100.0%	
	Number Met	13	13	13	13	13	13	78	0	0	78	100.0%	
	Number Partially Met	0	0	0	0	0	0						
	Number Not Met	0	0	0	0	0	0						
	Number Applicable	13	13	13	13	13	13						
	Rate Met	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%						

Note: A = Administrative; H = Hybrid; NA = Not Applicable to the method employed by the MO HealthNet MCHP; Administrative Method was used by the MO HealthNet MCHP and the item relates to the Hybrid Method; 2 = Met and validated through HEDIS software certification process and proper explanation in documentation or proper explanation in documentation. 1 = Partially Met; 0 = Not Met, validated through HEDIS software certification process, but no proper explanation of the process in documentation or no or insufficient explanation in documentation. * Item is not applicable to the measure being validated. Rate Met = Number Met / Number Applicable. **Source:** BHC, Inc. 2009 External Quality Review Performance Measure Validation



Documentation of Data and Processes

The objectives of this activity were to assess the documentation of data collection; the process of integrating data into a performance measure set; the procedures used to query the data set for sampling, numerators and denominators; and the ability to apply proper algorithms for the calculation of HEDIS 2009 Adolescent Well-Care Visits measure. Table 12 summarizes the findings of Attachment VI (Data and Processes Used to Calculate and Report Performance Measures) of the CMS Protocol. Item 7.2 did not apply to any MO HealthNet MCHPs for this measure, as none of the MCOs used non-standard codes. Items 7.3 (statistical testing of results and corrections made after processing), 7.4 (inclusion of external data sources), and 7.9 (consistent data from measure to measure) did not apply to this measure. Items 7.5, 7.7, and 7.10 are only applicable for the Hybrid method of calculation, and therefore did not apply to BA+. Each MO HealthNet MCHP calculating the measure met 100.0% of the criteria for processes used to calculate and report the HEDIS 2009 Adolescent Well-Care Visits measure.

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

Item	Audit Elements	MO HealthNet MCHP						All MO HealthNet MCHPs				
		BA +	CMFHP	Harmony	HCUSA	MOCare	Molina	Number Met	Number Partially Met	Number Not Met	Number Applicable	Rate Met
7.1	Data file and field definitions used for each measure.	2	2	2	2	2	2	6	0	0	6	100.0%
7.2	Maps to standard coding if not used in original data collection.	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
7.3	Statistical testing of results and any corrections or adjustments made after processing.	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
7.4	All data sources, including external data (whether from a vendor, public registry, or other outside source), and any prior years' data (if applicable).	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
7.5	Detailed medical record review methods and practices, including the qualifications of medical record review supervisor and staff; reviewer training materials; audit tools used, including completed copies of each record-level reviewer determination; all case-level critical performance measure data elements used to determine a positive or negative event or exclude a case from same; and inter-rater reliability testing procedures and results.	NA	2	2	2	2	2	5	0	0	5	100.0%
7.6	Detailed computer queries, programming logic, or source code used to identify the population or sample for the denominator and/or numerator.	2	2	2	2	2	2	6	0	0	6	100.0%
7.7	If sampling used, description of sampling techniques, and documentation that assures the reviewer that samples used for baseline and repeat measurements of the performance measures were chosen using the same sampling frame and methodology.	NA	2	2	2	2	2	5	0	0	5	100.0%
7.8	Documentation of calculation for changes in performance from previous periods (if applicable), including statistical tests of significance.	2	2	2	2	2	2	6	0	0	6	100.0%
7.9	Data that are related from measure to measure are consistent (e.g., membership counts, provider totals, number of pregnancies and births).	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
7.10	Appropriate statistical functions are used to determine confidence intervals when sampling is used in the measure.	NA	2	2	2	2	2	5	0	0	5	100.0%
7.11	When determining improvement in performance between measurement periods, appropriate statistical methodology is applied to determine levels of significance of changes.	2	2	2	2	2	2	6	0	0	6	100.0%
	Number Met	4	7	7	7	7	7	39	0	0	39	100.0%
	Number Partially Met	0	0	0	0	0	0					
	Number Not Met	0	0	0	0	0	0					
	Number Applicable	4	7	7	7	7	7					
	Rate Met	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%					

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

Source: BHC, Inc. 2009 External Quality Review Performance Measure Validation



Processes Used to Produce Denominators

The objective of this activity was to determine the extent to which all eligible members were included in the denominator, evaluate the programming and logic source codes, and evaluate the specifications for each measure. For the HEDIS 2009 Adolescent Well-Care Visits measure, the sources of data include enrollment, eligibility, and claim files. Table 13 summarizes the findings of Attachment X (Denominator Validation Findings) of the CMS Protocol. Items 10.5 (identification of gender of the member), 10.6 (calculation of member months or years), and 10.10 (Systems for estimating populations when they are unable to accurately be counted) were not applicable to the HEDIS 2009 Adolescent Well-Care Visits measure. Overall, 100% of the criteria were met for the processes used to produce denominators.

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

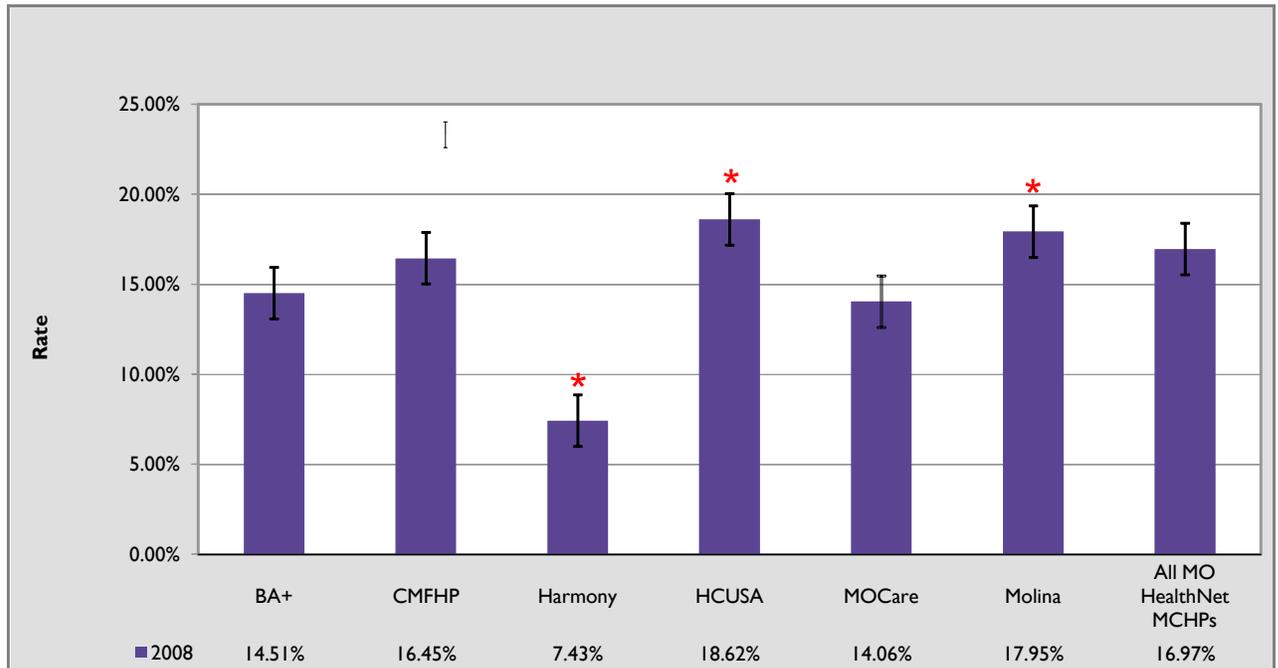
Item	Audit Elements	MO HealthNet MCHP						All MO HealthNet MCHPs				
		BA+	CMFHP	Harmony	HCUSA	MOCare	Molina	Number Met	Number Partially Met	Number Not Met	Number Applicable	Rate Met
10.1	All members who were eligible to receive the specified services were included in the initial population from which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

Note: A = Administrative; H = Hybrid; NA = Not Applicable to the method employed by the MO HealthNet MCHP; Administrative Method was used by the MO HealthNet MCHP and the item relates to the Hybrid Method; 2 = Met and validated through HEDIS software certification process and proper explanation in documentation or proper explanation in documentation. I =Partially Met; 0 = Not Met, validated through HEDIS software certification process, but no proper explanation of the process in documentation or no or insufficient explanation in documentation. * Item is not applicable to the measure being validated. Rate Met = Number Met / Number Applicable. Source: BHC, Inc. 2009 External Quality Review Performance Measure Validation.



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

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



Note: Error bars on the y-axis represent 95% confidence intervals; * indicates values are significantly lower or higher than the MOHealthNet average at the 95% level of significance. Enrollment as of the last week in December 2008 (the measurement year) was used to calculate the rate.

Sources: MO HealthNet MCHP HEDIS 2009 Data Submission Tool (DST); Missouri Department of Social Services, Division of Medical Services, State MPRI Session Screens, enrollment figures for all Waivers, December 26, 2008.

Processes Used to Produce Numerators

The objectives of this activity were to evaluate the MO HealthNet MCHPs' ability to accurately identify medical events, evaluate the ability to identify events from other sources, evaluate procedures for non-duplicate counting of multiple events, review time parameters and the use of non-standard code maps, and assess the processes and procedures for collecting and incorporating medical record review data. For the HEDIS 2009 Adolescent Well-Care Visits measure, the sources of data included enrollment, eligibility, and claim files. Table I4 shows the numerators, denominators, and rates submitted by the MO HealthNet MCHPs to the SPHA on the DST. The "combined" rates for HCUSA, MO Care, and Molinawere calculated by the EQRO based on reported rates for each region (Central, Eastern, and Western). The rate for all MO HealthNet MCHPs was 35.63%, with health plan rates ranging from 30.17% (Harmony) to 43.06 % (MO Care).

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

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

Note: DST = Data Submission Tool; NA = Not Applicable; EQRO = External Quality Review Organization (Behavioral Health Concepts, Inc.); LCL = 95% Lower Confidence Limit; UCL = 95% Upper Confidence Limit. The statewide rate for all MO HealthNet MCHPs was calculated by the EQRO using the sum of numerators divided by sum of denominators. There was no statewide rate or confidence limits reported to the SMA or SPHA.

Source: MO HealthNet Managed Care Organization HEDIS 2009 Data Submission Tools (DST)

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

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

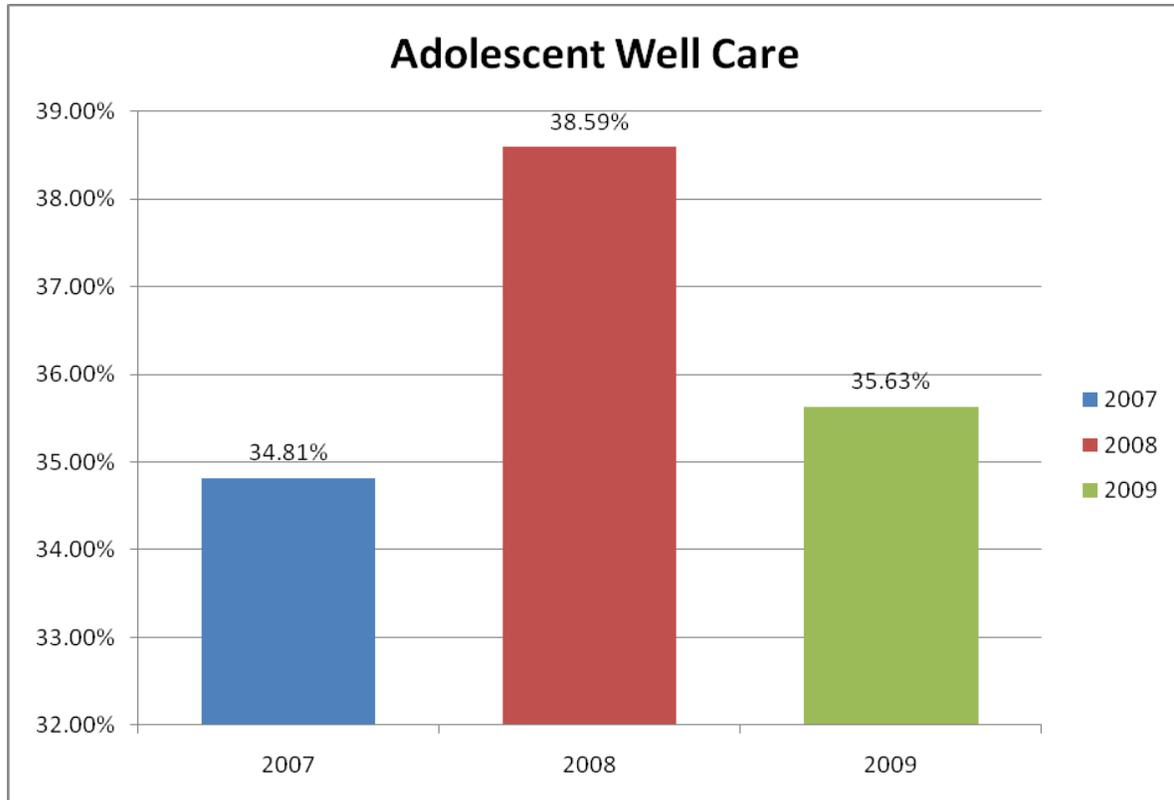
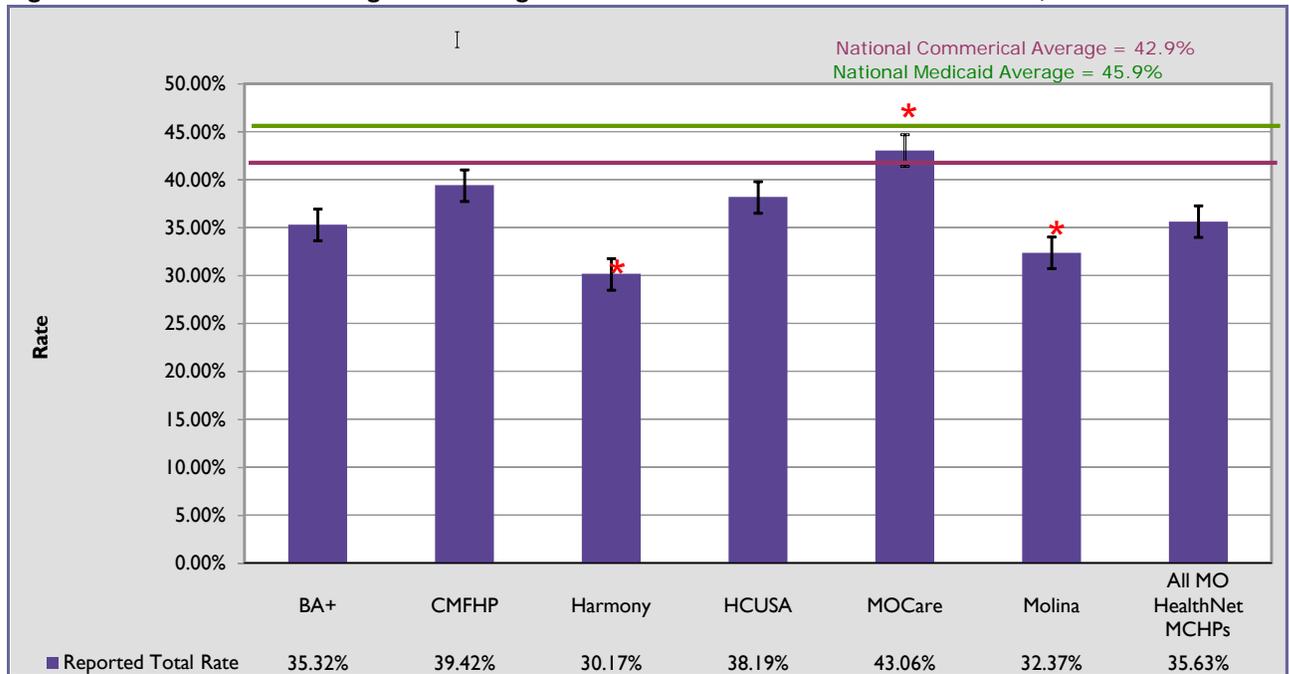


Figure 23 and Figure 24 illustrate the rates reported by the MO HealthNet MCHPs and the rates of administrative and hybrid hits for each MO HealthNet MCHP. The rate reported by each health plan was compared with the rate for all MO HealthNet MCHPs. Two-tailed z-tests of each MO HealthNet MCHP comparing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

