MO HealthNet Managed Care
Annual Evaluation

SFY 2009

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Executive Summary

Introduction

MO HealthNet Managed Care serves participants in 54 counties of Missouri, which are divided into three regions: Eastern, Central, and Western. MO HealthNet Managed Care contracts are competitively bid and are currently awarded to six health plans. Two health plans operate in all three regions resulting in a count of ten (10) health plans when doing regional comparisons. The MO HealthNet Division is required to monitor MO HealthNet Managed Care health plans to ensure compliance with the MO HealthNet Managed Care contracts.

The MO HealthNet Division (MHD) has conducted an Annual Evaluation of the MO HealthNet Managed Care Program for state fiscal year 2009 (SFY2009). The evaluation is divided into ten (10) sections: Development, Approval and Monitoring of the Quality Improvement (QI) Program, Population Characteristics, Quality Indicators, Accessibility of Services, Fraud and Abuse, Information Management, Quality Management, Rights and Responsibilities, Utilization Management and Performance Improvement Projects (PIPs). The Managed Care health plans also submitted work plans for SFY2010.

Information to conduct the annual evaluation was gathered from the MHD internal systems, Managed Care health plan reports submitted to the MHD, information gathered and provided by the Department of Health and Senior Services (DHSS), information gathered and provided by the Department of Insurance, Financial Institutions and Professional Registration (DIFP) and the 2008 Missouri External Quality Review Report of Findings submitted by Behavioral Health Concepts, Inc.

Legislative Changes

As a result of passage of House Bill 2011, 94th General Assembly, 2008 session, effective July 1, 2008, MO HealthNet Managed Care physician, dental, and optical rates were increased. MO HealthNet Managed Care physician reimbursement rates that were less than 62.5% of the Medicare reimbursement rate increased to 62.5% of the Medicare reimbursement rate. MO HealthNet Managed Care Dental reimbursement rates increased to 38.5% of the 50th percentile of UCR. MO HealthNet Managed Care Optical reimbursement rates for eye exams increased by $10.

Development, Approval and Monitoring of the QI Program

Development, approval and monitoring of the QI Program was measured by reviewing each Managed Care health plan's quality and compliance committees, the analysis of their quality improvement process, and the overall effectiveness of their quality improvement program including strengths and accomplishments as well as opportunities for improvement. This information was taken from the Managed Care health plan Annual Evaluations for SFY2009.

Strengths and Accomplishments

Health plans have implemented a variety of activities to enhance care provided to participants such as:

- All Managed Care health plans have a variety of oversight committees to monitor and work towards their QI program.
- Improvement in 79% of the Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) scores. Improved statewide average scores include:
  - Adolescent Well-Care Visits

    - Annual Dental Visits (all age ranges)
    - Asthma (all age ranges)
    - Chlamydia Screening Combined Rate
    - Prenatal and Post-Partum Care
    - Follow-Up After Hospitalization for Mental Illness within 7 and 30 Days of Discharge
- Preventive programs to educate participants.
- Design/redesign of websites for participants and providers.
- Development of a comprehensive pre-certification training manual for new and existing staff.
- Review of utilization data to identify under and over utilization resulted in opportunity to improve care.
- Enhancement of fraud and abuse program to improve identification of potential fraud and abuse.
- Development of interventions to improve coordination of care and services between behavioral health providers and PCPs.

Opportunities for Improvement

- Continue efforts to increase EPSDT, HEDIS, and CAHPS scores.
- Review and trend data related to PCP changes to identify opportunities for improvement.
- Implement adult wellness initiatives.
- Implement satisfaction surveys for participants receiving care management and disease management services.
- Continue efforts to increase network of providers.
- Decrease non-urgent emergency department (ED) utilization.
- Continue collaboration between the areas within QI and health plan management to ensure interventions to improve service and clinical care.

Population Characteristics

Population Characteristics were measured by reviewing each Managed Care health plan's race/ethnicity, special needs, identified languages, and opt-outs reported in the annual evaluations for SFY2009.

Across all Managed Care health plans during SFY2009 the race of participants consisted of 59.12% white, 36.49% black, 0.97% Hispanic, 0.67% multi-racial, 0.19% Asian, and 0.15% 'other'. There were also 2.41% of participants in which race/ethnicity was undetermined. There was a slight increase of white participants (+2.2%) and a slight decrease of black participants (-4.0%) from SFY2008 to SFY 2009.

Eastern region enrollees consisted of 50.12% black and 46.07% white; Central region enrollees consisted of 11.88% black and 84.20% white; and Western region enrollees consisted of 31.51% black and 62.99% white.

During SFY2009 there were 10,116 individuals identified with special health care needs and reported to the appropriate Managed Care health plan. Of these 48.96% were in the Eastern Region, 21.66% were in the Central Region, and 29.38% were in the Western Region.

In all Managed Care health plans during SFY2009 there were 58.99% of Managed Care enrollees whose primary language was English. Additionally, 0.63% enrollees listed Spanish as their primary language and 39.25% of enrollees had no primary language listed. The highest percentage of enrollees in each region who identified having a primary language identified English as their primary language with Spanish being a distant second.

In all Managed Care health plans during SFY2009 there were 269 Managed Care members that chose to opt-out of the Managed Care Program. This is a decrease of 50.6% from SFY2008. Of these 87.36% were processed by the enrollment broker and 12.64% were processed by the Participant Services Unit at MHD. Across regions, 47.96% of the opt-outs were in the Eastern region (an increase of 12.8% from SFY2008), 27.14% were in the Central region (a decrease of 8.0% from SFY2008), and 24.91% were in the Western region (a decrease of 4.8% from SFY2008). Of the total that chose to opt-out, 98.14% were 1915(b) Waiver participants and 1.86% were Children's Health Insurance Program (CHIP) participants.

The top five opt-out reasons are:

1. Better Benefits – 34.94%
2. Doctor Takes Straight MO HealthNet – 18.96%
3. No information Provided by Enrollment Broker – 18.22%
4. Met Medical Opt-Out Criteria – 10.78%
5. SSI Eligible – 8.92%

Of the 269 participants that chose to opt out, 84.76% opted-out after enrollment into a Managed Care health plan; 2.23% chose to opt-out prior to enrollment into a Managed Care health plan; and 13.01% indicated 'other'.

Quality Indicators

Quality Indicators were measured by reviewing each Managed Care health plan's performance measures, trends in quality indicators, and HEDIS indicators by Managed Care Health Plans Within Regions, Live Births. This information was taken from the Managed Care health plan Annual Evaluations for SFY2009.

The MHD and DHSS both gather HEDIS information from the Managed Care health plans on an annual basis. HEDIS is a standardized set of performance measures designed to enable purchasers and consumers to compare the performance of the Managed Care health plans. The HEDIS measures collected by the MHD are compiled into a statewide report to provide information back to the health plans. This enables the health plans to compare their performance to the other health plans and to see how their performance ranks against the statewide average.

Strengths and Accomplishments

- Educated providers in proper documenting in the medical record and accurate coding to ensure accurate reporting of HEDIS measures.
- Identified trends and established corrective action plans.
- Created focus studies and PIP's to further improve quality.

Opportunities for Improvement

- Set measurable goals.
- Provide physicians with a non-compliant participant list on an ongoing basis.

- Increase outreach and education to participants and providers.
- Continue to identify participants for case management, especially those considered high risk.
- Continue to utilize focus studies and PIPs as tools to improve services to participants.

Accessibility of Services

Accessibility of Services was measured by reviewing the health plan's average speed of answer, call abandonment rate, non-routine and routine needs appointments, access to emergent and urgent care, network adequacy and provider/enrollee ratios, 24 hour access and after hours availability, open and closed panels, cultural competency and requests to change practitioners. This information was taken from each Managed Care health plan's annual evaluation for SFY2009.

Strengths and Accomplishments

- Conducted workshops dealing with cultural competency to meet the unique and diverse need of participants including military veterans and their families.
- Web access/portals for participants, providers and participant advocates.
- Monitoring indicates adequate average speed of answer and call abandonment rate.
- Monitoring indicates adequate appointment standards and after-hours access to emergent and urgent care.

Opportunities for Improvement

- Monitor requests to change practitioners for trends in appointment standards, after hour availability, provider and provider staff behavior and other provider related issues.
- Monitor grievances and appeals for accessibility of services issues.
- Ensure provider directories are current so that participants are provided with accurate provider information.

Additionally, the Missouri Department of Insurance, Financial Institutions and Professional Registration (DIFP) evaluated access the annual access plans submitted by the Managed Care health plans. The DIFP calculates the enrollee access rate for each type of provider in each county the Managed Care health plans serve to determine if the average enrollee access rates for each county and the average enrollee access rate for all counties are greater than or equal to ninety percent (90%). The entire Managed Care population is used in the calculation for each Managed Care health plan.

Strengths and Accomplishments

- The 2009 Network Analysis completed by the DIFP determined that all Managed Care health plans met and exceeded the 90% standard. Six (6) Managed Care health plans obtained an overall network score of 100%, in their respective regions, with the remaining four (4) scoring 97% and greater.
- 9 of 10 health plans achieved 100% in the PCP distance standard per state regulation 20 CSR 400-7.095(3)(A)1.B. The remaining health plan achieved 99%.
- All health plan dentist/enrollee ratios were within the benchmark dentist/enrollee ratios found by the MHD research.

Opportunities for Improvement

- Ongoing monitoring of the provider network for open practices/providers accepting new patients.

- Continuous review of the behavioral health provider network to ensure adequate availability.

Fraud and Abuse

Fraud and Abuse was measured by reviewing each Managed Care health plan's prevention, detection and investigation practices as well as training and education. This information was taken from the Managed Care health plan annual evaluations for SFY2009.

Effective beginning in SFY 2006 the Managed Care health plans began using a uniform reporting system for their quarterly reports to the MHD. When appropriate, the Managed Care health plans report to and cooperate with the MHD Program Integrity Unit, Medicaid Fraud Control Unit (MFCU), the Attorney General's Office, and other agencies that conduct investigations for the purpose of exchanging information and strategies for addressing fraud and abuse, as well as allowing access to documents and other available information related to program violations.

Strengths and Accomplishments

- Conducts regular reviews and audits to guard against fraud and abuse.
- Full-time staff members, special committees, and investigation units to focus on fraud and abuse.
- Screens providers against the Office of Inspector General (OIG) debarred providers and other national lists.
- Coordinates among health plan departments to provide comprehensive prevention, identification, and investigation of fraud and abuse.
- Continued education to staff, providers and participants regarding fraud and abuse.
- Initiate and monitor lock-in on participants when warranted to reduce fraudulent use of pharmacy benefits and other services.
- Claim processing edits to better identify coding irregularities that may indicate fraud and abuse.

Opportunities for Improvement

- Ongoing research and evaluation of new ways to minimize fraudulent and abusive activities and implement enhancements to the fraud and abuse program.
- Implement corrective action plans to strengthen internal control of fraud and abuse activities.
- Identify new enrollees who were locked in to a previous health plan due to fraud and/or abuse.
- Fraud and abuse should be reported timely to the MHD and other agencies when appropriate.
- Quarterly fraud and abuse reports submitted to the MHD should be accurate and complete.
- Monitor member and provider grievance and appeals for trends that may indicate fraud and abuse.
- Continue to monitor claim submissions and implement additional edits to better identify potential fraud and abuse.
- Continue health plan staff, provider, and member training in fraud and abuse prevention and detection.