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

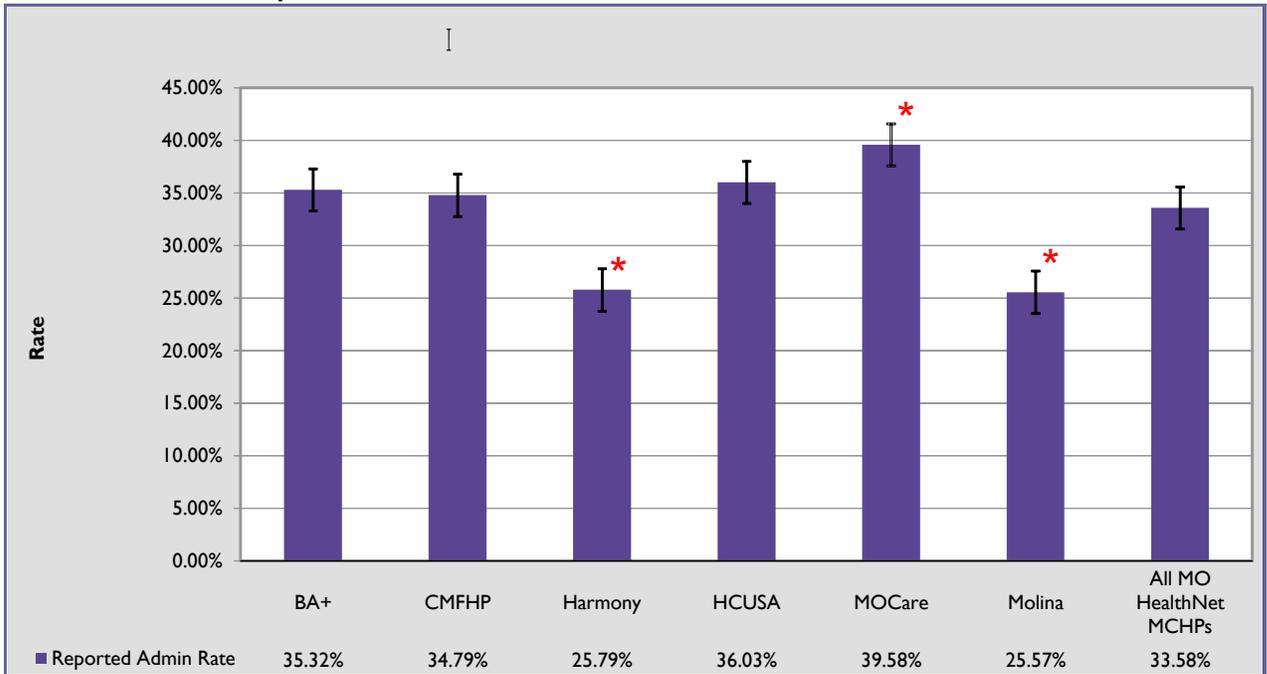
Figure 22 - MO HealthNet Managed Care Program HEDIS 2009 Adolescent Well-Care Visits, Rates



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

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

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

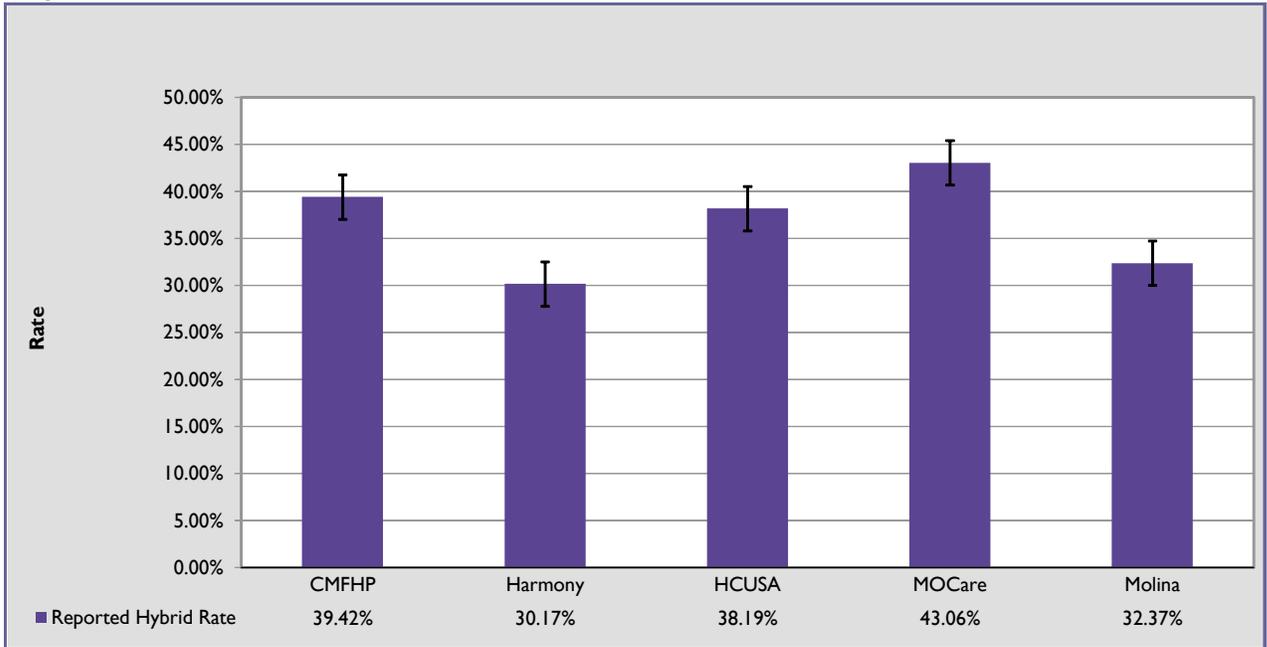


Note: Error bars on the y-axis represent 95% confidence intervals; * indicates values are significantly lower or higher than the MOHealthNet average at the 95% level of significance.

Sources: MO HealthNet MCHP HEDIS 2009 Data Submission Tool (DST); National Committee for Quality Assurance (NCQA).

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

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



Note: Error bars on the y-axis represent 95% confidence intervals

Sources: MO HealthNet MCHP HEDIS 2009 Data Submission Tool (DST); National Committee for Quality Assurance (NCQA)

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

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

MO HealthNet MCHP	Denominator (Sample Size)	Numerator Hits by Medical Records (DST)	Number Medical Records Sampled for Audit by EQRO	Number Medical Records Received for Audit by EQRO	Number Medical Records Validated by EQRO	Rate Validated of Records Received	Accuracy Rate	Error Rate	Weight of Each Medical Record	False Positive Records	Estimated Bias from Medical Records
Childrens Mercy Family Health Partners	411	19	19	19	19	100.0%	100.0%	0.0%	0.002	0	0.0%
Harmony Health Plan	411	18	18	18	18	100.0%	100.0%	0.0%	0.002	0	0.0%
Healthcare USA	1296	28	28	28	28	100.0%	100.0%	0.0%	0.001	0	0.0%
Missouri Care	432	15	15	15	15	100.0%	100.0%	0.0%	0.002	0	0.0%
Molina Healthcare	1353	92	30	29	29	100.0%	96.7%	3.3%	0.001	3	0.2%
All MO HealthNet MCHPs	3,903	172	110	109	109	100.0%	99.1%	0.9%	0.0003	2	0.0%

Note: DST = Data Submission Tool; EQRO = External Quality Review Organization (Behavioral Health Concepts, Inc.); Accuracy Rate = Number of Medical Records Validated by the EQRO/Number of Records Selected for Audit by EQRO; Error Rate = 100% - Accuracy Rate; Weight of Each Medical Record = 100% / Denominator (Sample Size); False Positive Records = Error Rate * Numerator Hits Reported by MCHP (DST); Estimated Bias from Medical Records = Percent of bias due to the medical record review = False Positive Rate * Weight of Each Medical Record. **Source:** MO HealthNet MCHP Data Submission Tools (DST); BHC, Inc. 2009 External Quality Review Performance Measures Validation.



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

Item	Audit Elements	MO HealthNet MCHP					
		BA+	CMFHP	Harmony	HCUSA	MOCare	Molina
12.1	Final Data Collection Method Used (e.g., MRR, hybrid,)	Administrative	Hybrid	Hybrid	Hybrid	Hybrid	Hybrid
12.2	Error Rate (Percentage of records selected for audit that were identified as not meeting numerator requirements)	NA	0.00%	0.00%	0.00%	0.00%	0.00%
12.3	Is error rate < 10%? (Yes or No)	NA	Yes	Yes	Yes	Yes	Yes
	If yes, MCHP/PIHP passes MRR validation; no further MRR calculations are necessary.	NA	Passes	Passes	Passes	Passes	Passes
	If no, the rest of the spreadsheet will be completed to determine the impact on the final rate.	NA	NA	NA	NA	NA	NA
12.4	Denominator (The total number of members identified for the denominator of this measure, as identified by the MCHP/PIHP)	5541	411	411	1,296	432	1,353
12.5	Weight of Each Medical Record (Impact of each medical record on the final overall rate; determined by dividing 100% by the denominator)	NA	NA	NA	NA	NA	NA
12.6	Total Number of MRR Numerator Positives identified by the MCHP/PIHP using MRR.	NA	NA	NA	NA	NA	NA
12.7	Expected Number of False Positives (Estimated number of medical records inappropriately counted as numerator positives)	NA	NA	NA	NA	NA	NA
12.8	Estimated Bias in Final Rate (The amount of bias caused by medical record review)	NA	NA	NA	NA	NA	NA

Note: A = Administrative; H = Hybrid; NA = Not Applicable to the method employed by the Health Plan; Administrative Method was used by the Health Plan and the item relates to the Hybrid Method; 2 = Met and validated through HEDIS software certification process and proper explanation in documentation or proper explanation in documentation. 1 = Partially Met; 0 = Not Met, validated through HEDIS software certification process, but no proper explanation of the process in documentation or no or insufficient explanation in documentation.

Source: BHC, Inc. 2009 External Quality Review Performance Measure Validation.

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

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

Item	Audit Elements	MO HealthNet MCHP						All MO HealthNet MCHPs				
		BA+	CMFHP	Harmony	HCUSA	MOCare	Molina	Number Met	Number Partially Met	Number Not Met	Number Applicable	Rate Met
13.1	The MCHP/PIHP has used the appropriate data, including linked data from separate data sets, to identify the entire at-risk population.	2	2	2	2	2	2	6	0	0	6	100.0%
13.2	The MCHP/PIHP has in place and utilizes procedures to capture data for those performance indicators that could be easily under-reported due to the availability of services outside the MCHP/PIHP.	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
13.3	The MCHP's/PIHP's use of codes used to identify medical events are complete, accurate, and specific in correctly describing what has transpired and when.	2	2	2	2	2	2	6	0	0	6	100.0%
13.4	The MCHP/PIHP correctly evaluated medical event codes when classifying members for inclusion or exclusion in the numerator.	2	2	2	2	2	2	6	0	0	6	100.0%
13.5	The MCHP/PIHP has avoided or eliminated all double-counted members or numerator events.	2	2	2	2	2	2	6	0	0	6	100.0%
13.6	Any non-standard codes used in determining the numerator have been mapped to a standard coding scheme in a manner that is consistent, complete, and reproducible as evidenced by a review of the programming logic or a demonstration of the program.	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
13.7	Any time parameters required by the specifications of the performance measure are adhered to (i.e., that the measured event occurred during the time period specified or defined in the performance measure).	2	2	2	2	2	2	6	0	0	6	100.0%
13.8	Medical record reviews and abstractions have been carried out in a manner that facilitates the collection of complete, accurate, and valid data.	NA	2	2	2	2	2	5	0	0	5	100.0%
13.9	Record review staff have been properly trained and supervised for the task.	NA	2	2	2	2	2	5	0	0	5	100.0%
13.10	Record abstraction tools require the appropriate notation that the measured event occurred.	NA	2	2	2	2	2	5	0	0	5	100.0%
13.11	Record abstraction tools require notation of the results or findings of the measured event (if applicable).	NA	2	2	2	2	2	5	0	0	5	100.0%
13.12	Data included in the record extract files are consistent with data found in the medical records as evidenced by a review of a sample of medical record for applicable performance measures. (From Medical Record Review Validation Tools)	NA	2	2	2	2	1	4	1	0	5	80.0%
13.13	The process of integrating administrative data and medical record data for the purpose of determining the numerator is consistent and valid.	NA	2	2	2	2	2	5	0	0	5	100.0%
	Number Met	5	11	11	11	11	10	59	1	0	60	98.3%
	Number Partially Met	0	0	0	0	0	1					
	Number Not Met	0	0	0	0	0	0					
	Number Applicable	5	11	11	11	11	11					
	Rate Met	100.0%	100.0%	100.0%	100.0%	100.0%	90.9%					

Note: A = Administrative; H = Hybrid; NA = Not Applicable to the method employed by the MO HealthNet MCHP; Administrative Method was used by the MO HealthNet MCHP and the item relates to the Hybrid Method; 2 = Met and validated through HEDIS software certification process and proper explanation in documentation or proper explanation in documentation. 1 = Partially Met; 0 = Not Met, validated through HEDIS software certification process, but no proper explanation of the process in documentation or no or insufficient explanation in documentation. * Item is not applicable to the measure being validated. Rate Met = Number Met / Number Applicable.
Source: BHC, Inc. 2009 External Quality Review Performance Measure Validation.



Sampling Procedures for Hybrid Method

The objectives of this activity were to evaluate the MO HealthNet MCHPs' ability to randomly sample from the eligible members for the measure when using the Hybrid Method of calculation. Table 18 summarizes the findings of Attachment XV (Sampling Validation Findings) of the CMS Protocol. Items 15.3 (each provider had an equal chance of being sampled) and 15.9 (documenting if the requested sample size exceeded the eligible population size) did not apply to any of the MO HealthNet MCHPs for this measure; and none of the items were applicable to BA+. Across all MO HealthNet MCHPs, the criteria for sampling were met 100.0% of the time. The health plans using the Hybrid Method of calculating the HEDIS 2009 Adolescent Well-Care Visits measure met 100.0% of the criteria for proper sampling.

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

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

Note: A = Administrative; H = Hybrid; NA = Not Applicable to the method employed by the MO HealthNet MCHP; Administrative Method was used by the MO HealthNet MCHP and the item relates to the Hybrid Method; 2 = Met and validated through HEDIS software certification process and proper explanation in documentation or proper explanation in documentation. 1 = Partially Met; 0 = Not Met, validated through HEDIS software certification process, but no proper explanation of the process in documentation or no or insufficient explanation in documentation. **Source:** BHC, Inc. 2009 External Quality Review Performance Measure Validation



Submission of Measures to the State

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

Final Validation Findings

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

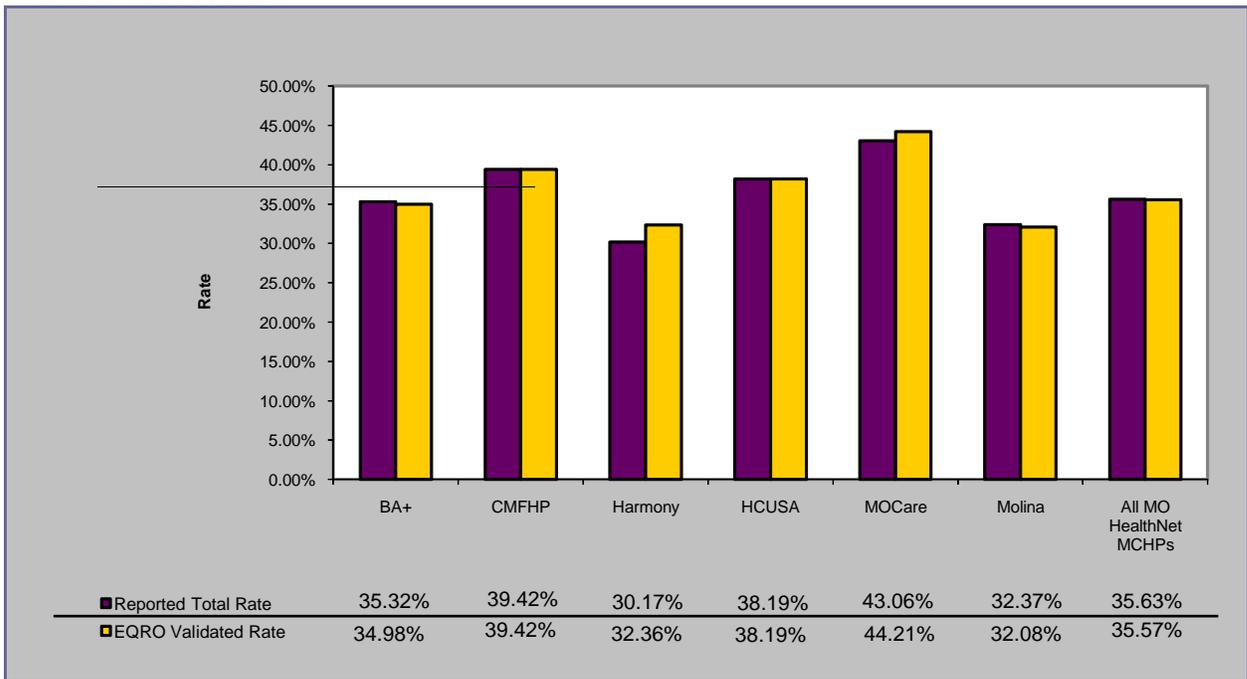
Figure 25 illustrates the differences between the rates reported to the SPHA and those calculated by the EQRO. The rate for all MO HealthNet MCHPs calculated based on data validated by the EQRO was 35.57%, while the rate reported by all health plans was 35.63%, a 0.06% overestimate.

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

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

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

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



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

HEDIS 2009 FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS

Data Integration and Control

The objective of this activity was to assess the MO HealthNet MCHPs' ability to link data from multiple sources. It is based on the integrity of the management information systems and the ability to ensure accuracy of the measures. For the HEDIS 2009 Follow-Up After Hospitalization for Mental Illness measure, the sources of data included enrollment, eligibility, and claim files. Table 20 summarizes the findings of Attachment V (Data Integration and Control Findings) of the CMS Protocol. The rate of items that were Met was calculated across MO HealthNet MCHPs and from the number of applicable items for each MO HealthNet MCHP.

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

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

Item	Audit Elements	MO HealthNet MCHP						All MO HealthNet MCHPs				
		BA+	CMFHP	Harmony	HCUSA	MOCare	Molina	Number Met	Number Partially Met	Number Not Met	Number Applicable	Rate Met
5.1	MCHP/PIHP processes accurately and completely transfer data from the transaction files (e.g., membership, provider, encounter/claims) into the repository used to keep the data until the calculations of the performance measures have been completed and validated.	2	2	2	2	2	2	6	0	0	6	100.0%
5.2	Samples of data from repository are complete and accurate.	2	2	2	2	2	2	6	0	0	6	100.0%
5.3	MCHP's/PIHP's processes to consolidate diversified files, and to extract required information from the performance measure repository are appropriate.	2	2	2	2	2	2	6	0	0	6	100.0%
5.4	Actual results of file consolidations or extracts were consistent with those which should have resulted according to documented algorithms or specifications.	2	2	2	2	2	2	6	0	0	6	100.0%
5.5	Procedures for coordinating the activities of multiple subcontractors ensure the accurate, timely, and complete integration of data into the performance measure database.	2	2	2	2	2	2	6	0	0	6	100.0%
5.6	Computer program reports or documentation reflect vendor coordination activities, and no data necessary to performance measure reporting are lost or inappropriately modified during transfer.	2	2	2	2	2	2	6	0	0	6	100.0%
5.7	The repository's design, program flow charts, and source codes enable analyses and reports.	2	2	2	2	2	2	6	0	0	6	100.0%
5.8	Proper linkage mechanisms have been employed to join data from all necessary sources (e.g., identifying a member with a given disease/condition).	2	2	2	2	2	2	6	0	0	6	100.0%
5.9	Examine and assess the adequacy of the documentation governing the production process, including MCHP/PIHP production activity logs, and MCHP/PIHP staff review of report runs.	2	2	2	2	2	2	6	0	0	6	100.0%
5.10	Prescribed data cutoff dates were followed.	2	2	2	2	2	2	6	0	0	6	100.0%
5.11	The MCHP/PIHP has retained copies of files or databases used for performance measure reporting, in the event that results need to be reproduced.	2	2	2	2	2	2	6	0	0	6	100.0%
5.12	Review documentation standards to determine the extent to which the reporting software program is properly documented with respect to every aspect of the performance measurement reporting repository, including building, maintaining, managing, testing, and report production.	2	2	2	2	2	2	6	0	0	6	100.0%
5.13	Review the MCHP's/PIHP's processes and documentation to determine the extent to which they comply with the MCHP/PIHP standards associated with reporting program specifications, code review, and testing.	2	2	2	2	2	2	6	0	0	6	100.0%
	Number Met	13	13	13	13	13	13	78	0	0	78	100.0%
	Number Partially Met	0	0	0	0	0	0					
	Number Not Met	0	0	0	0	0	0					
	Number Applicable	13	13	13	13	13	13					
	Rate Met	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%					

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

Source: BHC, Inc. 2009 External Quality Review Performance Measure Validation.

Documentation of Data and Processes

The objectives of this activity were to assess the documentation of data collection; the process of integrating data into a performance measure set; the procedures used to query the data set for sampling, numerators and denominators; and the ability to apply proper algorithms. Table 21 summarizes the findings of Attachment VI (Data and Processes Used to Calculate and Report Performance Measures) of the CMS Protocol. Item 7.2 did not apply as none of the MO HealthNet MCHPs used non-standard codes. Item 7.4 is also not applicable as a member would not receive services for this measure outside of the health plan's system. Items 7.3 (statistical testing of results and corrections made after processing), 7.5 (detailed medical record review methods and practices), 7.7 (sampling techniques), 7.9 (data consistency from measure to measure), and 7.10 (appropriate statistical functions for confidence intervals) did not apply to the measure, as the measure must be calculated using only the Administrative method. All MO HealthNet MCHPs met 100.0% of the criteria for calculating and reporting performance measures.

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

Item	Audit Elements	MO HealthNet MCHP						All MO HealthNet MCHPs				
		BA+	CMFHP	Harmony	HCUSA	MOCare	Molina	Number Met	Number Partially Met	Number Not Met	Number Applicable	Rate Met
7.1	Data file and field definitions used for each measure.	2	2	2	2	2	2	6	0	0	6	100.0%
7.2	Maps to standard coding if not used in original data collection.	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
7.3	Statistical testing of results and any corrections or adjustments made after processing.	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
7.4	All data sources, including external data (whether from a vendor, public registry, or other outside source), and any prior years' data (if applicable).	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
7.5	Detailed medical record review methods and practices, including the qualifications of medical record review supervisor and staff; reviewer training materials; audit tools used, including completed copies of each record-level reviewer determination; all case-level critical performance measure data elements used to determine a positive or negative event or exclude a case from same; and inter-rater reliability testing procedures and results.	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
7.6	Detailed computer queries, programming logic, or source code used to identify the population or sample for the denominator and/or numerator.	2	2	2	2	2	2	6	0	0	6	100.0%
7.7	If sampling used, description of sampling techniques, and documentation that assures the reviewer that samples used for baseline and repeat measurements of the performance measures were chosen using the same sampling frame and methodology.	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
7.8	Documentation of calculation for changes in performance from previous periods (if applicable), including statistical tests of significance.	2	2	2	2	2	2	6	0	0	6	100.0%
7.9	Data that are related from measure to measure are consistent (e.g., membership counts, provider totals, number of pregnancies and births).	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
7.10	Appropriate statistical functions are used to determine confidence intervals when sampling is used in the measure.	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
7.11	When determining improvement in performance between measurement periods, appropriate statistical methodology is applied to determine levels of significance of changes.	2	2	2	2	2	2	6	0	0	6	100.0%
	Number Met	4	4	4	4	4	4	24	0	0	24	100.0%
	Number Partially Met	0	0	0	0	0	0					
	Number Not Met	0	0	0	0	0	0					
	Number Applicable	4	4	4	4	4	4					
	Rate Met	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%					

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

Source: BHC, Inc. 2009 External Quality Review Performance Measure Validation.

Processes Used to Produce Denominators

The objective of this activity was to determine the extent to which all eligible members were included in the denominator, evaluate the programming and logic source codes, and evaluate the specifications for each measure. For the HEDIS 2009 Follow-Up After Hospitalization for Mental Illness measure, the sources of data include enrollment, eligibility, and claim files. Table 22 summarizes the findings of Attachment X (Denominator Validation Findings) of the CMS Protocol. Items 10.5 (identification of gender of the member), 10.6 (calculation of member months or years), and 10.10 (systems for estimating populations when they are unable to accurately be counted) were not applicable to this measure. Across all MO HealthNet MCHPs, 100% of criteria for calculating and reporting performance measures were met. The MO HealthNet MCHPs met 100% of the criteria for the process used to produce denominators.

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

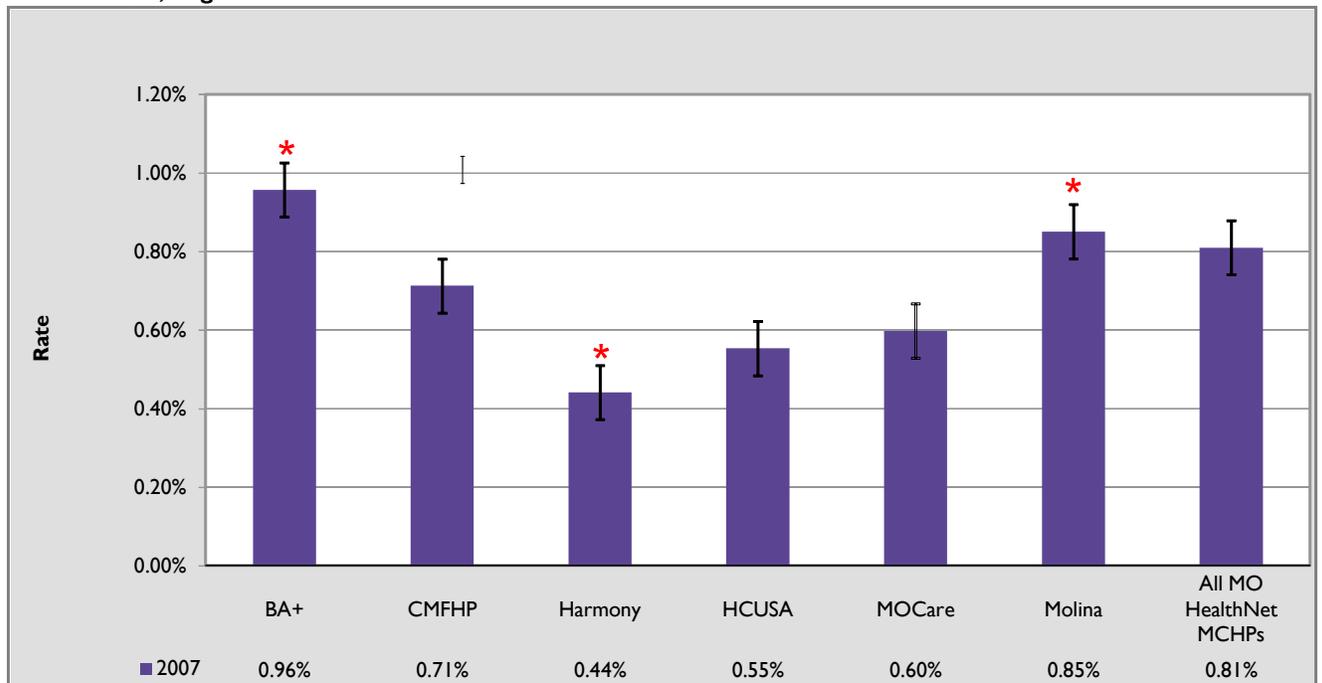
Item	Audit Elements	MO HealthNet MCHP						All MO HealthNet MCHPs				
		BA+	CMFHP	Harmony	HCUSA	MOCare	Molina	Number Met	Number Partially Met	Number Not Met	Number Applicable	Rate Met
10.1	All members who were eligible to receive the specified services were included in the initial population from which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

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

Source: BHC, Inc. 2009 External Quality Review Performance Measure Validation.

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

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



Note: Error bars on the y-axis represent 95% confidence intervals; * indicates values are significantly lower or higher than the MOHealthNet average at the 95% level of significance. Enrollment as of the last week in December 2008 (the measurement year) was used to calculate the rate.

Sources: MO HealthNet MCHP HEDIS 2009 Data Submission Tool (DST); Missouri Department of Social Services, Division of Medical Services, State MPRI Session Screens, enrollment figures for all Waivers, December 26, 2008.

Processes Used to Produce Numerators

The objectives of this activity were to evaluate the MO HealthNet MCHPs' ability to accurately identify medical events, evaluate the ability to identify events from other sources, evaluate procedures for non-duplicate counting of multiple events, review time parameters and the use of non-standard code maps, and assess the processes and procedures for collecting and incorporating medical record review data. For the HEDIS 2009 Follow-Up After Hospitalization for Mental Illness measure, the procedures for the Hybrid Method did not apply, as HEDIS 2009 technical specifications allow only for the use of the Administrative Method of calculating the measure.

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

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

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

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

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

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

Source: MO HealthNet Managed Care Organization HEDIS 2009 Data Submission Tools (DST).

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

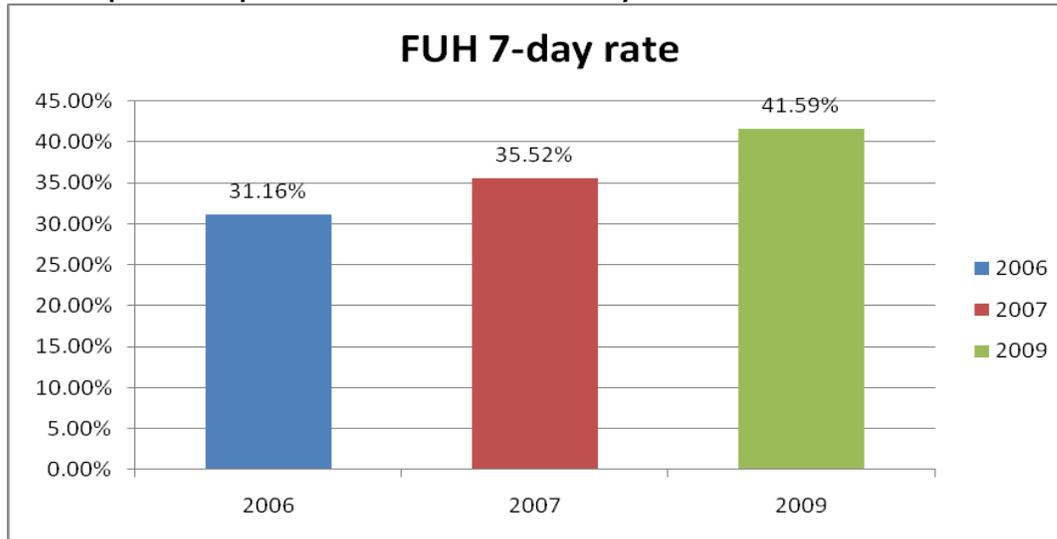
MO HealthNet MCHP	Eligible Population	Number Administrative Hits Reported by MCHP (DST)	Rate Reported by MCHP (DST)	Administrative Hits Validated by EQRO	Rate Validated by EQRO	Estimated Bias
Blue Advantage Plus	296	217	73.31%	217	73.31%	0.00%
Childrens Mercy Family Health Partners	393	270	68.70%	267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

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

Source: MO HealthNet Managed Care Organization HEDIS 2009 Data Submission Tools (DST).

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

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



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

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

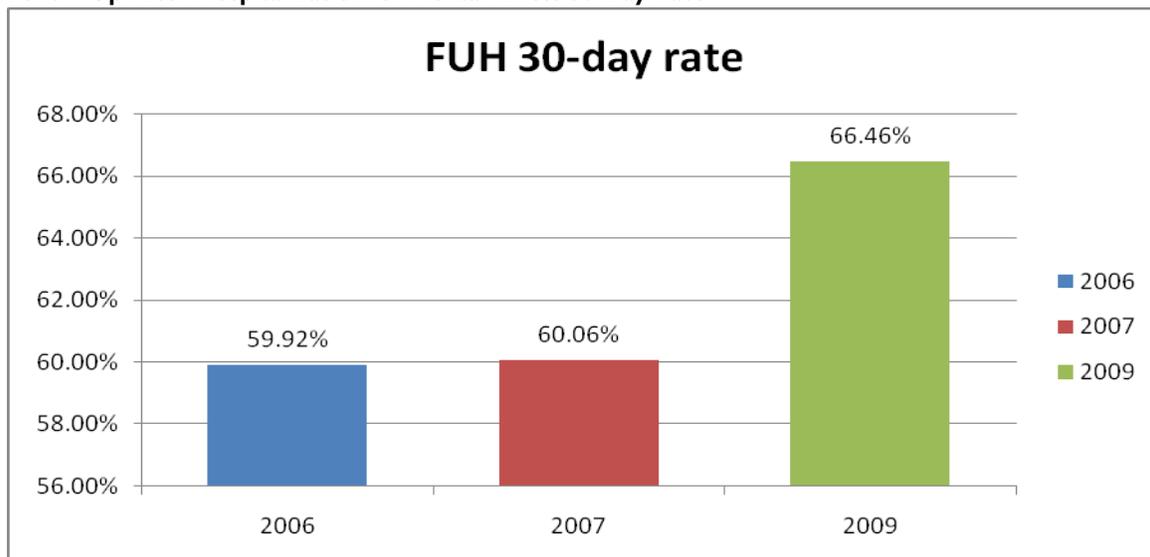
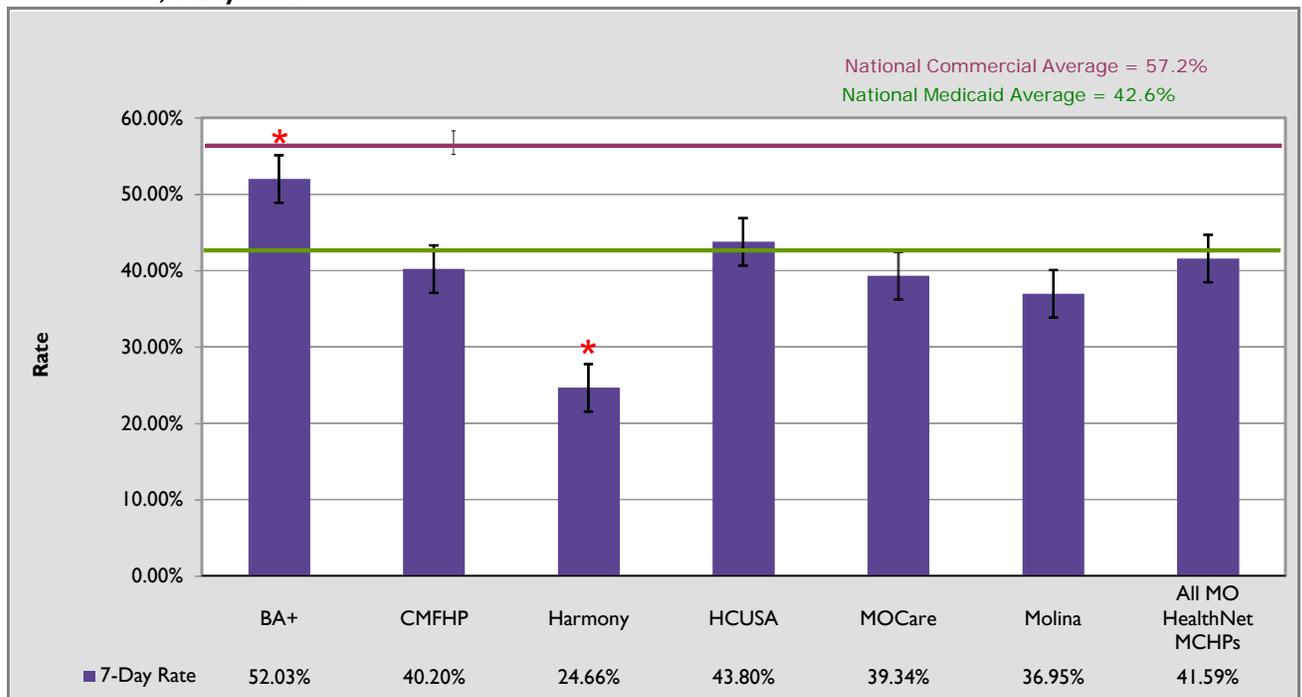