Information Management

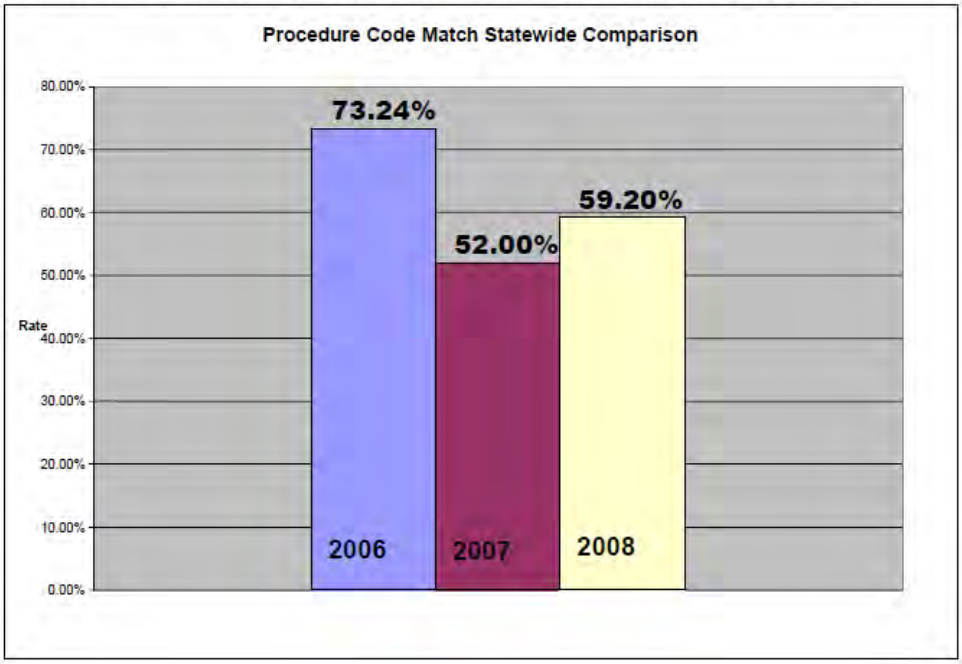
Information Management was measured by reviewing each Managed Care health plan's claims processing/timeliness of claims payment process, membership and provider enrollment. For this section the MHD used information from the 2008 External Quality Review Report of Findings submitted by Behavioral Health Concepts, Inc.

Encounter claims data are used by the SMA 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, etc.) 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 Managed Care health plans); 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 Managed Care member medical records. The match rates between the SMA database and Managed Care health plan medical records for claim type procedures were 59.20%, although an increase over 2007 (52.0%), a significant decrease from the 2006 match rate of 73.24% (see Figure 7). 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.

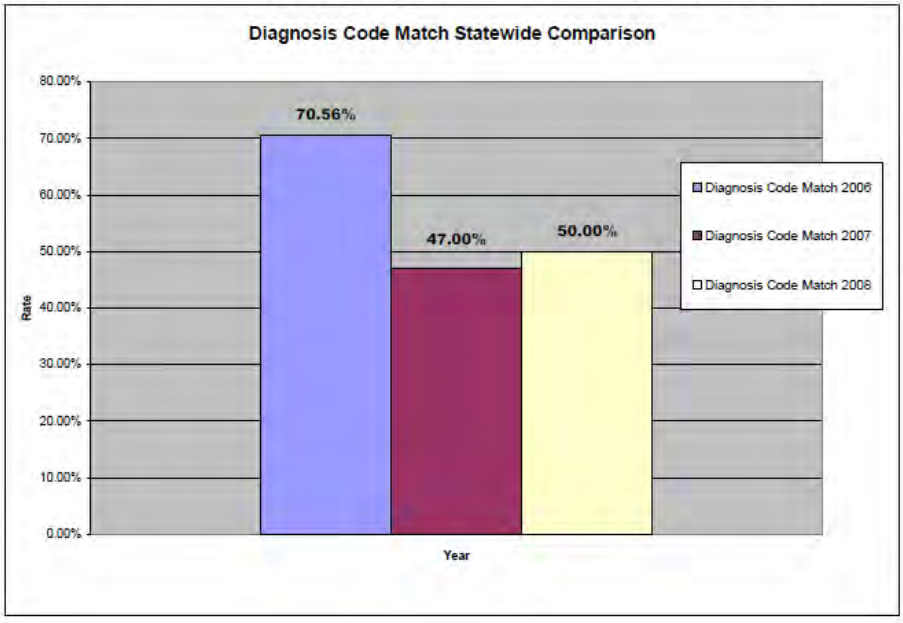
The match rates between the SMA database and Managed Care health plan medical records for claim type diagnoses were 50.0%, although an increase over 2007 (47.0%), this is significantly lower than the 2006 match rate of 70.56%. Medical records that did not have procedure codes that matched the SMA encounter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

Figure 8 – MO HealthNet Managed Care Program Statewide Rate Comparison for Procedures



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 Managed Care health plan records of paid and unpaid claims. All six Managed Care health plans 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.

Figure 9 – MO HealthNet Managed Care Program Statewide Rate Comparison for Diagnoses



Strengths

- All Dental and Pharmacy claim type fields examined were 100.00% complete, accurate and valid for all Managed Care health plans. The SMA encounter claims data critical fields examined for accepted and paid claims of this type are valid for analysis.
- All Managed Care health plans 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.
- The examination of the level, volume, and consistency of services found significant variability between Managed Care health plans 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 Managed Care health plan.
- There were no unmatched "paid" encounters within all claim types (Inpatient, Outpatient, and Pharmacy) for all Managed Care health plans.
- Unpaid claims represented less than .0001% of all claims submitted to the SMA during the period July 1, 2008 through September 30, 2008.

Areas for Improvement

- The Procedure Code field in the Outpatient Home Health, Outpatient Hospital and Outpatient Medical claim types included some invalid information. Most of this was due to blank fields or fields containing ".00".
- The Inpatient first diagnosis claim field contained incomplete, invalid, and inaccurate fields.

Quality Management

Quality Management was measured by reviewing each Managed Care health plan's provider satisfaction, care coordination, case management, disease management program, mental health care management including case management, clinical practice guidelines, credentialing and re-credentialing, medical record review, and subcontractor monitoring. This information was taken from the Managed Care health plan annual evaluations for SFY2009.

Strengths

- Increased efforts in screening of participants attributed to increase of participation in case management.
- Collaborative efforts with behavioral health subcontractors identify con-existing medical and behavioral health conditions referred to co-case management services.
- Disease management programs to focus on management of chronic long term conditions in an effort to prevent exacerbations and /or complications related to specific diagnosis.
- Outreach to participants through mailings to provide education on a wide variety of services, preventive care, and disease/care management.
- Credentialing and re-credentialing of providers to confirm their qualifications prior to participation and continue once they become part of the health plan's provider network.
- Subcontractor monitoring is ongoing to ensure the quality of care and quality of services provided on behalf of the health plan is in compliance with all requirements of their contract with the MHD. Corrective action plans are implemented and monitored when warranted.

Areas for Improvement

- Early identification of participants in need of case management and disease management.
- Adopt and distribute clinical practice guidelines to support optimal care outcomes to appropriate providers.
- Continue to provide health plan staff with tools to develop case management skills and to follow State protocols.
- Quality management encompasses a variety of opportunities to provide quality services to members. Health plans should continue to strive to identify, improve and accurately document all aspects relating to the quality of care and oversight to participants and network providers.

Rights and Responsibilities

Rights and Responsibilities were measured by reviewing each Managed Care health plan's member grievance and appeals; provider complaint, grievance, and appeals: and member confidentiality practices.

The MHD used quarterly reports submitted by the Managed Care health plans regarding member grievances and appeals: provider complaints, grievances and appeals: and information taken from each Managed Care health plan's annual evaluations. Beginning January 1, 2006 all health plans were required to use a standardized database for reporting member grievances and appeals and provider complaint, grievances, and appeals.

Strengths

- All Managed Care health plans report member grievances and appeals and provider complaints, grievances, and appeals via the required database on a quarterly basis.
- Reported member appeals were less than 3 per 1000 participants in SFY2009 across all health plans.
- Health plans are resolving most issues during the complaint and grievance process before reaching the appeal level.
- Health plans have written policies and procedures regarding member rights which comply with State and Federal regulations.

Areas for Improvement

- Ensure all member grievances and appeals and provider complaints, grievances, and appeals are recorded and submitted to the MHD on the quarterly reports. This must include issues received from MHD, state fair hearing requests, and from all other sources with a complaint, grievance, or appeal pertaining to, or on behalf of, a member or provider. SFY 2009 analysis revealed many complaints, grievances, and appeals referred to health plans by MHD staff are not being reported on the quarterly reports.
- Increase education and monitoring to transportation subcontractors, participants, and providers in an effort to reduce the number of complaints, grievances, and appeals for transportation.

Utilization management

Utilization Management was measured by reviewing each Managed Care health plan's utilization improvement program scope including discharges, inpatient visits, average length of stay, re-admissions, emergency department utilization, outpatient visits, over/under utilization, inter-rater reliability, timeliness of care delivery, and timeliness of prior

authorization/certification decision making. This information was taken from the Managed Care health plan annual evaluations for SFY2009.

Strengths

- A large scope of utilization management processes continuously monitor discharges, inpatient visits, average length of stay, re-admissions, emergency department utilization, outpatient visits, over/under utilization, inter-rater reliability, timeliness of care delivery, and timeliness of prior authorization/certification decision making.

Areas for Improvement

- Set measureable goals.
- Continue to monitor utilization patterns and implement processes as warranted by the patterns identified.
- Year-to-year comparisons are encouraged to measure improvements/declines.
- Increase outreach efforts to educate participants regarding appropriate use of emergency department services.

Performance Improvement Projects (PIPs)

Performance Improvement Projects were measured by reviewing clinical and non-clinical PIPs, as well as on-going interventions and improvements. For this section the MHD used information from the 2008 External Quality Review Report of Findings submitted by Behavioral Health Concepts, Inc.

For the Validating Performance Improvement Projects (PIP) Protocol, the EQRO validated two PIPs for each Managed Care health plan that were underway during 2008. 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 2008 validation process was made by the SMA in December 2008. 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
Readmission Performance Improvement
Improving Adolescent Well Care

Missouri Care
Partnership to Improve WIC Participation & Increase Well Child Visit Rates
Improving Adolescent Well Care

Children's Mercy Family Health Partners
Improving Dental Utilization Rates
Improving Adolescent Well Care

Blue Advantage Plus
Ambulatory Follow-Up After Hospitalization for Mental Health Disorders
Improving Adolescent Well Care

Harmony Health Plan
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 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 a prominent theme throughout all of the PIP submissions reviewed.

- One specific PIP worked to impact needed improvement in access to dental care (Children's Mercy Family Health Partners);
- Two health plans focused on the availability of appropriate aftercare when there is a surgery or hospitalization (Molina HealthCare of Missouri, and HealthCare USA);
- Five of the Statewide PIP submissions focused on improving the access to adolescent wellcare.
- All the projects reviewed utilized the format of the PIP to recognize improvements in access to care for members.
- One of the projects clearly focused on ensuring the members had adequate and timely access to services after being hospitalized for behavioral health related issues (BA+).
- One PIP focused on improving preventive services through a community partnership that also enhanced member access to ancillary services (Missouri Care).
- One PIP focused on a key aspect of prevention (Harmony Health Plan).
- The on-site discussions with health plan staff indicate that they realize that improving access to care is an ongoing aspect of all projects that are developed.