Figure 29 and Figure 30 illustrate the 7-Day and 30-Day rates reported by the MO HealthNet MCHPs. The rate reported by each MO HealthNet MCHP was compared with the rate for all MO HealthNet MCHPs, with two-tailed z-tests conducted at the 95% confidence interval to compare each MO HealthNet MCHP with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

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

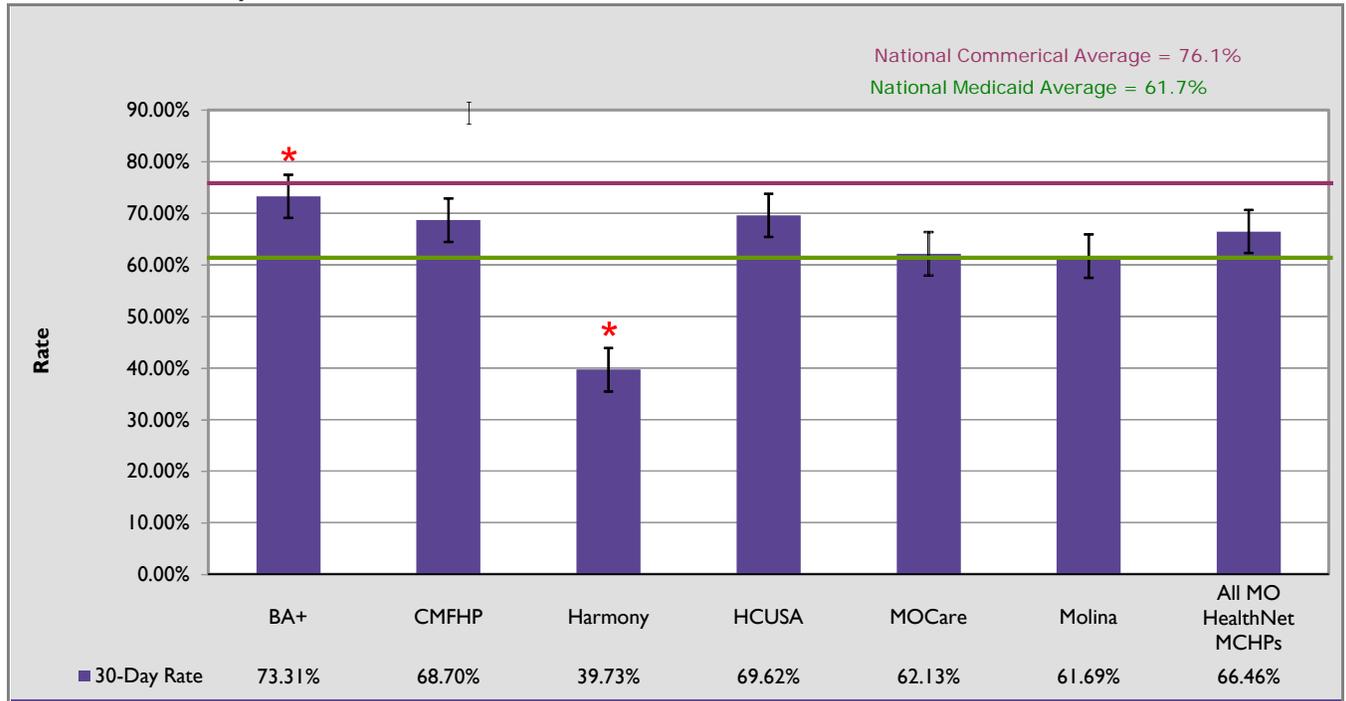
Figure 29 - MO HealthNet Managed Care Program HEDIS 2009 Follow-Up After Hospitalization for Mental Illness, 7-Day Rates



Note: Error bars on the y-axis represent 95% confidence intervals; * indicates values are significantly lower or higher than the MOHealthNet average at the 95% level of significance.

Sources: MO HealthNet MCHP HEDIS 2009 DST; National Committee for Quality Assurance (NCQA).

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



Note: Error bars on the y-axis represent 95% confidence intervals.

Sources: MO HealthNet MCHP HEDIS 2009 DST; National Committee for Quality Assurance (NCQA)

Table 25 shows the validation of numerators based on the review of numerator extract files and the medical record review. Item 13.2 was not applicable to the HEDIS 2009 Follow-Up After Hospitalization for Mental Illness measure. Item 13.6 did not apply, as none of the MO HealthNet MCHPs used non-standard codes. Items 13.8 through 13.13 relate to the Hybrid Method of calculation and were not applicable to the measure. Across all MO HealthNet MCHPs, 100% of the criteria for calculating numerators were met. Each of the MO HealthNet MCHPs met 100.0% of criteria for the calculation of the numerator.

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

Item	Audit Elements	MO HealthNet MCHP						All MO HealthNet MCHPs				
		BA+	CMFHP	Harmony	HCUSA	MOCare	MCP	Number Met	Number Partially Met	Number Not Met	Number Applicable	Rate Met
13.1	The MCHP/PIHP has used the appropriate data, including linked data from separate data sets, to identify the entire at-risk population.	2	2	2	2	2	2	6	0	0	6	100.0%
13.2	The MCHP/PIHP has in place and utilizes procedures to capture data for those performance indicators that could be easily under-reported due to the availability of services outside the MCHP/PIHP.	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
13.3	The MCHP's/PIHP's use of codes used to identify medical events are complete, accurate, and specific in correctly describing what has transpired and when.	2	2	2	2	2	2	6	0	0	6	100.0%
13.4	when classifying members for inclusion or exclusion in the numerator.	2	2	2	2	2	2	6	0	0	6	100.0%
13.5	The MCHP/PIHP has avoided or eliminated all double-counted members or numerator events.	2	2	2	2	2	2	6	0	0	6	100.0%
13.6	Any non-standard codes used in determining the numerator have been mapped to a standard coding scheme in a manner that is consistent, complete, and reproducible as evidenced by a review of the programming logic or a demonstration of the program.	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
13.7	Any time parameters required by the specifications of the performance measure are adhered to (i.e., that the measured event occurred during the time period specified or defined in the performance measure).	2	2	2	2	2	2	6	0	0	6	100.0%
13.8	Medical record reviews and abstractions have been carried out in a manner that facilitates the collection of complete, accurate, and valid data.	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
13.9	Record review staff have been properly trained and supervised for the task.	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
13.10	Record abstraction tools require the appropriate notation that the measured event occurred.	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
13.11	Record abstraction tools require notation of the results or findings of the measured event (if applicable).	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
13.12	Data included in the record extract files are consistent with data found in the medical records as evidenced by a review of a sample of medical record for applicable performance measures. (From Medical Record Review Validation Tools-Table 5, ATTACHMENT XII)	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
13.13	The process of integrating administrative data and medical record data for the purpose of determining the numerator is consistent and valid.	NA	NA	NA	NA	NA	NA	0	0	0	0	NA
	Number Met	5	5	5	5	5	5	30	0	0	30	100.0%
	Number Partially Met	0	0	0	0	0	0					
	Number Not Met	0	0	0	0	0	0					
	Number Applicable	5	5	5	5	5	5					
	Rate Met	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%					

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

Source: BHC, Inc. 2009 External Quality Review Performance Measure Validation.

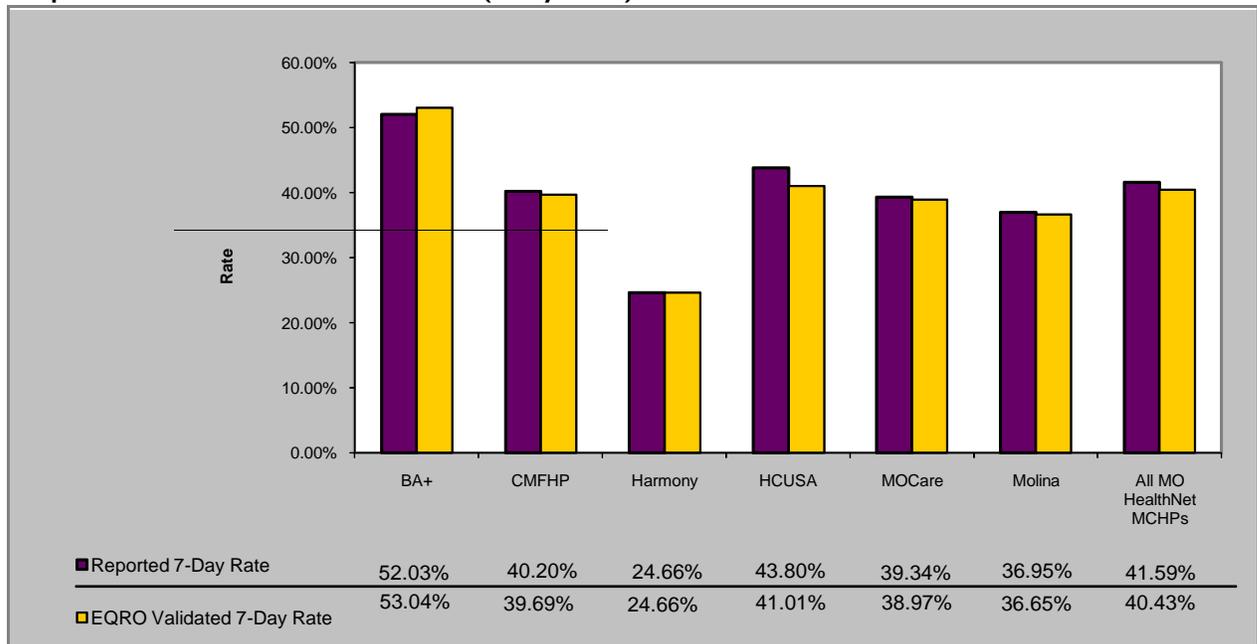
Submission of Measures to the State

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

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

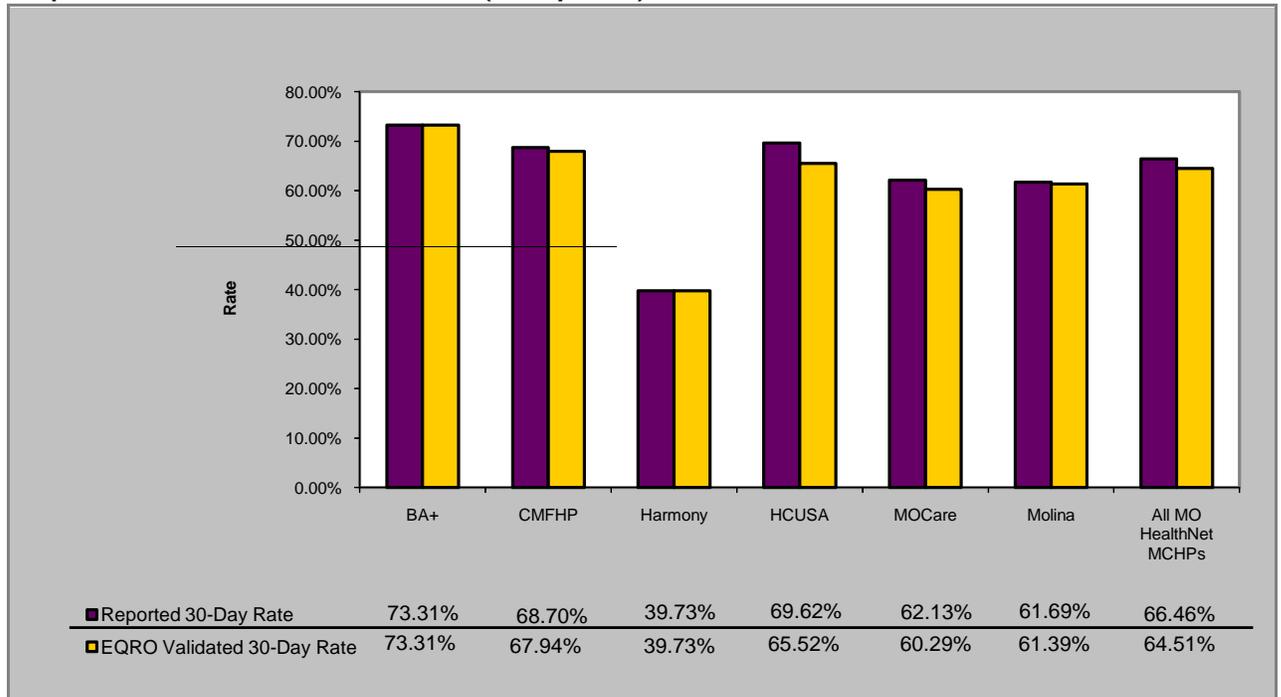
The 30-Day rate reported by MO HealthNet MCHPs ranged from 39.73% (Harmony) to 73.31% (BA+). The rate of all MO HealthNet MCHPs calculated based on data validated by the EQRO was 64.51%. The rate reported by MO HealthNet MCHPs was 66.46%, a 1.95% overestimate (see Figure 32).

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



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

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



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

Final Validation Findings

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

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

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

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

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

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

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

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

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

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

Table 29 summarizes the final audit ratings for each of the performance measures and MO HealthNet MCHPs. The final audit findings for each of the measures was based on the evaluation of processes for calculating and reporting the measures, medical record review validation findings, and MO HealthNet MCHP extract files from repositories. The ratings were based on the impact of medical record review findings and the degree of overestimation of the rate as validated by the EQRO. The calculation of measures was considered invalid if the specifications were not properly followed, if the rate could not be properly validated by the EQRO due to missing or improper data, or if the rate validated by the EQRO fell outside the confidence intervals for the measure reported by the MO HealthNet MCHPs on the DST.

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

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

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

3.5 Conclusions

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

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

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

QUALITY OF CARE

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

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

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

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

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

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

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

ACCESS TO CARE

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

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

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

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

TIMELINESS OF CARE

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

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

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

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

RECOMMENDATIONS

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

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

9.0 Healthcare USA



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9.1 Performance Improvement Projects

METHODS

DOCUMENT REVIEW

HCUSA supplied the following documentation for review:

- Follow-Up After Hospitalization for Mental Health Services
- Statewide Performance Improvement Project – Improving Adolescent Well Care
HCUSA

INTERVIEWS

Interviews were conducted with the project leaders for each Performance Improvement Project (PIP) by the EQRO team on July 15, 2010, during the on-site review, and included the following:

Jackie Inglis – VP Health Services
Kate Darst – Quality Improvement Director
Rudy Brennan – Quality Improvement Coordinator
Carol Stephens-Jay – Healthcare Consultant
Ann Mugo – Quality Coordinator
Janelle Biermann – Quality Improvement Specialist

The interviewees shared information on the validation methods, study design, and findings.

Technical assistance regarding study design and presentation of findings was provided by the EQRO. The following questions were addressed:

- How was the topic identified?
- How was the study question determined?
- Discuss the interventions and the outcomes.
- What were the findings?
- What does HCUSA want to study or learn from their PIPs?

The PIPs submitted for validation included a substantive amount of information. Additional analysis has occurred between the time of the original submission of information and the time of the on-site review. The Health Plan was instructed that they could submit additional information that included enhanced outcomes of the intervention. No additional information was received.

FINDINGS

The first PIP evaluated was the clinical PIP submission entitled “Follow-Up After Hospitalization Project.” The study topic presentation explained the research completed in justifying the decision for topic selection. The narrative included national, state and HCUSA specific data that provided support for topic choice. The topic choice was well documented, particularly explaining the impact on members. The justification for the topic choice informs the goal of strengthening partnerships, allowing greater continuity of care, and enhancing transitions between inpatient treatment settings and follow-up care. The project focused on a broad spectrum of services designed to enhance outpatient follow-up services. The goal of the project clearly enhances member services by avoiding additional in-patient treatment whenever possible.

There was no specific study question included in the documentation provided. The health plan submitted the information in the NCQA format, which does not require the development of a study question. This aspect of the PIP is rated as “not met.”

The only stated indicator was “Ambulatory Follow-Up rate after discharge from Inpatient Mental Health Hospitalization.” This was solely based on improving the HEDIS rate. It is based on the HEDIS technical specifications. However, the narrative indicated that the 2003 baseline was not developed using this process. This leaves a question about the comparability of the data included. The baseline indicator and the specifications of its development were not included in the information provided. The information provided did not provide adequate documentation to determine if the indicators would measure a change in health status, or if they were associated with improved member outcomes.

It can be assumed that the study addressed all members receiving inpatient treatment services. The narrative included did not overtly discuss the population and how they will be identified other than through a reference to the HEDIS technical specifications. The methodology designed to capture all members to whom the study applies was not included. The data collection approach that was used to capture the entire appropriate population was not referenced.

A study design was not included in the narrative or documentation provided. However, the information did include information indicating that data would be collected from programmed pulls from the health plan's claims and encounter data files. It is assumed that this data will be the basis of the HEDIS data that was analyzed. The NCQA form indicated that data would be collected on a quarterly basis and would be analyzed annually. This information is gathered from checked boxes on the NCQA form, and not from narrative included that provided insight into the health plan's processes. A study design that specifies the sources of data or why they are applicable is not present. A systematic method of collecting valid and reliable data could not be verified. The instruments or data collection tools that were used were not provided. As there was no actual study design, no prospective data analysis plan was available. There was narrative for each section of the "analysis cycle," which provided information that might have been included in a prospective plan, but no actual study design precluded the existence of this plan.

The name of the project leader was provided. However her qualifications or role in completion of the study were not specified. No additional information was available regarding team members who may have participated in this study, or the analysis of the data provided.

The interventions utilized in this study, their rationale, and the manner in which they were implemented is described. The intervention barriers and their impact on member behavior are included. However, the PIP is described as ongoing through 2009. The health plan did not include any information based on 2009 data collected.

There was some analysis of the data included in the narrative. However, this analysis was not based on a prospective data analysis plan. The data available through 2008 is provided in detail. The study documentation included tables and graphs regarding the information collected. The

results were explained in sufficient detail in the documentation provided through 2008. There was no preliminary or final information included for 2009.

The narrative does not specify if the same sources of data, the same method of data collection, or if the same tools were used. It appears that the 2003 baseline data was collected in an acceptable manner, but it is unclear if it is comparable to the methodology utilized in collecting and analyzing the HEDIS data. There was an increase in the first year of measurement after implementation of the PIP process and a decrease after the second year. Some explanation is provided but actual reasons for these differences must be assumed. There is no discussion of organizational success and no discussion of the differences experienced in the three MO HealthNet Managed Care regions. In the data collected for the 2007 measurement year, the findings indicated that the interventions applied had some positive effect. During 2008 the results appeared to show a decline in the number of members who received follow-up care in the prescribed time frames. There was no discussion about possible impacts that created this decline, or of the results of the 2009 interventions. There was not adequate data or analysis to make a determination that any observed performance improvement is true improvement. The health plan does not make any statements regarding their belief about the impact of the interventions that they operationalized. It is unclear if the health plan has an opinion about the impact of their interventions in creating any sustained improvement regarding members obtaining follow-up care after an inpatient hospitalization for mental health.

The second PIP evaluated was the HCUSA approach to the Statewide PIP “Improving Adolescent Well Care.” This study is a non-clinical project. The decision to choose this study topic was supported by information provided regarding the MO HealthNet Managed Care Statewide PIP combined report documentation. The application of this topic to HCUSA members was well researched and included throughout the narrative. The narrative further included an argument of the applicability of this topic to the HCUSA population. The topic selection criteria focused on improving a key aspect of member care, and explained the importance of improving the rates of adolescent well care screenings as an aspect of preventive care. All members of the age group studied, individuals between the ages of 12 – 21, are included. No members are excluded based on the existence of special health care needs.

The HCUSA specific study questions presented are: “Will provider reminders and provider education improve the HEDIS rate of adolescent well care?” “Will member reminders improve the HEDIS rate of adolescent well care?” “Will member and provider reminders in tandem improve the HEDIS rate of adolescent well care?” The Health Plan specific questions relate this study to their members and are focused on improving their outcomes, however these are the identical questions presented in the 2008 study. The protocols clearly state that: “if a PIP is continued from year to year, each year should include new and updated interventions to show that the PIP retains validity and the ability to affect change in organizational functions that will improve member services, or enhance outcomes for members.”

The indicators concentrated on the HEDIS rates which are quantifiable. The narrative did lack a discussion about the importance of this measure in improving the quality of member health care. The narrative indicates that the health plan recognizes that improving the rates of Adolescent Well Care may result in higher rates of prevention of adolescent related risky behaviors, such as drug use and unsafe sex. There is no measurement or study of the impact of these behaviors included in this study. The information provided clearly led the reader to understand that the focus of the study is to improve compliance with obtaining well care screenings, which may translate into improving outcomes regarding better adolescent health care. The population served by this study includes all three MO HealthNet Managed Care regions. Results are to be defined by region.

The initial study design information relies on the information developed for the statewide combined report. The study designed presented in the 2009 report was specific to HCUSA, and to their methodology for obtaining data. The health plan did include a discussion of how the Coventry Data Warehouse (CDW) will be utilized. How data will be extracted and reported is available. This data will be tracked and analyzed quarterly. The health plan uses NCQA certified software to calculate their HEDIS results, ensuring consistent and accurate data collection. The study design discussed the systematic method, using NCQA certified software, in which the data was to be collected. In addition the health plan reviews the data internally. The methodology for determining statistical significance was available. It was clear that the instruments to be used for data collection would create accurate and reliable data. The documentation further describes how the HEDIS and other annual data measures were to be

analyzed and reviewed within the health plan. The final rates were to be tested for statistical significance using Chi-square analysis. The effectiveness of the interventions is to be assessed with interim and final HEDIS rate production. Comparisons are to be made between regions and compared to the national Medicaid benchmark. In addition tracking interventions are to occur quarterly to assure that the interventions are implemented as planned.

The health plan specific intervention implemented included Customer Service electronic flags for missed appointments; a script for contacting members when these flags appear; and a comprehensive member and provider reminder system. The interventions were described in detail. An intervention tracking log was presented with the HEDIS 2009 and 2010 barriers, interventions and timeframes explained. All information was focused and measurable. It also showed how the health plan would provide evidence that they had an impact of adolescent well care visits.

An analysis of the findings was included. This analysis did specifically follow the presented data analysis plan. Each year's interventions and outcomes were reviewed. The information, including tables and graphs, was explained in the narrative included. The tables and graphs that highlighted the work produced were clearly presented, accurate, and understandable. The accompanying narrative was not only explanatory, but it provided the health plan's assessment of the outcomes presented.

The health plan presented information including baseline and repeat measurements. It included barrier analysis and any environmental factors that might have an impact on outcomes were explained. The analysis looked at the results regionally, and attempted to analyze statewide outcomes. The information provided did discuss the validity of the interventions and their relationship. The health plan included information on next steps in intervening to continue to improve the number of adolescent well care exams. They discussed a two-pronged approach for member and provider reminders for the remainder of the 2009 calendar year, which is a part of the intervention process. The 2009 update was included in the information provided. The health plan did analyze their outcomes based on the interventions implemented to date.

The calendar year 2007 PIP created a baseline measurement. The information from the original PIP was based on the statewide intervention effort. The interventions implemented were the same across all health plans. In calendar years 2008 and 2009, individual health plan interventions were implemented. The measurement methodology and baseline were used consistently. The health plan speculates that the attention placed on the issue of adolescent well care has created a number of improvements. Not only have the adolescent well care visits increased, but billing errors and other barriers to adequate measurements were corrected. The health plan believes that the coordinated effort, and focus on both member and provider reminders continue to have merit and should continue to positively impact this measure. Although the improvement seen at the end of 2008 was not as significant as in 2007, they are continuing their interventions focused on improving the availability of these visits for members.

CONCLUSIONS

QUALITY OF CARE

Both PIPs seek to improve the quality of services to members. The non-clinical PIP seeks to improve the rates of adolescent well care screenings that occur for Health Plan members. If the health plan continues to engage in appropriate follow-up it may be able to identify members who are not receiving screenings and continue to positively impact their behavior. The interventions described in the clinical PIP are clearly targeted to improve the quality and effectiveness of health care services for members who had a hospitalization for a mental health issue. By assisting members in obtaining timely after-care services, they should be able to stabilize effectively.

ACCESS TO CARE

The clinical PIP had a specific focus on access to care. The study sought to ensure that members received outpatient mental health in a timely fashion. However, this Performance Improvement Project was not sufficiently documented to make strong assumptions about its goals or effectiveness. The non-clinical PIP also included the theory of improving services by ensuring that members received well care screenings for a population that has been previously

hard to serve. The supporting documentation indicating how these PIPs would improve access to services was evident throughout the project.

TIMELINESS OF CARE

The services and interventions used in the clinical PIP may have the specific outcome of improving the timeliness of appropriate services for any member who has been hospitalized as the result of a mental health issue. In this PIP the areas of access, quality, and timeliness of care were of the utmost importance. The outcomes were not analyzed as current information was not provided. Timely access to care was a main focus of this project. The non-clinical PIP considered timeliness in looking at the members obtaining adolescent well care screenings yearly. The narrative provided discussed how the interventions employed would improve the members' awareness of the need for annual screenings, and reduce barriers to obtaining these services.

RECOMMENDATIONS

1. HCUSA has attempted to improve the timeliness, quality, and access to care for members requiring health care services in the process of each of these Performance Improvement Projects. The non-clinical project information clearly supported the goal of improving services and benefits to members in a timely manner. The information provided for the clinical PIP was limited and did not allow a thorough or complete evaluation of the work completed. Narrative information, responding to the requirements of the PIP protocols, is required to adequately assess these project. Use of the NCQA forms does not provide the information required to complete this evaluation.
2. The format of all PIPs should contain complete narrative information on all aspects of the project to ensure that the project is understandable and complete.
3. The health plan should continue to address how their projects are extended to and pertinent to all the MO HealthNet Regions served. Projects involving HEDIS measures assist in this as rates are provided for each Region. However, some analysis of the regional differences would benefit the project evaluation.
4. The Health Plan indicated that the processes described in both PIPs are to be incorporated in the regular agency processes. This is an important aspect of the PIP process and should occur to ensure that improvements continue on a sustained basis.

5. All health plans are given ample time to submit additions and corrections to PIPs after the on-site review. HCUSA should have taken the reviewers suggestions and submitted additional information and narrative. It is likely that this would have improved the PIP evaluation significantly.

9.2 Validation of Performance Measures

METHODS

This section describes the documents, data, and persons interviewed for the Validating Performance Measures Protocol for HCUSA. HCUSA submitted the requested documents on or before the due date of March 19, 2010. The EQRO reviewed documentation between March 19, 2010 and June 30, 2010. On-site review time was used to conduct follow-up questions and provide feedback and recommendations regarding the performance measure rate calculation.

DOCUMENT REVIEW

The following are the documents reviewed by the EQRO:

- The HCUSA NCQA RoadMap for the HEDIS 2009 data reporting year
- HealthcareData.com LLC's Compliance Audit Report for HEDIS 2009
- HCUSA's information systems policies and procedures with regard to calculation of HEDIS 2009 rates
- HCUSA meeting minutes on information system (IS) policies
- A sample of Catalyst's production logs and run controls
- National Council on Quality Assurance (NCQA)-certified HEDIS software certification report from Catalyst Technologies
- Data field definitions & claims file requirements of the Coventry Corporate Data Warehouse
- Data files from the Coventry Corporate Data Warehouse containing the eligible population, numerators and denominators for each of the three measures.
- HEDIS 2009 Data Submission Tool
- HEDIS 2009 product work plan

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

- ADV denom_num.xls
- ADV enroll.xls
- AWC denom_num.xls
- AWC enroll.xls
- AWC_Hybrid_Chases_View_2009.xls
- FUH denom_num.xls
- FUH enroll.xls

The initial numerator file submitted by HCUSA for the ADV measure did not contain the service dates needed to verify the reported HEDIS rates. The MCHP was asked to submit a corrected file that included the necessary service dates to allow for proper processing by the EQRO. However, the second file received also did not contain valid service dates. The hybrid file initially submitted for the Adolescent Well Care Visit measure (File 3) was not provided in the requested format and did not contain the correct data; the health plan was asked to resubmit.

INTERVIEWS

The EQRO conducted on-site interviews at HCUSA in St. Louis on Tuesday, July 13, 2010 with Carol Stephens-Jay, Consultant. Also available by phone were Rena David-Clayton and Geoff Welsh, who represented the software vendor Catalyst Technologies. This group was responsible for calculating the HEDIS 2009 performance measures. The objective of the visit was to verify the methods and processes behind the calculation of the three HEDIS 2009 performance measures.

FINDINGS

HCUSA calculated the Adolescent Well Care Visit measure using the Hybrid method. The remaining two HEDIS 2009 measures being reviewed (Annual Dental Visit and Follow-Up After Hospitalization for Mental Illness) were calculated using the Administrative method. The data file provided for the Annual Dental Visit measure was invalid, as no service dates were included.

This prohibited the EQRO from validating this measure; however, a modified “validation” was performed to provide data for comparison. MO HealthNet MCHP to MCHP comparisons of the rates of Annual Dental Visit, Adolescent Well-Care Visits, and Follow-Up After Hospitalization for Mental Illness measures were conducted using two-tailed z-tests. For comparisons that were statistically significant at the 95% confidence interval (CI), the z-score (z), the upper and lower confidence intervals (CI), and the significance levels ($p < .05$) are reported.

The combined rate for the HEDIS 2009 Annual Dental Visit measure reported by HCUSA to the SMA and the State Public Health Agency (SPHA) was 36.93%. This was significantly higher than the statewide rate for all MO HealthNet MCHPs (33.58%, $z = 0.78$; 95% CI: 31.57%, 42.28%; $p > .95$). This rate has trended upward or remained steady over the past three EQR report years: from 32.23% in 2007 to 36.93% in 2008 to 36.93% in 2009 (see Table 68 and Figure 51).

The reported Adolescent Well-Care Visit rate was 38.19%; this is comparable to the statewide rate for all MO HealthNet MCHPs (35.63%; $z = 0.37$, 95% CI: 34.39%, 42.00%; n.s.). This reported rate is higher than the rate (36.37%) reported by the health plan during the 2007 EQR review, but not quite as high (39.31%) as the 2008 EQR rate (see Table 68 and Figure 51).

The 7-day rate reported for the Follow-Up After Hospitalization for Mental Illness measure by HCUSA was 43.80%, which is comparable to the statewide rate for all MO HealthNet MCHPs (41.59%; $z = 0.48$, 95% CI: 36.62%, 50.98%; n.s.). This rate was also substantially higher than the rates reported by the health plan during the last periods this measure was audited in HEDIS 2006 and 2007 (29.04% and 27.35% respectively; see Table 68 and Figure 51).

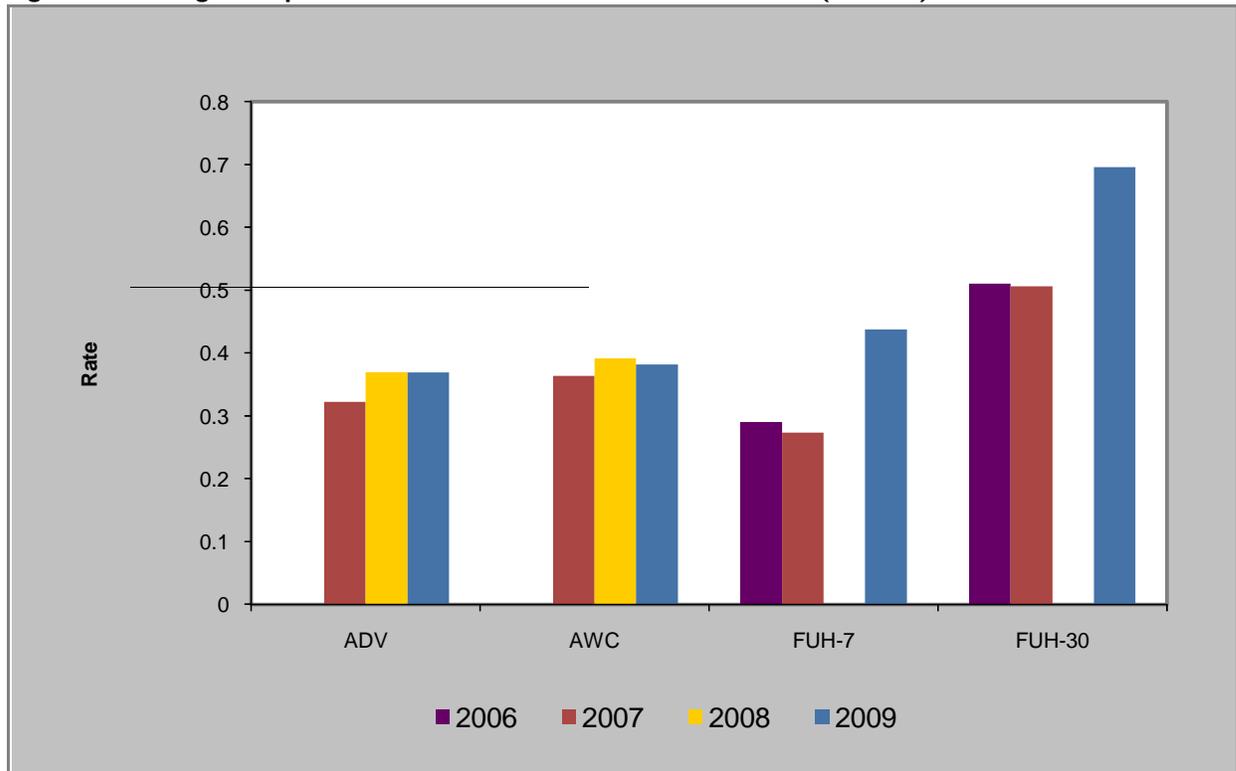
The Follow-Up After Hospitalization for Mental Illness measure 30-day rate reported by the health plan (69.62%) was also comparable to the statewide rate (66.46%; $z = 3.36$, 95% CI: 62.44%, 76.80%; n.s.). This rate has also continued to trend upward overall, from 51.03% in 2006 to 50.58% in 2007 to 69.62% in 2009 (see Table 68 and Figure 51).