The Statewide PIP was expanded to enable each health plan to address individual approaches to improving Adolescent Well Care. Five of these PIPs utilized interventions that informed or educated members about the availability of these services, and encouraged increased utilization of the health care services available.

Quality of Care
The PIPs reviewed exemplified the importance of providing quality health care to members. This was evident in the identification of the topics chosen for the clinical PIPs.

- *Molina HealthCare of Missouri:* The health plan recognized that reducing the number of members returning to the hospital with a wound infection after a Cesarean birth was of primary importance to them and their families. Members' risks were identified and interventions developed to reduce these risks;
- *HealthCare USA***:** The health plan identified the need to reducing the number of hospital readmissions after surgery to decrease the negative impact on members and their families. Research surrounding this issue was cited and the health plan's response included interventions to clearly improve the quality of care for members at risk.

- *Missouri Care:* The health plan chose a project, in partnership with another community agency – the WIC program, to increase members' utilization of this resource, while improving the number of children obtaining Well Child Visits. The interventions improved the quality of care for members in preventive health care and resource availability.
- *Children's Mercy Family Health Partners:* This health plan attacked one of the most difficult problems for the population they serve, which is the availability of dental services. The PIP improved the availability of providers, and members' knowledge and utilization of services, which is significant in increasing their quality of care.
- *Blue Advantage Plus:* Improving access to aftercare services when a member has been hospitalized for a mental health disorder. The health plan employed diligent interventions to improve the availability of aftercare services to members to ensure that they receive appropriate outpatient treatment, including in-home services.
- *Harmony Health Plan:* The health plan attacked one of the primary prevention services, lead screening, in an effort to improve both physicians attention to this need, and members' education regarding the importance and availability of these screenings.

Each of these topics clearly focused on improving the quality of health care, as well as the quality of life, for members. The interventions utilized focused on internal and external processes to improve the quality and availability of health care and preventive services. These PIPs addressed barriers to quality care and health outcomes, and were designed to positively impact the members served. These interventions addressed key aspects of member care and services, such as medication and treatment management; risk identification and stratification for various levels of care; monitoring provider access and quality services; and preventive care. These efforts exemplified an attention to quality healthcare services.

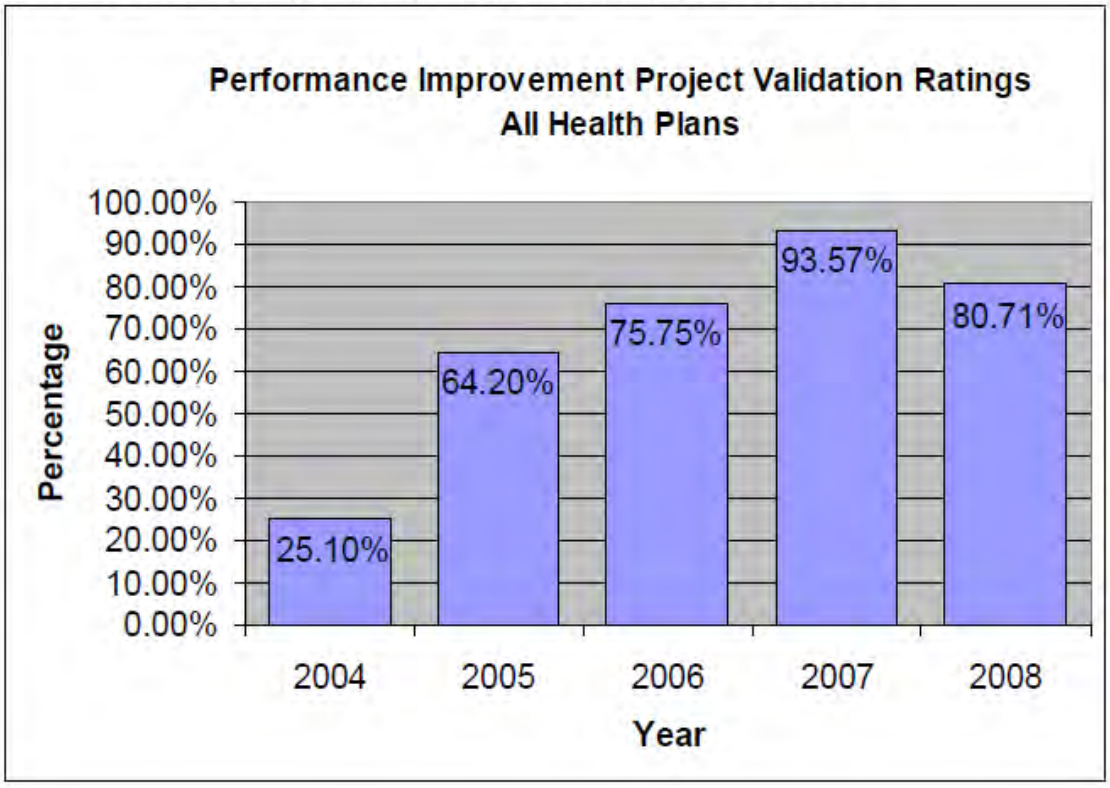
Timeliness of Care
Timeliness of care was not ignored as a crucial factor in the PIPs reviewed.

1. Three projects directly identified the need for timely aftercare for members who required inpatient hospitalization (Blue Advantage Plus, HealthCare USA, and Molina HealthCare of Missouri).
2. The remaining three projects focused on subjects such as timely utilization of preventive care (Missouri Care, and Harmony Health Plan), and improved access to dental services (Children's Mercy Family Health Partners). All of these projects identified the need for timely access to preventive and primary health care services as principal components for success.
3. The health plans related their awareness of the need to provide not only quality, but timely services to members as motivators for these projects. The health plans reflected this awareness in the way they addressed internal processes and direct service improvement.
4. Interventions included initiation of follow-up services prior to members leaving the hospital setting, authorization of in-home services, specific educational activities to improve self-care, and awareness of the advantages of utilizing preventive services. Five of the PIPs, related to improving Adolescent Well Care, stress the importance of obtaining timely screenings in their interventions. The health plans recognize that this is an essential component of effective preventive care.

Conclusion

The health plans have made significant improvements in utilizing the PIP process since the current measurement process began in 2004. Figure 1 indicates the improvements the health plans have made in providing valid and reliable data for evaluation. 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 2008 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 PIPs into daily operations when the study process is complete.

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



Managed Care Health Plan Best Practices

For the 2008 Missouri External Quality Review Report of Findings, Behavioral Health Concepts was requested 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	**Immunization Initiative** – This initiative provides education to members regarding the need for regular check-ups and the importance of obtaining required immunizations.
Children's Mercy Family Health Partners	**Wellness and Prevention** – This project synchronized the distribution of information to members in coordination with local and national recognition months for health screenings and disease management awareness.

Harmony Health Plan	**Pay for Quality Program** – This project focused on improving access to care and the delivery of quality services to members by rewarding providers when their individual statistics reflected their efforts to assist in improving member education and other preventive services.
HealthCare USA	**Cultural Competency Program** – This program strives to ensure that members receive appropriate care in a culturally-sensitive environment, and further ensures that health plan staff focus on cultural competency at all levels.
Missouri Care Health Plan	**"I CAN…Help My Child Stay Healthy" Project** – The health plan partnered with the Central Missouri Community Action Center ensure that all eligible children in the region were enrolled in Head Start, and that all children in Head Start obtain all preventive health care available. The goals of the partnership include decreased Emergency Room visits and improved parent health literacy.
Molina Health Care of Missouri	**Case Management for Pregnant Women** – **B**eginning **A**nother **B**eautiful **Y**ou through **C**oordination of care, **A**ssessment, **R**eferral and **E**ducation (B.A.B.Y. C.A.R.E.) has been implemented to improve obstetrical outcomes, reduce obstetrical-related hospital admissions and decrease the incidence of pre-term deliveries by identifying, educating and managing members with risk factors throughout their pregnancy.

Conclusion

Review of the SFY 2009 Annual Evaluations submitted by the Managed Care health plans reveal areas in which improvement is evident as well as declines in measures from SFY2008. Health plans should provide year-to-year comparison reports to measure progress/declines in self-reported measures to determine if goals are being met or if changes are warranted to existing processes.

Managed care health plans should only include in their annual evaluation processes and achievements relating to Managed Care and not what they have accomplished in other states and/or commercial lines. Health plans must also adhere to the required format and submit required data when submitting their annual evaluation.

The Managed Care health plans have submitted detailed work plans for the next year which outline their continued efforts in providing quality health care to participants in Managed Care while maintaining compliance with their contract with the MHD.

Annual Enrollment Analysis
For the MO HealthNet Managed Care Health Plans

Enrollment
On July 1, 2008, the start of State Fiscal Year 2009 (SFY09), there were 382,438 individuals enrolled in the MO HealthNet Managed Care Program compared to 401,314 individuals enrolled as of June 30, 2009. Enrollment in the MO HealthNet Managed Care Program increased by 18,876 individuals during SFY09. Statewide there were 850,722 participants enrolled in the Medicaid Program as of June 30, 2009. MO HealthNet Managed Care enrollees accounted for 47.2% of the total enrollment.

There were 196,694 enrollees (49.0%) in the Eastern region, 77,296 enrollees (19.3%) in the Central region, and 127,324 enrollees (31.7%) in the Western region at the end of SFY09. Individuals eligible for coverage under the 1915(b) Waiver accounted for 360,655 (89.9%) of the enrollees and 40,659 individuals (10.1%) were eligible under the Children's Health Insurance Program (CHIP).

Enrollment in the MO HealthNet Managed Care Program increased in all three MO HealthNet Managed Care regions during SFY09.

Please refer to Attachment #1 through Attachment #7.

Auto-Assignments
During SFY09 112,642 enrollees (28.1%) were auto-assigned to the MO HealthNet Managed Care health plans. Of these, 90,650 (80.5%) were eligible for coverage under the 1915(b) Waiver and 21,992 (19.5%) were eligible under CHIP. There were 45934 enrollees auto-assigned in the Eastern region, 25,293 in the Central region, and 41,246 in the Western region during the period July 2008 through June 2009. HealthCare USA in the Eastern region received the majority of the random auto-assignments (14.8%) while Molina HealthCare of Missouri in the Central region received the least amount of the random auto-assignments (1.6%).

Please refer to Attachment #8 through Attachment #10.

Member Selection
Statewide approximately 106,594 members selected a MO HealthNet Managed Care health plan during SFY09. Of those members selecting an MO HealthNet Managed Care health plan, 49,680 (46.5%) were in the Eastern region, 22,655 (21.3%) were in the Central region, and 34,310 (32.2%) selections were in the Western region.

Individuals eligible for coverage under the 1915(b) Waiver accounted for 81,436 of the selections and 25,248 CHIP members selected their own MO HealthNet Managed Care health plan.

The majority of members selected HealthCare USA (25,188) in the Eastern region, HealthCare USA (8,813) in the Central region, and Children’s Mercy Family Health Partners (11,216) in the

Western region. Molina HealthCare of Missouri in the Western region experienced the lowest number of member selections (1,441).

Please refer to Attachment #8 through Attachment #10.

Transfers

There were 25,417 individuals statewide that transferred between MO HealthNet Managed Care health plans during SFY09. Of these, 11,739 individuals (46.2%) transferred in the Eastern region, 5,661 (22.3%) in the Central region, and 8,017 individuals (31.5%) in the Western region.

During SFY09, there were 20,152 individuals eligible for coverage under the 1915(b) Waiver and 5,265 individuals eligible for coverage under CHIP that transferred between MO HealthNet Managed Care health plans.

Please refer to Attachment #11 and Attachment #12.

Supplemental Security Income (SSI) Opt-Outs

During SFY09 there were 269 MO HealthNet Managed Care enrollees that opted-out of the MO HealthNet Managed Care program. Of these, 87.36% were processed by the enrollment broker and 12.64% were processed by the Participant Services Unit at the MO HealthNet Division.

There were 47.96% opt-outs in the Eastern region, 27.14% in the Central region, and 24.91% in the Western region. Of the total that chose to opt-out 98.14% were 1915(b) Waiver participants and 1.86% were 1115 Waiver participants.

The top five opt-out reasons are:

1. Better Benefits – 34.94%
2. Doctor Takes Straight Medicaid – 18.96%
3. No Information Provided from Enrollment Broker – 18.22%
4. Met Medical Opt Out Criteria – 10.78%
5. SSI Eligible – 8.92%

Statewide, 84.76% of enrollees opted-out after enrollment in an MO HealthNet Managed Care health plan and 2.23% chose to opt-out prior to enrollment in an MO HealthNet Managed Care health plan. There were 13.01% that fell into an ‘other’ category.

Special Health Care Needs

During SFY09 there were 10,116 participants identified with special health care needs and were reported to the appropriate MO HealthNet Managed Care health plan. Of these 48.96% were in the Eastern Region, 21.66% were in the Central Region, and 29.38% were in the Western Region.

Race

Across all MO HealthNet Managed Care health plans during SFY09 the race of enrollees consisted of 59.12% white, 36.49% black, .97% Hispanic, .19% Asian, .67% multi-racial and .15% 'other'. There were also 2.41% of enrollees in which race/ethnicity was undetermined.

Eastern region enrollees consisted of 50.12% black and 46.07% white; Central region consisted of 11.88% black and 84.20% white; and Western region consisted of 31.51% black and 62.99% white.

With the exception of HealthCare USA in the Eastern Region, where blacks accounted for 57.07% and whites accounted for 39.45% of enrollees, the majority of all other MO HealthNet Managed Care health plan enrollees were white.

Languages Identified

In all MO HealthNet Managed Care health plans during SFY09 there were 58.99% of MO HealthNet Managed Care enrollees whose primary language was English. Additionally, .63% enrollees listed Spanish as their primary language and 39.25% of enrollees had no primary language listed.

Regionally, enrollees who identified English as their primary language were at 63.26% in the Eastern region; 53.30% in the Central Region; and 56.11% in the Western region. Enrollees who identified Spanish as their primary language were at .33% in the Eastern region, .29% in the Central region; and 1.27% Western region. Enrollees who did not identify a primary language were at 35.06% in the Eastern region, 45.48% in the Central region; and 41.67% Western Region.

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Development, Approval and Monitoring of the Quality Improvement Program

The following information was taken from the MO HealthNet Managed Care health plans' SFY 2009 Annual Evaluations:

Blue Advantage Plus of Kansas City

Quality and Compliance Committee

BCBSKC has an integrated quality and compliance system for its managed care programs. Under the direction of the governing bodies for each managed care program, the Quality Council is the internal committee responsible for day-to-day operations of the quality assessment and improvement program, and for approving recommendations made by other committees relative to the Quality Improvement Program. Other important quality management and compliance related committees include the Delegated Oversight Committee, joint BCBSKC/New Directions Delegated Oversight Committee, Medical and Pharmacy Management Committee, Care Connections Advisory Council, Peer Review Committee, and the BA+ Oversight Committee. These committees meet regularly to evaluate performance toward meeting goals, and to address quality concerns. Minutes and other appropriate documentation are available for each of these Committees.

The roles, functions, and responsibilities of each Committee within BCBSKC are included in the Quality Improvement System Description and Committee Charter. The committee chair is responsible for reporting and functioning of the Committee. The roles, functions and responsibilities of the Medical Director are clearly defined in the job description and the Quality Improvement System Description.

The Compliance Committee is chaired by the Director, Audit Services and Compliance Officer. The Committee meets monthly to address compliance issues. The Compliance Committee acts on reports of oversight activities from the Delegated Oversight Committee, the joint BCBSKC/New Directions Behavioral Health Delegated Oversight Committee, and the BA+ Oversight Committee. Minutes and other appropriate documentation are available.

Analysis of Quality Improvement Process

NCQA Accreditation –BCBSKC is accredited by the National Committee for Quality Assurance (NCQA) for certain of its health plans and programs. BCBSKC renewed its accreditation status of “Excellent”, the highest level possible, for its commercial HMO product, Blue-Care, by the National Committee for Quality Assurance (NCQA). The company’s Preferred-Care Blue PPO product also renewed its accreditation, receiving “Full” accreditation, the highest level awarded for PPO products by NCQA.

BCBSKC is also accredited by URAC for several programs, including Health Provider Credentialing (including the BA+ network), and Health Utilization Management.

Accreditation has been found to be associated with industry best practices. Accredited companies are more likely to measure and report quality performance.
BCBSKC’s corporate policies and procedures, and quality assessment and improvement

program structure, are designed to meet or exceed NCQA and URAC's standards. This infrastructure also supports BA+'s QA&I activities, ensuring that BA+ members and providers, and the State of Missouri benefit from gains in managing administrative costs and improving service and quality of healthcare that are realized from the BCBSKC Quality Improvement Program. Achieving the highest level of quality is clearly the expectation of the BCBSKC organization.

Our NCQA strategy for the next cycle of health plan survey requires BCBSKC to address several significant changes. One of the top priorities in 2009 for the accreditation strategies has been to evaluate BA+ compliance with NCQA standards. The 2009 contract for Medicaid managed care requires BA+ to achieve first-time NCQA accreditation by October 2011, so BA+ will be brought forward with BCBSKC during the already-scheduled survey in 2011.

Overall Effectiveness of the Quality Improvement Program
Strengths and Accomplishments
During three quarters of CY2008, BCBSKC placed in the top five out of 56 Blues reporting entities for Member Touchpoint Measures (MTM). During the third quarter of CY2008, BCBSKC was ranked first among all Plans. Each of the ten MTM Direct Measures within the 100 point MTM index is scored separately and the scores are summed to yield the total score. The combined score is the measure of overall operational performance. BCBSKC ended the year with an average for 2008 of 98.8, favorable to the corporate goal of 97.5 points.

MTM also provides the majority of the key performance measurements used to evaluate the effectiveness of the service quality improvement program and to drive service improvement efforts. In CY2008, nine MTM and three non-MTM measures were the primary means of quantitative evaluation of BCBSKC's performance in the "vital few" areas of operations performance for CY2008. These measures evaluate performance in the key process areas of member and group enrollment; claims operations; and customer service operations.

Service performance met or exceeded goal levels on a consistent basis in eight of the twelve service performance measures: enrollment timeliness; enrollment member accuracy; enrollment group accuracy; claims timeliness; claims frequency accuracy; inquiry accuracy telephone blockage rate; and telephone abandon rate.

Only four of the twelve performance measures did not meet CY2008 goals. The first, claims (dollar) accuracy, missed the goal by only 0.04 percent, and has remained virtually unchanged since CY2006. The second, inquiry timeliness, was 94.9 percent, which is an improvement over CY2006 and CY2007, but does not meet the new, higher, goal of 95 percent set for CY2007. The third, e-mail inquiry timeliness, was 51.7%, which increased by 18.2% in comparison to CY2007. The fourth, benefit phone inquiry accuracy, was 97.6 percent, which decreased slightly over one percent in comparison to CY2007.

During CY2008, BCBSKC continued to build out CareConnection, our comprehensive and integrated care management model. Using the data from the Enterprise Data Warehouse (EDW), predicted risk scores from analytical tools, and campaign engines using complex algorithms within the care management tools in CareAdvance Enterprise (CAE), a TriZetto

product, BCBSKC implemented significant improvements in the preventive health, disease management and case management programs reaching our members. However, problems with the CAE platform continued to plague the CareConnection program, to the extent that certain of the campaigns had to be placed on hold while the technical issues were being addressed in 2009.

Also in CY2008, BCBSKC had improvement in HEDIS "Effectiveness of Care" results. For five measures, more than any other Kansas City health plan, BCBSKC's health plans were the "Best in Kansas City:" These "Best in Kansas City" rates included:

- Diabetes – comprehensive eye exam (also "Best in Kansas City" in 2007 and 2006);
- Advising smokers to quit (also "Best in Kansas City" in 2007 and 2006);
- Cervical cancer screening (also "Best in Kansas City" in 2007 and 2006);
- Follow-up ambulatory visit within seven days after hospitalization for mental health diagnosis (also "Best in Kansas City" in 2007); and
- Breast cancer screening (also "Best in Kansas City" in 2007).

In addition to the "Best in Kansas City" ratings, BCBSKC's Blue-Advantage Plus Medicaid managed care product was also best in the State of Missouri for Medicaid plans for two measures: follow-up ambulatory visit within seven days, and within 30 days, after hospitalization for mental health diagnosis.

Opportunities for Improvement

Due to the distributed nature and number of performance improvement activities across the company, continued strong collaboration between the areas of Quality Management, Operations Support Services, Operations Performance Improvement, Population Management, and Care Management is needed to ensure that strong interventions to improve service and clinical care are ongoing, meaningful to the population, and measured and documented in a way that is acceptable to BCBSKC leadership and external reviewers. Meaningful integration of the quality improvement program goals with those of the corporate business plan will continue to focus on the following broad areas: improving the quality of health outcomes, decreasing healthcare costs, and improving service.

During CY2008, BCBSKC continued to deploy new functionality and process improvements which directly and indirectly support the pursuit of business excellence and provide resources for the systems and processes supporting quality improvement.

Decentralization of clinical and service/operational performance improvement activities continues to bring challenges of oversight, training, standardization of reporting, and communication. Reduction in head count through attrition brings the challenge of managing through contracted staff or restructuring of staff positions. The Quality Management Department continues efforts to provide ongoing refresher education on QI principles and accreditation standards. An important function of the Quality Management Department is to facilitate agreement on strong interventions to improve service and clinical care that are meaningful to the population served, and measured and documented in a way that is acceptable to BCBSKC leadership and external reviewers.

During CY2008, additional quality skills training was conducted using curriculum developed to

meet business needs identified in CY2005. Management and staff in Medical Services and Care Management Divisions received training on qualitative/causal analysis, Plan-Do-Check-Act methodology, and rapid cycle change, using the model used by the Institute of Healthcare Improvement.

Throughout CY2008, the Quality Management Department hosted continuing education through free and reduced-cost webinars and conference calls offered by NCQA, URAC and the BCBS Association on topics related to accreditation, quality improvement projects, and best practices. In CY2007, the StrengthsFinders training program was implemented at BCBSKC. During CY2007 and CY2008 many divisions completed the StrengthsFinder training programs. The concept of aligning individual talents and strengths with available roles has become part of the culture within the divisions. The StrengthsFinder program has been shown to be successful on several levels within these divisions.