Table 68 – Reported Performance Measures Rates Across Audit Years (HCUSA)

Measure	HEDIS 2006 Rate	HEDIS 2007 Rate	HEDIS 2008 Rate	HEDIS 2009 Rate
Annual Dental Visit (ADV)	NA	32.23%	36.93%	36.93%
Adolescent Well-Care Visits (AWC)	NA	36.37%	39.10%	38.19%
Follow-Up After Hospitalization for Mental Illness – 7-day (FUH7)	29.04%	27.35%	NA	43.80%
Follow-Up After Hospitalization for Mental Illness – 30-day (FUH30)	51.03%	50.58%	NA	69.62%

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

Figure 51 – Change in Reported Performance Measure Rates Over Time (HCUSA)



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

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

DATA INTEGRATION AND CONTROL

The information systems management policies and procedures for rate calculation were evaluated consistent with the Validating Performance Measures Protocol. This included both manual and automatic processes of information collection, storing, analyzing and reporting. For all three measures, HCUSA was found to meet all the criteria for producing complete and accurate data (see Attachment V: Data Integration and Control Findings). There were no biases or errors found in the manner in which HCUSA transferred data into the repository used for calculating the HEDIS 2009 measures. However, none of the data files provided to the EQRO were submitted in the requested data format (eg. .xls vs. @ delimited .txt).

DOCUMENTATION OF DATA AND PROCESSES

Although HCUSA uses a proprietary software package to calculate HEDIS measure rates, adequate documentation of this software and its processes was provided to the EQRO for review. The data and processes used for the calculation of measures were adequate (see Attachment VII: Data and Processes Used to Calculate and Report Performance Measures). HCUSA met all criteria that applied for all three measures.

PROCESSES USED TO PRODUCE DENOMINATORS

HCUSA met all criteria for the processes employed to produce the denominators of the performance measures validated (see Attachment X: Denominator Validation Findings). This involves the selection of eligible members for the services being measured. Denominators in

the final data files were consistent with those reported on the DST for the three measures validated. All members were unique and the dates of birth ranges were valid.

There were 98,716 eligible members reported and validated for the denominator of the Annual Dental Visit measure.

A total of 1,296 eligible members were reported and validated for the Adolescent Well-Care Visits measure.

A total of 1,073 eligible members were reported and validated for the denominator of the Follow-Up After Hospitalization for Mental Illness measure.

PROCESSES USED TO PRODUCE NUMERATORS

Two of the three measures were calculated using the Administrative Method (ADV, FUH). The remaining measure (AWC) was calculated using the hybrid methodology. Measures included the appropriate data ranges for the qualifying events (e.g., well-child visits, follow-up visits, or dental visits) as specified by the HEDIS 2009 Technical Specifications (see Attachment XIII: Numerator Validation Findings). A medical record review was conducted for the Adolescent Well-Care Visit measure.

The numerator files provided to the EQRO by HCUSA for the Annual Dental Visit measure did not contain valid service dates. Therefore, the EQRO was unable to validate this rate with the data provided. However, a modified validation procedure was performed (assuming all otherwise-valid hits also had valid service dates) to provide a basis for comparison. HCUSA reported a total of 36,451 administrative hits for the Annual Dental Visit measure; 36,195 of these hits were found by the EQRO. This resulted in a reported rate of 36.93% and a “validated” rate of 36.67%, an overestimate of 0.26%.

For the HEDIS 2009 Adolescent Well-Care Visits measure, there were a total of 467 administrative hits reported and 467 hits found. A total of 28 medical records were requested; all 28 were received and were able to be validated by the EQRO, resulting in a 100% validation

rate for this measure. Therefore, the reported and validated hybrid rates were both 38.19%, showing no bias in the rate.

The number of administrative hits reported for the 7-day rate for the HEDIS 2009 Follow-Up After Hospitalization for Mental Illness measure was 470; the EQRO found 440. This resulted in a reported rate of 43.80% and a validated rate of 41.01%. This represents a bias (overestimate) of 2.80% for this measure.

The Follow-Up After Hospitalization for Mental Illness 30-day calculation showed 747 reported hits; of these, the EQRO was able to validate 703 of them. This yielded a reported rate of 69.62% and a validated rate of 65.52%, an overestimated bias of 4.10%.

SAMPLING PROCEDURES FOR HYBRID METHODS

The Hybrid Method was used for the Adolescent Well-Care Visits measure. CMS Protocol Attachment XII; Impact of Medical Record Review Findings and Attachment XV: Sampling Validation Findings were completed for this measure.

SUBMISSION OF MEASURES TO THE STATE

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

DETERMINATION OF VALIDATION FINDINGS AND CALCULATION OF BIAS

As is shown in Table 69, the health plan overestimated the Annual Dental Visit and Follow-Up After Hospitalization for Mental Illness measures. No bias was observed in the Adolescent Well-Care Visits measure.

Table 69 - Estimate of Bias in Reporting of HCUSA HEDIS 2008 Measures

Measure	Estimate of Bias	Direction of Estimate
Annual Dental Visit	0.26%	Overestimate
Adolescent Well-Care Visits	No bias	N/A
Follow-Up After Hospitalization for Mental Illness (7-day)	2.80%	Overestimate
Follow-Up After Hospitalization for Mental Illness (30-day)	4.10%	Overestimate

FINAL AUDIT RATING

The Final Audit Rating for each of the performance measures was based on the findings from all data sources that were summarized in the Final Performance Measure Validation Worksheet for each measure (see Table 70). The Annual Dental Visit measure was determined to be Not Valid because the correct service dates were not provided in the data. The rate for the Follow-Up After Hospitalization for Mental Illness measures was overestimated, but still fell within the confidence intervals reported by the health plan. The rate for the Adolescent Well-Care Visits measure was Fully Compliant with specifications.

Table 70 - Final Audit Rating for HCUSA Performance Measures

Measure	Final Audit Rating
Annual Dental Visit	Not Valid
Adolescent Well-Care Visits	Fully Compliant
Follow-Up After Hospitalization for Mental Illness	Substantially Compliant

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

CONCLUSIONS

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

QUALITY OF CARE

HCUSA's calculation of the HEDIS 2009 Follow-Up After Hospitalization for Mental Illness measure was substantially compliant with specifications. This measure is categorized as an Effectiveness of Care measure and is designed to measure the effectiveness/quality of care delivered. HCUSA's rate for this measure was consistent with the average for all MO HealthNet MCHPs. The health plan's members are receiving the quality of care for this measure consistent with the care delivered to all other MO HealthNet Managed Care members. Both the 7-day and 30-day rates were above the National Medicaid Averages and below the National Commercial Averages for this measure. The health plan's members are receiving a quality of care for this measure higher than the average National Medicaid member but below the average National Commercial member across the country. However, these rates were significantly higher than the rates reported by the health plan during the audit of the HEDIS 2007 measurement year, indicating an improvement in the quality of services received by members over the past two years.

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

ACCESS TO CARE

The Annual Dental Visit measure was determined to be Not Valid due to missing data needed by the EQRO; however, if the missing service dates had been found to be within range, this measure would have been substantially compliant with specifications. This measure is categorized as an Effectiveness of Care measure. Because only one visit is required for a positive "hit", this measure effectively demonstrates the level of access to care that members are receiving. HCUSA's reported rate for this measure was significantly higher than the average for all MO HealthNet MCHPs. This rate was higher than the rate reported by the health plan during the 2007 report, and consistent with the rate reported in the 2008 audit.

This shows that HCUSA members are receiving more dental services than in the past. The health plan's dedication to improving this rate is evident in the increasing averages. HCUSA's members are receiving the quality of care for this measure higher than the level of care delivered to all other MO HealthNet Managed Care members. This rate was below the National Medicaid Average for this measure; the health plan's members are receiving a lower access to care than the average National Medicaid member.

The EQRO was unable to validate this rate within the reported 95% confidence interval and therefore is unable to specify substantial confidence in the calculated rate.

TIMELINESS OF CARE

The health plan's calculation of the HEDIS 2009 Adolescent Well-Care Visits measure was fully compliant. This measure is categorized as a Use of Services measure and is designed to measure access to and timeliness of the care defined. The health plan's reported rate for this measure was consistent with the average for all MO HealthNet MCHPs. The rate was higher than the rate reported for the 2007 EQR report year; however, the rate was lower than the rate reported for the same measure during the 2008 report. HCUSA's members are receiving the timeliness of care for this measure consistent with the care delivered to all other MO HealthNet Managed Care members. However, this rate was lower than both the National Medicaid and National Commercial averages for this measure. The health plan's members are receiving a lower timeliness of care than the average Medicaid or Commercial member across the nation.

The EQRO was able to fully validate this rate and thereby has extreme confidence in the calculated rate.

RECOMMENDATIONS

1. The Adolescent Well-Care Visits rate showed a decrease over the previously audited rate in 2008. The EQRO recommends that the health plan monitor this decrease and attempt to determine the possible reasons for this decline.
2. Continue to utilize the Hybrid methodology for calculating rates when allowed by the specifications.
3. Continue to conduct and document statistical comparisons on rates from year to year.
4. Work to increase rates for the Annual Dental Visit and Adolescent Well-Care Visit measures; although they were consistent with the average for all MO HealthNet MCHPs, they were at or below the National Medicaid averages.
5. HCUSA should thoroughly review both the data request format file and the resultant data extract files for accuracy prior to submitting data to the EQRO. This will ensure that the EQRO receives the most complete data possible for validation.

9.3 Validation of Encounter Data

FINDINGS

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

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

For the Medical claim type, there were 555,393 encounter claims paid by the SMA for the period July 1, 2009 through September 30, 2009.

1. The Outpatient Claim Type field was 100.00% complete, accurate and valid.
2. The Outpatient Participant ID field was 100.00% complete, accurate and valid.
3. The Outpatient First Date of Service field was 100.00% complete and accurate, and valid.
4. The Outpatient Last Date of Service field was 100.00% complete and accurate, and valid.
5. The Outpatient Units of Service field was 100.00% complete, accurate and valid.
6. The Outpatient Procedure Code field was 100.00% complete and accurate, and valid.
7. The Outpatient Place of Service field was 100.00% complete, accurate and valid.
8. The first Diagnosis Code fields were 100.0% complete, accurate valid.
9. Although the second through fifth Diagnosis Code fields are optional according to the Health Plan Record Layout Manual, the second, third, fourth, and fifth Diagnosis Code fields fell well below the 100.00% threshold set by the SMA for completeness, accuracy and validity. The second Diagnosis Code field was 18.40% complete, accurate and valid. All remaining fields (n=453,194) were blank.
10. The third Diagnosis Code field was 20.34% complete and accurate (blank fields n= 442,393), and only 19.53% valid, with 4,534 fields containing invalid code "X01".
11. The fourth Diagnosis Code field was 10.92% complete and accurate (blank fields n= 494,742), and only 10.60% valid, with 1,756 fields containing invalid code "X01".
12. The fifth Diagnosis Code field was 1.76% complete and accurate (blank fields n = 545,604), and only 1.32% valid, with 2,420 fields containing invalid code "X01".

For the Dental claim type, there were 119,045 encounter claims paid by the SMA for the period July 1, 2009 through September 30, 2009. All fields examined were 100.00% complete, accurate and valid.

For the Home Health claim type, there were zero twenty-three (23) encounter claims paid by the SMA for the period July 1, 2009 through September 1, 2009. All fields examined, except the third, fourth, and fifth Diagnosis Code fields were 100.0% complete, accurate and valid. Those Diagnosis Code fields were all blank, thereby making those fields incomplete, inaccurate and invalid.

For the Inpatient claim type, there were 9,801 encounter claims paid by the SMA for the period July 1, 2009 through September 1, 2009.

1. The Inpatient Claim Type field was 100.00% complete, accurate and valid.
2. The Participant ID field was 100.00% complete, accurate and valid.
3. The Admission Type field was 100.00% complete, accurate and valid.
4. The Admission Date field was 100.00% complete and accurate, and valid.
5. The Discharge Date field was 100.00% complete with the correct number of characters (size). The correct type of information (date format) was present 93.50% (with 637 entries of “99999999”); thereby the Discharge Date field was 93.50% accurate and valid.
6. The Bill Type field was 100.00% complete, accurate and valid.
7. The Patient Status field was 100.00% complete and accurate, and valid.
8. The first Diagnosis Code field was 76.16% complete, accurate and valid. The remaining fields (n=2,337) were blank.
9. Although the second through fifth Diagnosis Code fields are optional according to the Health Plan Record Layout Manual, the second, third, fourth, and fifth Diagnosis Code fields fell below the 100% threshold for completeness, accuracy, and validity established by the SMA (76.16%, 75.61%, 52.50%, and 39.20%, respectively).
10. The First Date of Service field was 100.00% complete and accurate, and valid.
11. The Last Date of Service field was 100.00% complete and accurate, and valid.
12. The Revenue Code field was 100.00% complete, accurate, and valid.
13. The Units of Service field was 100.00% complete, accurate and valid.

For the Outpatient Hospital claim type, there were 184,080 encounter claims paid by the SMA for the period July 1, 2009 through September 30, 2009.

1. The Outpatient Claim Type field was 100.00% complete, accurate and valid.
2. The Participant ID field was 100.00% complete, accurate and valid.
3. The First Date of Service field was 100.00% complete, accurate and valid.
4. The Last Date of Service field was 100.00% complete, accurate and valid.
5. The Units of Service field was 100.00% complete, accurate and valid.
6. The Outpatient Procedure Code field was 97.73% complete, accurate, and 85.98% valid. There were 21,641 invalid entries of “00000” and 4,174 missing values.
7. The first Diagnosis Code field was 100.00% complete, accurate and valid.
8. Although the second through fifth Diagnosis Code fields are optional according to the Health Plan Record Layout Manual, the second, third, fourth, and fifth Diagnosis Code fields fell below the 100% threshold for completeness, accuracy, and validity established by the SMA (59.35%, 54.29%, 26.66%, and 13.39%, respectively).

For the Pharmacy claim type, there were 362,611 claims paid by the SMA for the period July 1, 2009 through September 30, 2009. All fields examined were 100.00% complete, accurate and valid.

What Types of Encounter Claim Data are Missing and Why?

Based on the above analysis of the accuracy, completeness, and validity of the data in the SMA encounter claims extract file for HCUSA, an error analysis of the invalid entries was conducted for fields which were lower than the 100.00% threshold specified by the SMA. There were very few errors encountered in the critical fields examined across all claim types. The Inpatient claim type contained invalid data in the Discharge Date fields. The Revenue Code field contained blank entries. For the Outpatient Hospital claim type, the Outpatient Procedure Code fields contained invalid entries.

What is the Level of Volume and Consistency of Services?

When comparing the rate of encounter claim types per 1,000 members, the rate of Outpatient Hospital claims was significantly lower than the average for all MO HealthNet MCHPs. All other encounter claim types were consistent with the average for all MO HealthNet MCHPs. This suggests average rates of encounter data submission and good access to preventive and acute care. This could also be a function of the fact that HCUSA has the greatest number of encounter claims processed for all plans and thereby the outliers (if there are any) are not as prominent.

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

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

Of the 858,518 Outpatient encounter claim types in the SMA extract file for July 1, 2009 through September 30, 2009, 100 encounters were randomly selected. Providers were requested to submit medical records for review. There were 87 medical records (87.0%) submitted for review.

The 2007 match rate for procedures was 52.0%, with a fault rate of 48.0%. The match rate for diagnoses was 39.0%, with a fault rate of 61.0%. The 2008 match rate for procedures was 74.0%, with a fault rate of 26.0% and the match rate for diagnoses was 59.0% with a fault rate of 41.0%. For the 2009 review, the match rates were 64.0% for procedures and 55.0% for diagnosis. This is a decrease in both rates from the prior year's review.

What Types of Errors Were Noted?

An error analysis of the errors found on the medical record review for procedure, diagnosis, name of drug dispensed, and quantity of drug dispensed was conducted. For the diagnosis code in the medical record, the reasons for diagnosis codes not matching the SMA extract file were missing or illegible information (n = 39) and incorrect (n=6). For the procedure code in the medical record, the reasons for procedure codes in the SMA extract file not being supported by documentation in the medical record were missing information (n = 32), incorrect (n=3) and upcoded (n=1). Examples of missing information included no code; codes listed that were not supported, or codes that did not match the procedure description.

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

Since HCUSA included internal control numbers that matched those of the SMA, the planned analysis of comparing MO HealthNet MCHP encounter data to the SMA encounter claim extract file was performed. The SMA defined “unpaid claims” as those claims that the health plan denied for payment, unpaid claims do not include claims paid via a capitation plan.

For the Pharmacy Claim type (n= 362,611), only one encounter claim submitted to the EQRO was of “denied” status, all others were of “paid” status. The Inpatient Claim type (n=9,801), contained two (2) encounter claims with “denied” status. For the Outpatient Hospital and Medical Claim Types (n= 739,473), 21 “denied” claims were submitted by HCUSA but all other encounter claims were of “paid” status. Of the encounter claims submitted by HCUSA, 57 records were unmatched with the SMA encounter data. There was a “hit” rate of 99.99% between HCUSA encounter claims and the SMA encounter data.