Children's Mercy Family Health Partners

Quality and Compliance Committee

The Children's Mercy Family Health Partners (CMFHP) Board of Directors has ultimate authority and responsibility for oversight of the Quality Management Program.

1. Quality Management activities are reported as requested to the Board of Directors by the Medical Director or appropriate staff. Credentialing material is reported quarterly by the Medical Director or appropriate staff.
2. The Medical Oversight Committee (MOC) approves the Quality Management Plan and substantive modifications to the plan.

The MOC has the authority and responsibility to direct the development and implementation of the internal Quality Management Plan, provide overall direction in matters of medical management and monitor the quality of care that CMFHP members receive. The committee meets semiannually to provide program oversight.

The MOC does oversight of the Health Services Committees, Medical Management Committee and Quality Management Committee, which includes the subcommittees that report to them. In addition, the MOC reviews annual work plans, audit results, physician satisfaction surveys, risk management issues and activities of subcommittees. MOC also periodically reviews clinical care, quality of service, Utilization Management reports, provider and pharmacy profile reports, service standards and other quality improvement activities.

Analysis of Quality Improvement Process
Overall Effectiveness of the Quality Improvement Program
Strengths and Accomplishments

As a result of Children's Mercy Family Health Partner's review of 2008-2009 quality performance and improvement efforts, the following strengths and accomplishments were realized in that timeframe:

- Developed a strategy for achieving NCQA accreditation – included hiring an Accreditation Manager, engaging the services of a consultant, providing staff training on NCQA standards, and implementing NCQA workgroups and a steering committee
- Developed a comprehensive Pre-certification Training Manual for new and existing staff
- Completed redesign of the CMFHP website for members and providers
- Completed evaluation and began implementation of a diabetes disease management initiative, aimed at distribution of practice guidelines, reminder systems to members, member lists and reminders to primary care providers, a diabetic newsletter for members, and support of diabetic education through community resources
- Expanded ER Care Management program to include additional high volume facilities
- Continued expansion of disease management programs into additional offices, as well as expanded the asthma program to central Kansas
- Completed software enhancements to the Care Management System (CARE) to support the implementation of online medical reviews and documentation of all clinical functions within Health Services
- Enhanced fraud and abuse program to increase involvement from Provider Relations and Claims/Operations, as well as implemented additional trigger reports to improve identification of potential fraud and abuse issues
- Completed pediatric and adult care management education to high volume providers in Missouri
- Developed and implemented a lead CEU program for providers and their staff
- Began development of a depression disease management program in collaboration with New Directions Behavioral Health, our behavioral health vendor
- Completed cross-training of staff in Prior Authorization and Utilization Review
- Expanded development and use of internal clinical criteria as guidelines for clinical staff decision making
- Strong HEDIS measure performance related to Timeliness of Prenatal Care, Follow-up after Mental Health Hospitalization in 30 days, Well Child in the First 15 Months of Life, and Use of Appropriate Medications for Asthma

Opportunities for Improvement

As a result of Children's Mercy Family Health Partners' review of 2008 quality performance and improvement efforts, the following opportunities for improvement were identified as initiatives for 2010:

- Organization-wide assessment of readiness for NCQA and completion of required processes and procedures to ensure compliance with all standards
- Update the care management documentation system (CARE) to ensure NCQA documentation compliance with complex case management standards
- Implement satisfaction surveys for members receiving care management and disease management services
- Analyze top diagnoses followed in care management, adopt and distribute clinical practice guidelines to support optimal care outcomes to appropriate providers
- Identify barriers to use of spirometry in asthmatics and develop an intervention to improve outcomes

- Implement adult wellness initiatives (i.e. newsletter and reminders)
- Explore other medias to get education to members and providers (i.e. Twitter, online communities, texting)
- Develop a formal inter-rater reliability process for clinical staff decision making
- Implement monitoring system for turnaround times in clinical staff decision making that is more inclusive than the quarterly audit process
- Implement a system to collect race and ethnicity information according to NCQA CLAS standards
- Improve HEDIS measures for Comprehensive Diabetes Care, Breast and Cervical Cancer Screening, Advising Smokers to Quit, Follow-up for Children with ADHD Medications, and Childhood Immunizations Combo 2
- Continue to develop new mechanisms for detecting fraud and abuse
- Enhance delegation requirements for NCQA compliance
    - Investigate barriers to diagnosing obesity in primary care provider offices

Harmony Health Plan of Missouri

Quality and Compliance Committee
Analysis of Quality Improvement Process
Overall Effectiveness of the Quality Improvement Program
Strengths and Accomplishments
Opportunities for Improvement

The purpose of the Quality Improvement Program is to establish a systematic process of measurement, analysis and intervention to assess and improve the quality of service and clinical care provided to Harmony Health Plan/WellCare members. The measures chosen for review are comprehensive, including increasing preventive health services to members, improving clinical quality of care for members, improving customer satisfaction, decreasing cost of care without compromising quality, and decreasing administrative costs.

QUALITY IMPROVEMENT COMMITTEE

The Quality Improvement Committee is responsible for promoting the goals and objectives of the health plan by overseeing the implementation of the Quality and Utilization Management Programs including clinical and service quality, utilization management, credentialing, delegation oversight, and behavioral health management. The QI Committee meets monthly but not less than eight times per year. During 2008, the Quality Improvement Committee met ten times. Minutes are recorded and maintained for each meeting.

The Committee is chaired by the Chief Executive Officer or his designee. Membership is comprised of the following individuals and/or their representatives: The Medical Director, Director of Quality Improvement, Director of Health Services, Director of Credentialing, Director of Appeals and Grievances, and Representatives of Executive Management. The Committee met as indicated on approved minutes. The Committee reports to the Board of Directors.

Committee Initiatives/Focus for 2009 – 2010

- Oversight of Local, State and Federal Regulatory Compliance
- Review and approval of QI and UM Program Description, Work plan and Annual Evaluations
- Oversight of quality measurement Performance Improvement Projects
- Oversight of HEDIS performance measures
- Oversight of Clinical Quality Improvement
- Oversight of Service Quality Improvement
- Oversight of the Credentialing and Re-credentialing Program
- Oversight of Delegation Program
- Oversight of the Utilization, Disease and Case Management Program
- Oversight of the Behavioral Health Program
- Oversight of the Appeals and Grievance Program
- Oversight of the Consumer Advisory Program

MEDICAL ADVISORY COMMITTEE

The Medical Advisory Committee is the principal physician committee that oversees clinical quality improvement, utilization management, customer service quality improvement and appeals and grievances activities. The Committee meets quarterly but not less than 3 times per year. The Committee met as indicated on approved minutes. Minutes are recorded and maintained for each meeting.

The Committee is chaired by the Medical Director. Membership is comprised of the following individuals and/or their designees: Medical Directors, Representative(s) of Executive Management, and Physician Advisors representing primary care, surgery, obstetrics, and sub-specialties as assigned, Director of Corporate Quality Improvement, Director of Quality Improvement, and Director of Health Services. The committee reports to the Quality Improvement Committee.

Committee Initiatives/Focus for 2009 – 2010

- Oversight of clinical and administrative studies (Performance Improvement Projects), HEDIS Measure Performance, Disease/Case & Utilization Management Programs, Member/Provider Surveys, and Medical Record Review
- Oversight of Customer Service Quality Improvement Initiatives
- Oversight of Appeals and Grievances Activities
- Oversight of Clinical Practice Guidelines
- Oversight of Preventive Health Guidelines

APPEALS AND GRIEVANCE COMMITTEE

The Health Plan's Appeals and Grievance Committee monitors appeal trends, and appeals overturn rates as part of the ongoing monitoring activities. They review administrative and benefit member and provider medical necessity appeals and grievances and make final determinations. All appeal and grievance activities are reported to the Medical Advisory and Quality Improvement Committees. If a trend is identified of overturned denials relating to

medical necessity or benefit coverage, an in-depth review of the utilization decision process will be undertaken with the implementation of an intervention plan, as appropriate.

The Committee is chaired by the Medical Director. Membership is comprised of the following individuals and/or their designees: Medical Director; Director of Appeals & Grievance; Appeals & Grievance staff, as appropriate; Physician Advisor(s); One (1) health plan employee; Representatives from Legal or Compliance, as necessary. Voting members include the Medical Director, Physician Advisors, and one (1) health plan employee, all whom have been unaffiliated with the case prior to the review.

Committee Initiatives/Focus for 2009 – 2010

- The Appeals and Grievance Committee will continue the review of member and provider medical necessity appeals and the review of administrative and benefit appeals.
- Continue managing workflow productivity improvements as a result of enhancements to systems and operational processes.
- Continue focus on initiatives with Customer Service to evaluate trends related to provider complaints, Primary Care Provider changes.
- Continue joint project with Claims to conduct root cause analysis of No Prior Authorization Denials.
- Overturn rates will be further explored in 2010 comparing internal and external reviews. These results will be tracked and trended. Any issues that arise from this analysis will be targeted for root cause analysis with corrective action as needed.
- The external review process will be analyzed to determine which specialties are most frequently used. A discussion regarding the findings will be brought to the group.
- Continued upgrades to Appeals and Grievance Database
- Implementation of new technology for scanning and workflow solutions
- Review appeals issues in appropriate committees accordingly

Delegation Oversight Committee

The Delegation Oversight Committee coordinates and oversees all delegated activities ensuring that delegated agencies adhere to contractual, regulatory, and accreditation requirements. The Delegation Oversight Committee ensures compliance with regulatory, contractual, and accreditation standards by maintaining appropriate policies and procedures; monitoring potential delegation activities; completing pre-delegation audits; executing delegation implementation; completing annual delegation audits; monitoring agencies on corrective action; monitoring vendor reporting and data submission.

The Delegation Oversight Committee coordinated compliance with regulatory, contractual, and accreditation standards for 15 delegated entities by maintaining appropriate policies and procedures; completing pre-delegation audits; executing delegation; completing annual delegation audits; monitoring vendors on corrective action; monitoring vendor data submission and performance reporting. There were six delegated entities terminated.

Committee Initiatives/Focus for 2009 - 2010

- Maintain appropriate policies and procedures.

- Monitoring potential delegation activities.
- Completing pre-delegation audits.
- Executing delegation implementation.
- Completing annual delegation audits.
- Monitoring agencies on corrective action.
- Monitoring vendor reporting and data submission.

PHARMACY AND THERAPEUTICS COMMITTEE

The Pharmacy and Therapeutics Committee is the keystone for maximizing rational drug use and managing the complexities surrounding their safe and effective use for WellCare Health Plans. The purpose of the Committee is to function in an advisory, educational, and quality improvements capacity as it relates to drug use. The objective of the committee is to improve the quality of care by: promoting appropriate prescribing and drug selection, establishing and adopting standards of care practices, and managing the cost of pharmaceutical care.

The Committee met as indicated in meeting minutes.

Committee Initiatives/Focus for 2009 – 2010

- Recommending or assisting in the selection of drugs for the Preferred Drug List
- Recommending/assisting in the adoption of, or formulation of broad professional policies regarding evaluation, selection and therapeutic use of drugs
- Participating in the development, implementation and review of clinical pathways for medications
- Initiating and/or directing Medication Use Evaluation (MUE) studies and reviewing the results of such activities. Advise on potential problems related to the over utilization or inappropriate utilization of drugs.
- Assisting in the quality improvement program designed to detect possible or potential issues
- Providing a forum for the review, revision, and approval of policies and procedures, guidelines, standards, etc.

CUSTOMER SERVICE QUALITY IMPROVEMENT WORK GROUP

The Customer Service Quality Improvement Work Group functions as a multidisciplinary work group to identify opportunities for improvement in the customer service provided to our members and providers. The Customer Service Quality Improvement Work Group met as indicated in official meeting minutes.

The Director of Customer Service chairs the work group. Membership includes, but is not limited to, Representatives from Operations, Health Services, Provider Relations, Legal Affairs, Quality and other ancillary departments as identified. Minutes are recorded and maintained for each meeting. The work group reports to the Medical Advisory Committee

The committee reviews data relevant to member and provider grievances and appeals to ensure that individual member and provider issues are addressed, resolutions are appropriate and timely, and that the process is compliant with regulatory standards. Dedicated to the continuous quality

improvement process, the committee facilitates open and consistent communication among members, providers, the QIC and other company departments.

Committee Initiatives/Focus for 2009 – 2010

- Enhance the process to review and trend grievance and appeal data to identify opportunities for improvement.
- Enhance the process to review and trend data related to Primary Care Providers changes to identify opportunities for improvement.
- Enhance the process to review and trend member satisfaction data to understand root causes, process issues (e.g., claims, process issues, plan responsiveness to customer needs/expectations) to identify opportunities for improvement.
- Utilize dis-enrollment codes to identify trends and opportunities for improvement in customer satisfaction and retention.
- Continue to increase service levels and quality (e.g., grade of service, abandonment, and average speed of answer).

HealthCare USA

Quality and Compliance Committee

Quality Management Committee (QMC)

The QMC is delegated by the governing body and administration to prioritize and coordinate all organization wide quality and utilization/performance improvement activities in accordance with the approved Quality Improvement Program Strategy. In addition to the Board of Managers, a review of and recommendations related to quality improvement activities are received from the Executive Quality Committee, the Physician Advisory Council and other departments and committees of HealthCare USA.

The QMC is comprised of HealthCare USA leaders, the Medical Director, and at least five network physicians, credentialed by either HealthCare USA or a delegated entity. The Medical Director, Vice President of Health Services, provider relations and other physicians recommend physicians from the community for participation on the committee. The Medical Director, serving as the chairperson, makes final selection decisions.

The QMC meets at least quarterly, or more often at the call of the Chair. Business is conducted by written agenda, which is maintained on file with the minutes of each meeting.

The QMC oversees the quality and utilization/performance improvement function organization wide, as well as all key processes associated with successful implementation and outcomes. Specifically, the QMC shall:

- Develop, modify, and approve the Quality Improvement Program Strategy prior to approval by the Board of Managers.
- Approve quality and utilization management initiatives based on organization strategic priorities, the QI strategic plan and available resources.

- Prioritize quality and utilization management initiatives and other quality improvement projects based on actual or potential impact on improving outcomes of care and service, member safety, increasing membership, decreasing costs and, review of data and review of organization priorities and objectives.
- Oversee and support cross-functional, interdisciplinary teams; facilitate the involvement of various settings, departments, and/or services in support of team activities.
- Contribute to the plan and design of organizational mechanisms and methodologies to support cross-functional, interdisciplinary quality and utilization management/performance improvement activities.
- Review aggregated data/information feedback from customer satisfaction surveys, utilization management processes, adverse/sentinel events, and other data/information impacting organizational performance.
- Review periodic data and outcome summaries from quality and utilization performance improvement initiatives.
- Oversee a confidential peer review process whereby all practitioner-specific issues are referred to the appropriate peer review committee or manager.
- Determine and support the education and training needs of the organization related to quality and utilization performance improvement.
- Evaluate the effectiveness of the quality and utilization/performance improvement activities of the departments.
- Provide timely summary information concerning improvements in organization performance to all involved.

Compliance Management Committee

Regulatory Compliance staff report all activities, policies, and compliance updates and issues to the Compliance Management Committee (CMC). The Manager of Regulatory Compliance chairs the CMC and is responsible for the plan's overall compliance with applicable Federal and State and regulations. The Manager of Regulatory Compliance chairs the CMC and acts as the plan's key contact for monitoring and maintaining policies and procedures and marketing distributions, tracking annual approval of these documents, as well as state submissions. The Manager of Regulatory Compliance reports directly to the CEO and the CMC reports directly to the Board of Managers.

Within these positions, maintaining and monitoring Health Insurance Portability and Accountability Act (HIPAA) compliance and managing business associate agreements with physician consultants, other subcontractors and vendors is administered. Regulatory QI staff and Finance Department staff monitor and maintain the Medicaid fraud and abuse program as described in the fraud and abuse policies and procedures. All fraud and abuse cases, as well as coordination, prevention and detection activities, are reported quarterly to the CMC and annually to the State agency. All functions within the Regulatory Compliance department and all fraud and abuse activities are incorporated into the health plan's Compliance Plan. This Plan adheres

to the seven elements of a Compliance Plan, consistent with the Office of Inspector General (OIG) compliance elements.

Education for all compliance standards is provided to employees, members and providers via a variety of different avenues in order to ensure understanding. Education is key to administering compliance and lessening deficiencies. Regulatory Compliance staff conduct internal audits to ensure compliance with all applicable regulations and requirements, including but not limited to the code of federal regulations (CFRs), the code of state regulations (CSRs), HIPAA requirements and the deficit reduction act (DRA). All findings are presented to the CMC to aid in setting compliance standards, the identification of vulnerable areas and associating risk (low, medium, or high) and to monitor ongoing compliance accordingly. The CMC is responsible for initiating corrective action plans as deficiencies are detected.

The CMC reports summary activities at least annually to the Quality Management Committee, the Executive Quality Committee, and at least annually to the Board of Managers. Annually, the CMC evaluates the impact of the Compliance Plan using audit results and oversight information. This information is presented to and approved by the Quality Management Committee (QMC), as delegated by the Board of Managers.

Executive Quality Committee & Physician Advisory Council

HealthCare USA developed an Executive Quality Committee and a Physician Advisory Council (PAC) in 2007. The Executive Quality Committee reviews, makes recommendations, and approves the activities of the Quality Management Committee, the Credentialing Committee, Peer Review Committee, Complaints, Grievances and Appeals Committee, and the Compliance Management Committee, including non-clinical issues related to regulatory compliance, corporate compliance and fraud and abuse. The Committee meets at least quarterly and includes members of senior leadership and the Senior Executive. The committee is responsible for reviewing the activities and providing feedback to the individual committees.

The purpose of the PAC is to provide advice and guidance in areas such as physician services, plan activities affecting physician providers in the community, medical and pharmacy management and specialty programs. The PAC was expanded in 2009 to have a PAC in each region. The Medical Director(s) appoints at least eleven (11) community physician members to reflect a balance of viewpoints, education and experience representing physician practice in rural areas, underserved and urban areas. The PACs meet at least bi-annually and reports to the QMC.

Analysis of Quality Improvement Process

HealthCare USA implemented the rapid cycle methodology in 2007 and continues to use of this methodology to identify, prioritize and accelerate improvement processes and to maintain a focus on targeted improvements. This methodology identifies, implements and measures change to processes. This methodology is flexible in the ability to incorporate lean, six sigma and other performance improvement tools and methods. With the rapid cycle methodology, an overall project goal or aim is defined with specific process and outcome measures. Improvements occur through small rapid PDSA (Plan, Do, Study and Act) cycles or tests of change identified and implemented by a multi-disciplinary team. Decisions to expand, revise or stop a test of change are based on review of data collected, analyzed and reviewed at team meetings.

The PDSA cycle of change involves four steps. A Plan for a test of change is set based on theory and best practice. Do, on a small scale, a test to determine effectiveness without wasting resources. Study the outcomes of the small scale implementation and Act by applying the change to a larger population, stopping the change or revising the change. Outcomes of small tests of change can be seen in real time or a nearly immediate basis, which allows numerous cycles of tests of change to occur in a short period of time. There are often several PDSA cycles for each improvement project implemented.

This quality improvement process has allowed HealthCare USA to more efficiently manage, evaluate and track clinical and operational quality improvement projects. The on-going education and evaluation of the program helps HealthCare USA improve and maintain best practices in managed care, as well as practices that are consistent with evidenced based clinical practice guidelines and national quality improvement standards.

Overall Effectiveness of the Quality Improvement Program

HealthCare USA's Quality Improvement Programs have been effective in meeting and exceeding many of the goals set for individual projects and organizational objectives. Through the analysis and evaluation of past outcomes and current data, the plan has been able to implement multiple improvement projects, workgroups and task forces to improve outcomes of care and service, safety, satisfaction and costs across all three (3) regions of Missouri.

HealthCare USA continues to meet the needs of our diverse membership, expanded services and established strong partnerships with agencies and organizations dedicated to improving the lives of the general population, minority cultures and other disparate populations in Missouri. HealthCare USA continues to strengthen partnerships in rural communities to help prevent avoidable out-migration of care and provide the best services for this population.

In 2008 and 2009, the EPSDT/HEDIS work group implemented additional improvements to focus resources and coordinate efforts across functional areas of the organization. Changes implemented with a multi-disciplinary team reduced duplication of efforts and focused resources, resulting in implementation of many interventions and an overall improvement in measures from calendar year 2008 and again in 2009, without an increase in resource utilization. The most significant improvements have been seen in adherence to asthma medications, timeliness of prenatal care, adolescent well care, Chlamydia and cervical cancer screening, mental health follow up after hospitalization and annual dental visits. HealthCare USA will continue this approach in achieving the HEDIS National Medicaid 75th percentile or higher for all HEDIS measures.

HealthCare USA's 2008 and 2009 Child CAHPS member satisfaction survey rates continue to improve in most areas as compared to previous years. The results for Health Plan Overall for Eastern and Central regions were significantly above the 2007 and 2008 Medicaid averages. The HealthCare USA Overall rate significantly improved in the Western region in 2008 and 2009. In 2009 the Adult CAHPS survey was completed statewide to establish a baseline for the survey required for NCQA accreditation. HealthCare USA will continue to strive to meet and exceed the needs of membership and improve satisfaction with the Plan.

The HealthCare USA provider network has remained appropriate for the membership. HealthCare USA members had 100 percent access to Primary Care Providers in Central, Eastern, and Western regions in Missouri. The appointment availability and after hours access study revealed appropriate access. Results of surveys and audits are used by the Provider Relations Department to educate providers identified as not adherent to the standards individually and through newsletters and the provider web site with for all providers. Provider Relations staff also complete closed panel investigations and do secret shopper surveys to verify that providers are adherent to access standards.

HealthCare USA continues to support a robust Fraud and Abuse Program. A "lunch-n-learn" staff education program and monthly regulatory compliance on-line quizzes were provided in addition to periodic updates and reminders in newsletters and other employee communications.

HealthCare USA maintains a focus on ensuring effective and efficient processing of data in the claims, membership, and provider software systems. Data tracking and reporting for each of these areas continue to meet or exceed company and state standards. HealthCare USA continues to assess processes to identify opportunities and implement activities to improve information systems.