For the Dental Claim type, HCUSA submitted 119,045 encounter claims. Only 4 of these encounter claims were of “denied” status; all other claims were of “paid” status. There were 00 unmatched records between HCUSA and the SMA, yielding a 99.99% “hit” rate.

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

For all claim types, the unmatched encounters were missing ICN numbers which are required to match the encounter to that of the SMA. Therefore, there were no documented “missing” claims from the SMA database.

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

While the MO HealthNet MCHP did submit the data in the requested format (including most ICN numbers), there are a number of ways to improve the data quality by improving the database system. As the Internal Control Number is only assigned by the State database when a claim is paid, it is difficult to match the MO HealthNet MCHP data of “unpaid” and “denied” claims to the SMA data. As the Internal Control Number is unique only to the encounter, the ICN may be represented in multiple lines of data. To match the MO HealthNet MCHP data to the SMA data to specific fields, this requires a unique line number. Therefore each service provided within an encounter would have a separate line of data with a unique line identifier.

CONCLUSIONS

STRENGTHS

1. All encounter data was submitted in the specified format and included internal control numbers (ICNs) which allowed the EQRO to conduct planned comparisons of the MO HealthNet MCHP and SMA data files.
2. The critical field validation of five of the six claim types (Home Health, Inpatient, Outpatient Hospital, Dental and Pharmacy) resulted in few fields under the SMA established threshold of 100.00% accuracy, completeness, and validity.
3. The critical fields examined for the Dental and Pharmacy claim types were 100.00% complete, accurate and valid.

AREAS FOR IMPROVEMENT

1. For the Medical claim type, there were invalid entries for the Procedure Code fields.
2. For the Outpatient Hospital claim type, there were invalid data in the Outpatient Procedure Code field.
3. The health plan submitted fewer records than they have in the past years' reviews and had lower match rates.

RECOMMENDATIONS

1. Examine and revise as needed internal system edits for invalid procedure codes in the NSF/CMS 1500 file layout for the Outpatient Procedure Code and run validity checks after the programming of new edits.
2. Ensure that Admission Date, Discharge Date, and Diagnosis fields are complete and valid for the Inpatient (UB-92) claim types, and institute error checks to identify invalid data.
3. Submit all medical records for Encounter Data Validation as missing records are counted as invalid in the analysis. Consider having records shipped to the plan from the provider prior to sending them to the EQRO, as numerous incomplete records were received, which also contributed to the analysis.

9.4 MO HealthNet MCHP Compliance with Managed Care Regulations

METHODS

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

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

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

Document Review

The Division of Medical Services supplied:

- State of Missouri Contract Compliance Tool (including DMS responses and comments)
- HealthCare USA Annual Evaluation Report (2009)

The following documents were requested for on-site review:

- Member Handbook
- Provider Handbook
- 2009 Marketing Plan and Materials
- Case Management Policy
- Quality Improvement Committee Meeting Minutes - 2009

Additional documentation made available by HCUSA included:

- HCUSA of Missouri Organizational Chart
- Care Management: Case Management, Complex Case Management, and Disease Management Policy
- Assessment of Members with Special Health Care Needs policy

INTERVIEWS

Interviews were conducted with the following groups:

Case Management Staff

Denise Sommerer, RN – Case Manager, Jefferson City
Cynthia James, RN – Case Manager
Tasha Sharp, RN – Case Manager
Valerie Walter, RN – Complex Case Manager
Janet Wilson, RN – Complex Case Manager
Jennifer Pickens, RN – Complex Case Manager
Beverly Krohn, RN – Case Manager
Kammara Jackson, RN – NICU Disease Management

Plan Administration

Jackie Inglis, VP Health Services
Resmi Jacob-Schrieber, Director of Provider Relations
Lisa Fillback, Health Services, Pre-Authorization/Complex Case Management
Christine Miller, Manager, Case Management
Kate Darst, Manager, Disease Management

Case Management Interviews

- Explain the referral process. How are referrals received?
- Discuss the case management assessment process. How are members defined into the need for case management? When are members excluded?
- What makes a member eligible for care coordination or case management services?
- Describe typical case management activities. How many members do you serve at one time? Give examples of how case management services have been beneficial to members.
- What services are provided to members with special health care needs?
- Discuss actions that have occurred to increase your knowledge of community resources that are available for members with mental health care needs.
- What areas do case managers serve? What is the size of case loads?

Findings

Interviews and case record reviews revealed a staff with a strong focus on member services with a commitment to appropriate documentation and record keeping. The reviewers' impressions of the case records read were provided. There was evidence of intense case coordination and appropriate responses by case managers. When services needs were identified, service delivery activities were reflected in the notes available. The administrative staff expressed a strong commitment to supporting case management activities. The results of this commitment were evident in the records reviewed. Cases indicated referrals from providers and hospitals. In many cases authorizations existed for in-home health services. Case managers maintained current information about members through communications with the home health providers seeing the family, even if they were not able to contact them by telephone or letter. In a case involving a child with an elevated lead level, the case manager maintained contact with the family through in-home service providers, and community-based resources. Even though the family did not directly return the case managers' telephone contacts, she was able to verify continued lead level testing, and a reduced lead level for the child.

In cases involving referrals for behavioral health services, the documentation included references to on-going communication between case managers and the behavioral health providers. In a complex case management case, the member was diagnosed with left ventricular hypertrophy, and signs of depression. The case notes indicated that the case manager assisted in obtaining a vest defibrillator for the member, and engaged the member in accepting behavioral health case

management to deal with the depression. The case manager maintained frequent contacts with the member throughout involvement with this health plan member.

In another case a child was diagnosed with cellulitis of the right index finger. The member's mother spoke Arabic, although the father did speak English. The case manager showed a caring and thorough approach to working with the family. Following the initial treatment of the wound, a home health nurse was approved to assist with dressing changes and IV antibiotic administrations. The case manager was tenacious in maintaining contact with the parents. The case was not closed until a final report was received from the home health provider.

The case managers described their role as being service oriented and being there to assist members. They make significant efforts to engage members so that they are comfortable calling the health plan and case manager to request assistance. The case managers report that they are trained, from the beginning of their employment, to be invested in this process. They assist members in dealing with social issues, particularly when they inhibit the member from accessing needed health care services.

Referrals for case management come from member calls, PCPs, specialists, health risk assessments, Member Services, MH Net, the 24-Hour Nurse Line, various state agencies, home health professionals, claims analysis, and from members themselves. The case managers report receiving anywhere from 3 to 10 new referrals per day.

The actual process for case management includes a check for member eligibility, a review of the system to obtain a history that points to the services needed, a review of pharmacy claims, and any previous case notes. All of these activities prepare a knowledge base about the member prior to the initial contact. The case managers, after a member accepts case management services, complete the assessment process. A standard assessment includes information from the member, nurses involved with the family, and the PCP. They investigate any additional questions generated by these interviews. The care plan is then generated based on the member's responses and questions they have, discharge summaries, and information provided by the physicians or medical providers involved. The case managers report that they are able to assess a member's ability to navigate the health plan and medical system based on these

discussions. During these conversations with members a need for additional referrals for behavioral health services are often identified as well. The case managers believe that education is an essential component of their contacts with members. Resources, such as lead inspections, are often explained. These explanations also include the benefits that are available from other community based agencies.

The case managers interviewed were aware of community based resources throughout all three of the MO HealthNet Managed Care Regions that the health plan serves. They collaborate with staff at these agencies, and around the state to identify resources for their members. All case managers do complex case management. During the discussions with the case managers, including those contacted through conference calling, it was obvious that they were aware of the cases reviewed, and used these members as examples of the work they were describing. The case managers' comments indicated a very strong involvement with their members.

There is one case manager who is the main contact for members receiving NICU services for all three managed care regions. She is keenly aware of the resources available to these infants and their families. NICU babies are routinely followed for eighteen (18) months. All babies born at 32 or fewer weeks of gestation, or having a birth weight of less than 1500 grams, or any other complications at birth, are included in a High Risk Program. There were sixty infants enrolled in this program at the time of the on-site review. Contact with mothers is made regularly, and many of these families have access to in-home nurses. Case managers work through the in-home providers to ensure that adequate services are available to the family.

The case managers work with the Disease Management nurses. The Disease Management staff goes out into the community to collaborate with other resource organizations. They provide information on the assistance available through the health plan. The health plan is actively involved in a variety of community organizations and groups. They also attend provider group meetings and share information on the services available to members and methods to contact the health plan and home health agencies.

HCUSA has Community Development staff that goes to health fairs and other events. Obstetrical information and other issues such as SIDS, symptoms of alcoholism, and other problems are presented. The health plan also holds “Baby Showers” that are open to all pregnant members. The case managers reported that at the most recent Baby Shower, held at St. Mary’s Hospital in St. Louis County had approximately forty (40) attendees. The health plan assists with coordinating transportation for any member that needs it to attend these events. The Baby Showers are produced in all three MO HealthNet Managed Care regions at least annually.

Administrative Interviews

- Is the health plan continuing to operate the Physicians’ Advisory Group? How is this working? Elaborate on the outcomes.
- Give examples of measures that the Health Plan implemented to improve the follow-up process for members included in the State’s Special Needs report.
- Discuss the recent changes in case management, and record keeping requirements.
- Discuss the health plan’s relationship with MH Net. What is working? Are any program improvement activities occurring?
- Is the health plan working with the C-STAR program? Discuss current activities.
- Discuss current challenges in the health plan and what is occurring to deal with these challenges.

Findings

A summary of the morning’s discussion was provided to the administrative staff. The reviewers’ impressions of the case records reviewed, the intense case coordination that was observed, and the responses to service delivery expectations were provided. The administrative staff expressed a strong commitment to support case managers in their activities was observed.

The administrative staff discussed the Physician’s Advisory Council. This group has been actively involved in defining the roles of the case managers, but particularly in the Disease Management Program. Program reviews are provided at their meetings, and the physician’s group provides feedback on these activities and their experiences with both the case and disease managers.

The health plan also operates a members’ advisory committee in all three regions. This group provides insight and feedback on existing services, program initiatives, and community

development activities. The health plan views these meetings as an essential component of their operations.

The health plan has initiated a new system to ensure that members in all Disease Management programs receive similar services. They are attempting to meet all corporate expectations and NCQA regulations. This will allow follow-up with all members to ensure that they are receiving all tests and screenings in their best interest. The health plan believes this process will enhance their tracking for issues related to improving HEDIS measures, and will better follow provider activities to ensure that they are providing the expected services. The system also requires a health risk assessment to be completed for the members involved in Disease Management. The assessment is available to accompany the member to the provider's office.

In the rural areas served by the health plan, HCUSA is identifying differences in the populations served, and the resources available. HCUSA is identifying alternative language needs in these areas, and working with the University of Missouri hospital and clinics to better serve diverse groups.

The health plan reports the continuation of co-location of MH Net case managers within their offices. This places a greater emphasis on coordination of care and assists in providing behavioral health information to PCPs. The co-location of behavioral health and physical health case managers, who both participate in grand rounds, increases discussion and information sharing on in-common members.

The health plan has made an effort to improve utilization and communication with the C-STAR programs. Staff members identify and work with C-STAR providers. They are going to meetings with these agencies and are attempting to improve communication avenues about in-common patients. The health plan staff is discussing the importance of care coordination at these meetings. They report that C-STAR staff did not readily understand the health plan's role in members' care. These efforts have improved acceptance into C-STAR for members and the communication with these agencies about member treatment.

ENROLLEE RIGHTS AND PROTECTIONS

A strong commitment to member rights continues to be a cornerstone of HCUSA's service philosophy. The emphasis placed on continuous quality improvement by the health plan was apparent in both the documentation reviewed and throughout staff interviews. Quality services to members, with a particular emphasis on families and children, were observed within the organization. HCUSA views cultural diversity as an essential component of their interactions with members. The health plan maintains cultural diversity as a cornerstone of initial and ongoing staff training. HCUSA employs staff that speaks different languages and is able to provide written materials in languages other than English. Maintaining the ability to serve a culturally diverse population with a variety of special service needs is shown by the health plan's approach to their work and to their interactions with members.

HCUSA has expanded its ability to communicate with visually and reading impaired members by contracting to produce their member handbook and other materials in Braille and on CD. They have information translated into other languages as well.

Staff was asked how a member becomes eligible for care coordination or case management services. They report that certain conditions automatically trigger a referral for case management, but more often, opening a case management case is in response to a situational need or medical condition. After any referral is received, case management contacts the member. Any type of referral creates a trigger for the case manager assigned to apply their algorithm and the completion of an assessment. The algorithm provides a baseline for the degree of intervention that a member will require. The case managers relate that they use all means necessary to contact the member. They believe their persistence positively impacts their success.

Typical case management activities include locating members and assessing their medical and ancillary needs. The case managers often make referrals for members to community based services that will assist them. This often includes working with a social worker, who is on-site at HCUSA, from MHNnet to ensure that mental health referrals are fulfilled in a timely fashion. The case managers and social worker believe this has contributed to improvement in their ability to achieve care coordination for members.

The case managers have developed a NICU program that provides case management for the transition of newborns being released from the hospital to home. They collaborate with nurses at St. Louis Children's Hospital on this project and on a project for children diagnosed with Sickle Cell Anemia. An active outreach program is in place through the Post-Partum Department to ensure that follow-up services are in place as needed. Another outreach program is in place to inform members about services related to ADHD.

The case managers also described their Baby Shower program that is now available in all areas of the MO HealthNet Managed Care regions. These "Showers" are held at physician's offices, hospitals, and clinics. Transportation is provided and vendors are present, including representatives from Parents as Teachers, and the SIDS prevention program. A bank representative is included to assist members in setting up savings accounts for infants. Other community resources are included and information is given to all members present. They also provide gifts, as approved by the SMA, to all members who attend. The case managers believe this program sets members up to have success with their newborns and small children, as it assists the member in becoming aware of resources available to them.

HCUSA is making efforts to leverage community relations in all three MO HealthNet Managed Care regions. They work with the FQHCs in these regions and have developed a number of special projects. The health plan is working with LINC in the Western MO HealthNet Managed Care region, which is the local community partnership group, and the Spanish Center to ensure that they are addressing the needs that might be peculiar to the Kansas City population. They are working with community groups in the MO HealthNet Managed Care Central Region to address issues specific to the rural population. One example is that HCUSA providers are conducting dental screening at community based activities.

As a follow-up on their asthma initiatives, the health plan provided information on a project that is occurring in all three MO HealthNet Managed Care Regions. The health plan monitors member adherence to physician visits and medication. When a member does visit their physician or pharmacy, they are asked to verify all contact information and future commitment to keeping appointments. After attending so many appointments, they receive a gift card, with information on "Kids' Health" aimed at parents, teens, and younger children.

Case managers and the social worker in their department also exhibited a strong sense of collaboration and coordination. This collaborative effort includes the MH Net case manager, with whom they exchange information freely. The social worker provides a linkage with community based agencies that can provide the members with services that may exceed their health care needs.

The staff reports that an administrative assistant processes the report received from the SMA regarding children with special health care needs. After locating the members appearing on the list, their chart is flagged and information is forwarded to the case manager regarding the member's specific needs. The case manager contacts these members to ensure that they attend scheduled appointments, and to provide additional information regarding available services. The health plan may also contact other agencies such as WIC and the Family Support Division to ensure that they have accurate contact information and are aware of needed services.

The case managers maintain communication with the Disease Management Nurses, and the Concurrent Review Nurses to make sure that they obtain timely referral information. The Member Services staff often identifies members with special health care needs during Welcome Calls. This information is sent to the case managers immediately after a call is completed. The case managers' members who are in their case management program often refer friends and others who then self-refer. The case managers interview these individuals and complete an assessment, which often leads to the identification of a need for case management services.

The health plan does have case management staff located in all three MO HealthNet Managed Care regions. They utilize the Health Risk Assessment received through the SMA as much as possible. The health plan reports that community connections, particularly in the rural areas, and provider referrals are more effective in identifying members with special health care needs.

Ratings of compliance with Enrollee Rights and Protections (100%) indicate that HCUSA continues to make a concerted effort to improve their compliance in this area. The health plan completed all required policies and these were approved by the SMA. Interviews with administrative and case managers indicate a commitment to ensure that all approved policies are operationalized in daily work activities. They actively seek to maintain this level of success, and

further to ensure that these policies are operationalized in interactions with health plan members. The Health Plan had a stated goal of 100% compliance with SMA contract requirements and federal regulations, which was achieved for the fourth year.