Overall provider satisfaction with HealthCare USA and the Customer Service Department has continued to improve since 2007. HealthCare USA continued the provider seminars in 2008 and 2009, to improve communication and collaboration with providers in each region. In 2009, over 15 seminars were held across all three regions of Missouri. Physician Management Advisory Councils (PMAC) continue to meet routinely for on-going provider education, to help increase provider office staff knowledge about new programs, processes and projects, as a forum for provider office staff to identify and discuss barriers and challenges they are encountering, and to make suggestions for improvements in our programs, processes and projects.

Within Health Services, opportunities to improve clinical, functional, cost, safety and satisfaction outcomes through utilization management, case management and disease management programs were identified. Changes, resulting in improvements and additional opportunities, have been implemented. Details of various clinical and operational performance improvement projects are included in the detailed sections of the annual evaluation.

To improve communication, coordination, consistency and on-going education, daily in-patient rounds, combined case management and disease management rounds twice a week, and grand rounds with the Medical Directors, Concurrent Review, Case and Disease Management staff continued. Staff from MHNet began co-locating in 2009 to improve ease of communication and coordination. HealthCare USA social work continue assist in resolving social issues that impact medical outcomes. Routine care management rounds with one of the high volume FQHCs continue and additional face to face routine care management meetings have been started with other providers.

Health Services staff continue to asses the needs of members identified by the state health risk assessment and refer to appropriate services within the Plan. In addition, a standardized process

for adult and child health risk assessments was implemented using a national vendor, SynCare. Data from this health risk assessment is transferred to the clinical staff, where individual members identified as having elevated risk levels are referred for additional assessments, identification, and resolution of specific resource needs. Diagnosis specific clinical and functional health risk and member-defined needs assessments have been implemented as part of the High Risk OB, Asthma and NICU Disease Management programs. These are also being developed for implementation in the Sickle Cell Disease Management program and the revisions to the Diabetes program.

Review of utilization data, including hospital readmissions, emergency department (ED), prenatal care and pharmacy data to identify under and over utilization resulted in identification of an opportunity to improve early identification and intervention for members at risk for post partum depression and for members diagnosed with ADHD. Focus studies in collaboration with MHNet were implemented and will continue in 2010.

In addition to improving communication, coordination and collaboration with HealthCare USA clinical staff, MHNet continued to focus improvement efforts on ambulatory care and family therapy for children and adolescents. MHNet has an ongoing ambulatory follow-up performance improvement project (PIP) to address the needs of patients following discharge for a mental health illness. HEDIS 2008 and 2009 data analysis show significant improvement in measures of Follow-Up After Hospitalization for a Mental Illness both at the 30 days interval and at 7 days post-discharge.

MHNet has also continued to implement interventions to improve coordination of care and services between behavioral health providers and primary care providers. A variety of strategies have been implemented focusing on members receiving family therapy for children and adolescents and members receiving pharmacotherapeutic interventions for behavioral health diagnoses.

The Quality Management Committee continued the annual review and approval of all evidence based clinical practice guidelines (CPGs) and review and approval for adoption of new CPGs. A list and summary of the content of the guidelines are available on the HealthCare USA provider website and in the provider manual. Direction about how to obtain written copies of complete CPGs electronically and in writing are included on the website, in denial letters and periodically in the newsletters and in new provider packets.

For every project, where evidence-based clinical practice guidelines and best practice protocols are available, they are reviewed by the QMC and PAC, adopted, and incorporated as the basis for member and provider education and other interventions. Other evidence-based clinical practice guidelines, such as the American Diabetic Association guideline for diagnosis and treatment of diabetes and the guidelines for assessing and managing obesity, have been adopted and are the basis for projects related to these topics.

HealthCare USA continues to effectively manage the credentialing and re-credentialing needs of the provider network. New providers continue to be added to the network and existing providers are re-credentialed at least every 36 months. The credentialing department function was moved

to the provider relations department in November of 2008. The 15 delegated credentialing entities have continued to pass annual on-site oversight evaluations and routine reporting requirements. Monthly calls with the Credentialing Verification Organization (CVO) continue to improve ongoing coordination and collaboration between the CVO and Provider Relations staff working in this area. In September of 2009, fifty files were reviewed by the URAC on-site surveyor and found to be adherent to all credentialing and re-credentialing standards.

In 2009, the quality improvement team changed the process for on-going provider monitoring on-site visits and medical record reviews to complete an audit of a random sample of 5-10% of provider with clean and green files and 100% of providers who do not have a clean and green file in the credentialing or re-credentialing process. Quality improvement staff will continue to do complete investigations when a quality of care issue or safety issue is identified that cannot be resolved with a documentation request and discussion with the provider involved. The chart audit tool has been enhanced to not only assess for EPSDT, HEDIS elements, general documentation guidelines, and adherence to evidence based clinical practice guidelines, but to also assess the provider site for adherence to safety standards. Claims are reviewed for consistency between documentation in the clinical record and claims data submitted to HealthCare USA. On-going provider education is completed with each visit.

While very few providers scored less than 80% during 2008 and 2009, a plan of correction and schedule to re-audit continues to be completed for those who do score less than 80%. The most frequent issue identified with the addition of claims review is a lack of claim/encounter filing for services provided. All issues identified during on-site audits and medical record reviews were resolved without additional progressive action being required.

Improving coordination of care and services with subcontractors and other providers through improved communication and collaboration continued to be an area of focus in 2008 and 2009. Mental health services are contracted to MHNet, dental services to Doral Dental, transportation services to MTM, pharmacy adjudication through October 1, 2009, to Caremark Pharmaceuticals and the 24 hour nurse line to McKesson. In addition to routine attendance and reporting to the QMC, co-locating behavioral and medical care management and combined rounds as described earlier, MTM and Doral Dental participate in rounds on an ad hoc basis. Both actively participate and report activities at QMC meetings each quarter and participate in other on-going performance improvement activities. In addition to the corporate oversight and routine reporting, daily member call logs are provided by McKesson for review and follow up by HealthCare USA clinical staff.

Provider complaints, grievances and appeals and member grievances and appeals have been an area of focused improvement since 2007, on-going through 2008 and 2009. A multi-disciplinary, interdepartmental team focused efforts on decreasing the rate of complaints, grievances and appeals received. The team also monitors overturn rates and timeliness on an on-going basis. Data is reviewed at department meetings related to accuracy to identify trends, complete barrier analyses related to interventions tested and define new interventions or tests of change. Complaints and grievances are also screened for potential quality of care issues and referred when appropriate.

The utilization management staff and medical directors monitor performance data including number of calls received, turn around times, denial rates, overturn rates, and the outcomes of inter-rater reliability and documentation chart audits. New resources have been dedicated to increasing current and new employee knowledge through participation in InterQual® train-the-trainer education programs and implementation of a revised process and a tool for on-going member files reviews and interactive case presentations and discussions. A performance improvement project focused on improving UM decision making and documentation to reduce variability and improve documentation was started in 2009. We anticipate continuing this as we complete preparations for the NCQA accreditation survey process.

Strengths and Accomplishments

In 2008 and 2009, HealthCare USA continued to collaborate and share best practices with national resources, subject matter experts and with local community based partners and stakeholders to more efficiently and effectively implement programs to continue to improve clinical, functional, cost, satisfaction and safety related outcomes of care and service.

In addition to programs focused on member and provider services and assuring on-going contract compliance, HealthCare USA maintained compliance with URAC standards, as evidenced by the outcome of the 2009 on-site interim monitoring survey. "URAC is a not-for-profit organization that promotes continuous improvement and efficiency of health care management through process of accreditation, education and measurement" (URAC, 2007). The accreditation process evaluates quality procedures, operations and accountability for health care organizations through nationally recognized, publicly available standards, thus increasing transparency for consumers, providers and regulators. HealthCare USA continues to prepare for achievement of NCQA accreditation by the end of 2010.

As a result of our commitments and efforts, in addition to URAC accreditation, the following lists examples of some of the successes HealthCare USA achieved during 2008 and 2009 in improving member access to quality healthcare, improving outcomes of care, services, safety, satisfaction and reducing costs:

- Expansion of the Balanced Scorecard for on-going tracking and comparison to goals for key clinical, operational, safety and satisfaction measures resulting in earlier identification of opportunities for improvement and successes achieved. Measures to specifically assess health care disparities are being added.
- Selection by the National Initiative for Children's Healthcare Quality (NICHQ) for poster presentations of the Asthma and High Risk OB Disease Management Programs at the 4th National Forum for best practices.
- Enhancement of employee knowledge including:
    - The State contract, fraud and abuse, HIPAA and national URAC and NCQA standards throughout the Plan.
    - Completion of InterQual® train-the-trainer program and implementation of the InterQual® inter-rater reliability testing and on-going education.
    - Completed implementation of the CLAS standards for cultural competency by end of 2nd quarter, 2009 and including implementing multiple opportunities for staff and provider participation in training.

- Improved collaboration, coordination, and information sharing with providers, subcontractors and members through:
    - Expansion of PCP on-site visits, care management meetings and on-going routine PMAC meetings for education in areas such as: documentation, communicable disease reporting, mental health access, medical record management, access standards, 24-hour availability requirements, HEDIS and EPSDT, evidence based clinical practice guidelines, and HealthCare USA requirements.
    - Successful completion of peer to peer educational baby showers incorporating mentoring of high risk OB members by members who delivered, but had high risk pregnancies in each region in 2009; implementation of the CODE BEAR programs in Eastern region and Western region in 2009.
- Improvement in EPSDT participation ratios, HEDIS measures and CAHPS scores through:
    - On-going provider education.
    - On-going member incentive programs for pregnant member's adherence to prenatal and post partum visits and for asthmatics adherence to NAEPP asthma guidelines for PCP visits, medication refills and identification of a rescue person.
- Continued expansion of interdepartmental and cross care settings, multi-disciplinary performance improvement teams to address over and under utilization and patient safety including (but not limited to):
    - Non-urgent/avoidable ED performance Improvement project
    - Hospital readmissions performance improvement project
    - Synagis utilization performance improvement project
    - Post-partum depression focus study
    - Obesity reduction performance improvement project
    - Cultural competency/the reduction of healthcare disparities
- Continued evaluation and improvements in the special needs processes.
- Continued development of new and enhancement of existing strategic community partnerships in all regions to improve equitability as evidenced by:
    - Successful community health fairs providing physicals, dental screenings and other services in the local communities of all three regions.
    - Successful implementation of a student nurse internship program, medical record abstractors and coder's externship program and implementation of an MPH internship program in collaboration with St. Louis University School of Public Health.
    - Selection by NCQA as one of five field test sites nation wide for child measures. Other plans nation-wide that were selected include Americgroup, Kaiser Permanente, Promedica and Community Partners of Louisiana.
- Improved processes to assess member and provider satisfaction and to identify needs and gain subject matter expertise by:
    - Implemented a revised process for program specific satisfaction surveys to increase the member response rate.
    - Expanded active participation on the High Risk OB Task Force and Asthma Task Force, the NICU team and the Sickle Cell Disease Management program development to include external subject matter expertise from across all three regions.