Table 71 – Subpart C: Enrollee Rights and Protections Yearly Comparison (HCUSA)

Federal Regulation	HCUSA		
	2007	2008	2009
438.100(a) Enrollee Rights: General Rule	2	2	2
438.10(b) Enrollee Rights: Information Requirements	2	2	2
438.10(c)(3) Alternative Language: Prevalent Language	2	2	2
438.10(c)(4,5) Language and Format: Interpreter Services	2	2	2
438.10(d)(1)(i) Information Requirements: Format/Easily Understood	2	2	2
438.10(d)(1)(ii) and (2) Information Requirements: Format Visually Impaired, and Limited Reading Proficiency	2	2	2
438.10(f) Information for All Enrollees: Free Choice, etc.	2	2	2
438.10 (g) Information to Enrollees: Specifics/Physician Incentive Plans	2	2	2
438.10(i) Special Rules: Liability for Payment/Cost Sharing	2	2	2
438.100(b)(2)(iii) Enrollee Rights: Provider-Enrollee Communications	2	2	2
438.100(b)(2)(iv,v) Rights to Refuse Services/Advance Directives	2	2	2
438.100(b)(3) Right to Services	2	2	2
438.100(d) Compliance with Other Federal/State Laws	2	2	2
Number Met	13	13	13
Number Partially Met	0	0	0
Number Not Met	0	0	0
Rate Met	100.0%	100.0%	100.0%

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

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

BEHAVIORAL HEALTH

The liaison social worker from the behavioral health subcontractor, MH Net, was included in the case manager interview during this on-site review. Questions were asked of the health plan to follow-up on information from prior reports. The Behavioral Health Organization's (BHO) system underwent enhancements to capture baseline information on members receiving behavioral health services. MH Net continues the practice of authorizing family therapy, in

addition to required individual therapy, for all children under age 21 who need behavioral health services. This additional resource is thought to assist in ensuring that each family has an understanding of the issues facing their child, that the entire family would be working together to ameliorate problems, and that the family would understand the child's emotional functioning. The BHO, it is reported, works closely with HCUSA to identify expectant mothers to ensure that required behavioral health services were in place in an effort to prevent post partum problems. The BHO continues its concerted effort to ensure that information and educational material is translated into different languages. Multilingual providers are available to members.

The Health Plan, in collaboration with MHNNet, reports making a concerted effort to offer adequate case management services between the two agencies. They provide case management to any member requiring a hospital admission, who attempts suicide, during and immediately after pregnancy, who has a history of non-compliance, and/or those with serious disease management issues. Case managers maintain regular phone contacts to ensure coordinated and necessary services and supports, such as transportation, are in place. HCUSA reports that having a MHNNet liaison on-site has improved coordination of care issues.

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT

Access Standards

HCUSA continues to work with both members and providers to ensure proper access to services is available. The health plan maintains a large provider network throughout all three MO HealthNet Managed Care regions. They continue to recruit providers to expand available services, particularly in the Central Missouri area. This network enables members to have an adequate choice of both PCPs and specialty providers. The health plan does authorize the use of out-of-network providers when this will best meet a member's healthcare needs.

HCUSA reports that a number of new urgent care centers opened in St. Louis, which are now under contract. The health plan has also recruited within its own network. They now have a number of PCPs with weekend and evening hours. This information is published in brochures that are distributed to members. Members, in some cases, are now assigned to physicians'

groups, rather than to just one PCP, which assists in the availability of convenient appointment times, and sometimes eliminates the message that a specific PCP has a closed panel. This practice enables members to see the PCP of their choice in close proximity to their home.

The health plan reports that with the availability of both the Washington University and St. Louis University systems, the number of specialists, particularly in the area of orthopedics, has greatly improved. The case managers in the Western and Central Regions work with their hospitals to identify a specialty provider for specific member's needs. They relate that finding behavioral health providers in the MoHealthNet expansion counties was previously a problem, but this has greatly improved during 2009.

A continuing effort by HCUSA is recruiting dental providers. They report that their work with Doral Dental has created positive results in all three regions. Doral continues to participate in expansion activities with the health plan. They are improving their customer service network, and adding administrative services with HCUSA. Doral Dental has focused efforts in the Central MoHealthNet Managed Care region with success. Doral Dental placed a provider representative in the Central Region to ensure that ample recruitment occurred and that a representative was available locally to assist in problem solving when this was required. They have also recruited a number of dentists who ensure availability to HCUSA members. The health plan continues its efforts to monitor their provider network for accessibility and availability of both primary care physicians and specialists in all three MO HealthNet Managed Care Regions. They report that they have recruited a new orthopedic group in the Eastern Region, which has greatly improved access to these services for their members. The health plan has "non-par" provider agreements that they utilize as needed. HCUSA reports that they have this type of agreement with an orthopedic group in the Central Region, and are now working with the University of Missouri Health Care System.

The health plan makes an effort on behalf of members to share information about changes in provider availability, and to provide assistance in making appointments or identifying an appropriate provider if necessary. HCUSA has developed community based programming in all three Regions. These include programs dealing with back pain, asthma, and the baby showers. The case managers report that they get a reminder when a member is overdue for an EPSDT

examination. This information is then relayed to the member and their PCP. The health plan is also participating in member events, such as Back to School Fairs, to provide information about the availability and accessibility of services. In the Western MO HealthNet Managed Care Region, an FQHC, Swope Health Services, is providing school physicals, dental screenings, and vision screenings for children. HIV screens and mammograms are provided for adults.

Case managers discussed their efforts to ensure that members obtain timely and appropriate services. They directly contact PCPs and specialists if barriers exist to obtaining appointments or other necessary services. Case managers also discussed members' rights to refuse case management services. When this occurs, the case managers attempt to educate members on other community services available, and how to work with their providers. The case manager then sends a post card with their name and a message that they can be available again if the member has future service needs.

Ratings of compliance with Access Standards regulations (100%) are excellent for the third year, and reflect the fact that all HCUSA policies have been submitted, reviewed, and approved by the SMA, and that the practice validated at the on-site review supports that all requirements are occurring. The health plan has improved in this area each year, and continues to strive to meet all required SMA contract requirements and federal regulations.

Table 72 – Subpart D: Quality Assessment and Performance Improvement: Access Standards Yearly Comparison (HCUSA)

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

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

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

Structures and Operation Standards

HCUSA instituted a number of measures to improve practice in this area in previous years that have continued during 2009. The health plan holds quarterly oversight meetings with all subcontractors in each region to discuss service provision and to monitor their activities. The meetings are used to monitor key performance indicators and to review provider panels. Annual evaluations are completed on each subcontractor and daily contact is maintained.

HCUSA reported this increased contact and monitoring allows them to address administrative and member issues in a timely and effective manner.

On-site reviews continued to be conducted by Provider Relations staff during 2009 to assess providers' use of practice guidelines, and to review that all required documentation is in place. This has been effective in ensuring the quality and timely provision of care. The health plan is currently URAC accredited, and are actively working toward obtaining their NCQA accreditation. On site visits, to complete credentialing, occur at least annually for PCPs and OB/GYNs. An on-site visit occurs with any office where a complaint has been reported. The health plan reviews areas related to member safety and cleanliness, which reflect the majority of issues. Some delegated credentialing occurs with larger providers, such as Cox and St. John's in Springfield, Missouri.

HCUSA created a provider advisory group, which began functioning in the Eastern Region, but is now operational in all three MO HealthNet Managed Care regions. The committee is made up of high volume providers and representatives from across specialties. The sharing of ideas and information pertaining to any member dissatisfaction is encouraged. These groups seek provider feedback and provide information in a framework that allows the health plan to develop a true partnership with their provider network.

Ratings for compliance with Structure and Operation Standards (100%) reflected completed and approved policy and procedures in this area for the third year.

Table 73 – Subpart D: Quality Assessment and Performance Improvement: Structure and Operation Standards Yearly Comparison (HCUSA)

Federal Regulation	HCUSA		
	2007	2008	2009
438.214(a,b) Provider Selection: Credentialing/Re-credentialing	2	2	2
438.214(c) and 438.12 Provider Selection: Nondiscrimination	2	2	2
438.214(d) Provider Selection: Excluded Providers	2	2	2
438.214(e) Provider Selection: State Requirements	2	2	2
438.226 and 438.56(b)(1-3) Disenrollment: Requirements and limitations	2	2	2
438.56(c) Disenrollment Requested by the Enrollee	2	2	2
438.56(d) Disenrollment: Procedures	2	2	2
438.56(e) Disenrollment: Timeframes	2	2	2
438.228 Grievance System	2	2	2
438.230(a,b) Subcontractual Relationships and Delegation	2	2	2
Number Met	10	10	10
Number Partially Met	0	0	0
Number Not Met	0	0	0
Rate Met	100.0%	100.0%	100.0%

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

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

Measurement and Improvement

The MO HealthNet MCHP continued to use InterQual as a guide for decision-making in terms of utilization review. InterQual criteria were originally cited when asked about practice guidelines. However, the health plan has instituted a number of practice guidelines and has instituted a number of initiatives to ensure their distribution to and use by providers. HCUSA's Medical Director ensures that monitoring utilization of practice guidelines is occurring at the provider level.

HCUSA continued to have a well developed internal written quality assessment and improvement program. The Health Plan shared their Quality Management Charter and minutes from meetings with reviewers. The Quality Management Program focused on monitoring, assessment, and evaluation of clinical and non-clinical service delivery. The result has been the implementation of quality programs that target members with special healthcare needs, but also

provided enhanced services to all members. HCUSA indicated that they recognized the need to stratify data by MO HealthNet Managed Care region. The Quality Management charter ensured that meetings occur at least quarterly on a regular schedule and had representatives from all sections of the organization, as well as including providers. The quality management process ensured that the health plan maintained a record of activities, recommendations, accomplishments, and follow-up.

The health plan did report data for Validating Performance Measures, which is validated in the appropriate section of this report. However, one Performance Measure could not be validated as the data was submitted erroneously. The health plan did submit clinical and non-clinical Performance Improvement Projects. The details of the audit are located in the appropriate section of this report. HCUSA continues to operate a health information system that meets required standards. Encounter data was submitted in the format requested so that appropriate validation could occur. The details of this process are located in the Validating Encounter Data section of this report.

Ratings for compliance with Measurement and Improvement regulations (90.90%) reflect the completion of all policy and procedures in this area. The decline in this rating reflects the health plans inability to submit all data for validation of Performance Measures in the correct format. The health plan did submit the remainder of required data in requested formats, allowing the proper validation processes to occur.

Table 74 – Subpart D: Quality Assessment and Performance Improvement: Measurement and Improvement Yearly Comparison (HCUSA)

Federal Regulation	HCUSA		
	2007	2008	2009
438.236(b)(1-4) Practice Guidelines: Adoption	2	2	2
438.236(c) Practice Guidelines: Dissemination	2	2	2
438.236(d) Practice Guidelines: Application	2	2	2
438.240(a)(1) QAPI: General Rules	2	2	2
438.240(b)(1) and 438.240(d) QAPI: Basic Elements of MCO Quality Improvement and PIPs	2	2	2
438.240(b)(2)(c) and 438.204(c) QAPI: Performance Measurement	2	2	1
438.240(b)(3) QAPI: Basic Elements/Over and Under Utilization	2	2	2
438.240(b)(4) QAPI: Basic Elements regarding Special Healthcare Needs	2	2	2
438.240(e) QAPI: Program Review by State	NA	NA	NA
438.242(a) Health Information Systems	2	2	2
438.242(b)(1,2) Health Information Systems: Basic Elements	2	2	2
438.242(b)(3) Health Information Systems: Basic Elements	2	2	2
Number Met	11	11	11
Number Partially Met	0	0	0
Number Not Met	0	0	0
Rate Met	100.0%	100.0%	90.90%

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

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

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

GRIEVANCE SYSTEMS

Rating for compliance with Grievance Systems regulations (100%) indicates that the HCUSA completed all requirements regarding policy and practice in their grievance system. This is the sixth year that HCUSA has been 100% compliant in the area of Grievance Systems and reflects that the health plan considers this an important aspect of compliance in both policy and practice. Out-of-network providers are informed of policies and procedures regarding complaints, grievances and appeals through the Provider Manual and Web Link.

The health plan resolves to obtain timely grievance resolution for both members and providers. The grievances are placed in their health information system, which tracks timeframes and generates notices and letters. Specific staff is assigned to appeals for members. They assist in obtaining the most complete information to present to an appeals committee. The member is notified by telephone and in writing of any decision to ensure that they have the information as quickly as possible. HCUSA utilizes an appeals form for members and does provide assistance with the written request for an appeal.

During the case manager interviews it was learned that these staff are not integrally involved in the Grievance and Appeal process. They are aware of their role in the referral process. They reported that the health plan receives approximately sixty grievances per month, forty appeals per month, and 1-2% may become a State Fair Hearing. They estimated that 75% of calls come directly from members.

Outside physicians are utilized for review of the case and responsible for the final appeal decision. The Compliance Analysts all reported that adverse decisions are often the result of a lack of complete medical information. When additional information is available the denial is often overturned. All decisions are recorded in the health plan system, and appropriate correspondence is sent to members and providers.

Table 75 – Subpart F: Grievance Systems Yearly Comparison (HCUSA)

Federal Regulation	HCUSA		
	2007	2008	2009
438.402(a) Grievance and Appeals: General Requirements	2	2	2
438.402(b)(1) Grievance System: Filing Requirements - Authority	2	2	2
438.402(b)(2) Grievance System: Filing Requirements - Timing	2	2	2
438.402(b)(3) Grievance System: Filing Requirements - Procedures	2	2	2
438.404(a) Grievance System: Notice of Action - Language and Format	2	2	2
438.404(b) Notice of Action: Content	2	2	2
438.404(c) Notice of Action: Timing	2	2	2
438.406(a) Handling of Grievances and Appeals: General Requirements	2	2	2
438.406(b) Handling of Grievance and Appeals: Special Requirements for Appeals	2	2	2
438.408(a) Resolution and Notification: Basic Rule	2	2	2
438.408(b,c) Resolution and Notification: Grievances and Appeals - Timeframes and Extensions	2	2	2
438.408(d)(e) Resolution and Notification: Grievance and Appeals - Format and Content of Notice	2	2	2
438.408(f) Resolution and Notification: Grievances and Appeals - Requirements for State Fair Hearings	2	2	2
438.410 Expedited Resolution of Appeals	2	2	2
438.414 Information about the Grievance System to Providers and Subcontractors	2	2	2
438.416 Recordkeeping and Reporting Requirements	2	2	2
438.420 Continuation of Benefits while Appeal/Fair Hearing Pends	2	2	2
438.424 Effectuation of Reversed Appeal Resolutions	2	2	2
Number Met	18	18	18
Number Partially Met	0	1	0
Number Not Met	0	0	0
Rate Met	100%	100%	100%

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

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

CONCLUSIONS

HCUSA continued to exhibit a commitment to completing, submitting and gaining approval of required policy and procedures by the SMA, and developing operations that ensure that these procedures are reflected in daily operations. The health plan maintained improvements to achieve 100% compliance in all sections of the protocol for the fourth year. The operations and practices revealed during interviews at the on-site review indicated a commitment by HCUSA to provide quality healthcare services to its members. Health plan activities focused on: enhancing preventative services; creating new approaches to providing access to services, such as the development of after-hours clinics; obtaining member input on issues; engaging provider input regarding improving and delivering services effectively; and to responding to prior authorizations and grievances in a timely and efficient manner.

The health plan incorporated methods to track required policy submission into daily administrative practice and took this process seriously. The practice observed at the time of the on-site review provided confidence that services to members is their primary focus and that there was a commitment to comply with the requirements of the MO HealthNet Managed Care contract and federal regulations.

It is also noted that all staff interviewed reflected the health plan's culture of respect for members and the priority for meeting member service needs. Staff members were open and animated in their responses. They were eager to give examples of how they assist members in normal and extraordinary circumstances.

QUALITY OF CARE

The staff at HCUSA exhibits a commitment to excellence that creates an atmosphere where both members and providers experience quality services. The provider relations staff made regular contacts with providers to troubleshoot problems that may be reported by members, and to assist provider staff in making interactions with members and the health plan less complicated. Efforts within the communities served, involvement with FQHCs, and with Community Mental Health Clinics, are examples of HCUSA's working to produce quality care in the most convenient environment, and working to improve access to care for members. These

relationships have also allowed education to occur that improves the quality of services for both the member and organizational level. Case Managers relate the importance placed on training and collaboration to ensure that they are aware of issues that may arise and can respond quickly and efficiently to ensure that members have access to quality health care.

ACCESS TO CARE

HCUSA provided numerous examples of initiatives they are involved in to ensure that members have information on obtaining services and have adequate access to services. Several projects were explained that bring providers directly to places where members are available. The health plan has also undertaken provider recruitment and retention efforts that ensure that providers are available to members throughout all three MoHealthNet Managed Care Regions served.

Internally HCUSA, as an organization, has made efforts to ensure interdepartmental integration to create thorough knowledge of their service delivery system thus enabling staff to assist members effectively. Staff exhibited enthusiasm in describing the services they deliver and a desire to ensure that members' health care needs are met in spite of the barriers sometimes experienced.

TIMELINESS OF CARE

HCUSA was able to complete all required policies and procedures in a timely manner, to ensure compliance with State contract requirements and federal regulations. The focus on obtaining timely health care services and responses to member needs reflects the attention needed to effectively provide a managed system of services to members. HCUSA has also initiated a number of practices that enhanced timely response and resolution of grievances and appeals for both members and providers. This decision-making process enables members to obtain the healthcare they require in a timely manner. The health plan recognizes the importance of timely and adequate services.

RECOMMENDATIONS

1. Retain the focus on complying with documentation requirements to the same standards as those reflected in the daily practice within the health plan.
2. Continue development in the area of utilization of available data and member information to drive change and support opportunities for organizational growth and development.
3. Continue to track policies and other materials required for annual review.
4. Continue the commitment to oversight of subcontractors, such as MHNet and Doral Dental. Quarterly reviews ensure that member services are at the level the MCO requires.
5. Maintain involvement in community-based services and activities.
6. Continue training efforts with front line staff to ensure that they are versed in health plan policy and procedures and remain confident in their interactions with and advocacy for members.