HealthCare USA believes the following have been key to our success:

- Support of an organizational framework for quality improvement that encourages on-going active learning, knowledge sharing, team work and open communication.
- Development and enhancement of technologies to identify actionable opportunities and track, trend and report clinical and non-clinical service, safety and satisfaction metrics.
- Commitment to collaborate and align incentives with members, stakeholders and other organizations for performance improvement activities focused on improving outcomes of care, service, safety and satisfaction to maximize timeliness, efficiency, effectiveness, patient-centeredness and equitability.
- Commitment to continuously improving organizational and administrative capacity to assure that enrollee's protection remains the focus of our work.

Opportunities for Improvement

Continue efforts to increase our network of appropriate providers, particularly specialists, to continue to improve equitability and timeliness, and reduce out-migration, as evidenced by both access and availability metrics pediatric mental health and pediatric dental services in particular, but for all services covered under the current contract and any future expansions.

- Continue efforts to improve monitoring mechanisms that support the ongoing evaluation of our network and ensure that all services covered are available and accessible to members while avoiding unnecessary out-migration of services.
- Continue to improve clinical and non-clinical outcomes for safety, efficiency, effectiveness, timeliness and patient-centeredness by increasing the number of members screened, enrolled and actively participating in appropriate well care activities, case management or disease management services and programs.
- Continue to identify opportunities to improve member adherence to treatment and preventive/well-care guidelines, by testing different interventions to eliminate real and perceived barriers to care and services, with success evidenced by improved EPSDT participation ratios and HEDIS rates and decreases in over and under utilization of services.
- Continue to collaborate with the State regarding screening data on members with special health care needs, lead screening and other processes that impact care and services for all Medicaid managed care members across the state.
- Continue to evaluate and refine member outreach educational activities and mechanisms to improve safety, efficiency and effectiveness, and patient-centeredness of outreach activities.
- Continue to monitor and improve information management and transparency through on-going internal and external data reporting, record reviews, and review of provider and member feedback processes.
- Continue to improve the processes and tools utilized to assess and measure key aspects of quality of care, quality of services, and safety.
- Continue to partner with community stakeholders and the Cultural Competency Committee to identify and decrease disparities in healthcare across Missouri.
- Continue to improve working relationships and coordination internally and with providers and members by seeking input and feedback to align incentives, improve quality of care, quality of service, as measured by CAHPS and program specific satisfaction surveys.
- Continue to seek input and feedback from and collaborate with members to reduce barriers to care and services and continue to improve member satisfaction.

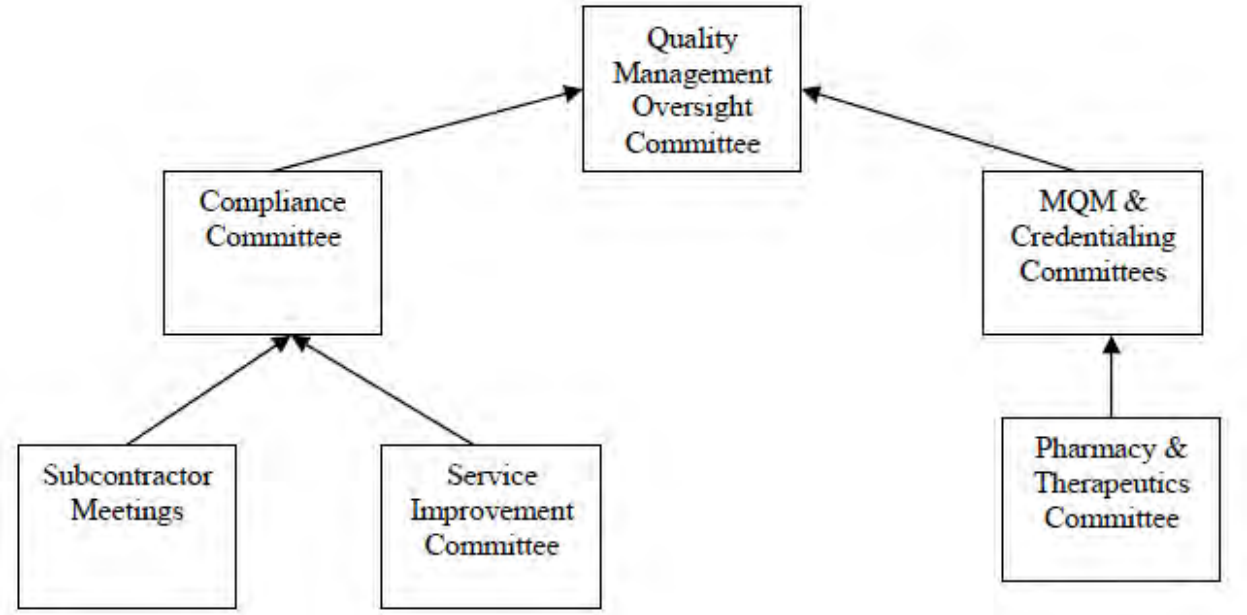
- Identify gaps in care and continue to address collaboration with the behavioral health vendor to improve continuity of care across settings and through transitions for members with behavioral health needs and co-morbid medical conditions.
- Continue to assess and identify opportunities to improve utilization management decision-making.
- Institute a regular, on-going, interdepartmental and interdisciplinary forum for patient safety concerns and projects.

Missouri Care

Quality and Compliance Committee

Several committees oversee the Missouri Care Quality Improvement Program. The structure of the committees is presented in Figure 1. All quality committees report up through the Quality Management Oversight Committee (QMOC), which has ultimate accountability for the quality management program. The following is a description of each of the quality committees, their roles and key issues identified through these committees in SFY 09.

Figure 1: Missouri Care Quality Committee Structure



Medical Quality Management Committee (MQM)

The MQM Committee advises and makes recommendations to the Senior Medical Director and to the QMOC on matters pertaining to the quality of care and services provided to members. The committee is made up of a diverse body of providers from the Missouri Care network. The Committee uses the peer review process to evaluate and address specified care, service, or utilization issues arising from the activities of health care professionals or providers in order to improve the quality and appropriate utilization of health care available to members.

During SFY 09 the MQM Committee met quarterly. The committee reviewed five potential quality of care cases that were elevated to the committee by the CMO. After reviewing the cases, the committee determined four were assigned a Severity Level 1 and one was assigned "track and trend" status with an action plan. Severity Levels assigned by the committee designate the seriousness of quality of care or utilization issues and inform options for further action. All levels of severity are tracked and any further action documented in the file of the health care professional or provider.

The committee also advised Missouri Care on HEDIS performance measure improvement initiatives and Performance Improvement Projects. In November 2008 the committee approved the 2008 Annual Evaluation, the 2009 Quality Improvement Plan/Work Plan, and the 2009 Utilization Management Plan. All of these plans were updated for the new 10/1/2009 contract and the revised plans were approved in August 2009. Also approved in August were Missouri Care's new Cultural Competency Plan and Work Plan, and the development of a new Community Outreach Advisory Council on Health (COACH).

Credentialing Committee
The Credentialing Committee advises the Senior Medical Director on the credentialing and recredentialing of health care providers in the Missouri Care provider network. In 2009 this Committee was merged with the MQM Committee. In November 2008 Missouri Care partnered with Aetna's credentialing verification organization, At Credentials, Inc (ACI), to provide primary source verification services for credentialing and re-credentialing. The committee met four times in SFY 09. During this period, 321 providers were presented to the committee for initial credentialing and 146 were presented for re-credentialing. The committee recommended approval of 319 of the initial credentials and 146 of the recredentials. ACI presented 6 denials to the committee for initial credentialing. The recommended denials, with the exception of two, were later recommended for approval. The committee also reviewed the annual audit reports of the 7 delegated credentialing organizations. No corrective action was taken for any of the delegates.

Pharmacy and Therapeutics (P&T) Committee
The Senior Medical Director is responsible for directing and overseeing management of Missouri Care's pharmacy services with the advice and participation of the Pharmacy and Therapeutics Committee (P&T). Missouri Care contracts with Express Scripts, Inc. (ESI) for pharmacy benefits management. ESI administers the pharmacy benefit through a network of pharmacy providers. However, Missouri Care is responsible for oversight of pharmacy activities, utilization and quality concerns, resource management, and complaints.

The P&T and ESI Committees met three times in SFY 09, and accomplished the following: formulary review, clinical pharmacy reviews (requests for prior authorization and non-formulary medications), and tracking high volume, high cost drugs. The Preferred Drug List was reviewed and submitted to the state for approval in SFY 09. The committee developed a transition process to ensure a smooth transition to pharmacy benefit coverage by the state effective 10/1/09. Missouri Care's pharmacy generic fill rate increased from 78% in SFY 08 to 82.1% in SFY 09.

ESI continued to work on decreasing the price of single-source brand prescriptions; fulfilling its' contractual obligations to Missouri Care as the pharmacy benefits manager.

Service Improvement Committee (SIC)
The SIC advises and makes recommendations to the QMOC and Missouri Care's management team about member and provider service concerns. During SFY 09, 79 issues were brought to committee and all were reviewed and resolved. The major concerns for this time period were dental access and pharmacy issues. Formulary questions were forwarded to Missouri Care's Senior Medical Director for peer-to-peer education, while cases suggestive of substance abuse were referred to case management. Missouri Care was well aware of the dental issues facing our members, and continues to work closely with Doral Dental to increase access.

Quality Management Oversight Committee (QMOC)
The committees previously described and the Compliance Committee report to the QMOC. The QMOC integrates quality management activities throughout the health plan and provider network. The committee is made up of the Missouri Care management team. The team met quarterly during SFY 09. The committee reviews the minutes and issues from the other quality committees. Additionally, each department manager reported on his or her own internally developed measures of quality. Examples include NICU admission rates, percent of claims received through EDI, and member and provider appeals. The content and completeness of the measures were reviewed during SFY 09 and revised as appropriate.

Compliance Committee
The Missouri Care Compliance Committee meets in conjunction with the QMOC, and is comprised of the same voting members of the QMOC. During compliance meetings, issues are discussed that include, but are not limited to, HIPAA issues, policies and procedures, state notifications, state reporting requirements, and fraud and abuse. The Compliance Committee tracked 21 issues in SFY 09. Most of the reported issues were resolved within the same month. All issues can be identified by one of the following four categories:

Reportable Compliance Items
Reportable compliance items include search warrants, interviews/investigations, risk management issues, reports to the compliance hotline or exit interviews. There were two reportable compliance items reported in SFY 09 in which a phone number for Doral Dental was made available to members before it was activated. Law enforcement requested one member's record.

Suspected Fraud and/or Abuse
Suspected fraud and/or abuse items include concerns related to providers, members, employees or subcontractors. There were three suspected fraud and/or abuse items reported in SFY 09. The first case was a request from MHD for information regarding a particular provider. The second case involved a pharmacy which allegedly and inappropriately charged members' a dispensing fee. The third case was a request from MHD for claims data and information regarding DME equipment and supplies.

Security Incidents
A security incident may involve issues related to human life and safety, systems and data, or facilities. There was one incident where records were inadvertently destroyed by the records storage contractor.

Privacy Incidents
Privacy issues encompass reviews of proposed disclosure, requests for records, and accidental disclosures or complaints. There were 14 privacy incidents reported in SFY 09. They included seven accidental disclosures of PHI -- four via inadvertent faxes, two RAs sent to the wrong provider, and one member identification (DCN) number printed on an envelope. There were also six requests for a copy of member records and one request to review a proposed disclosure of patient records. Lastly, one member claimed that Missouri Care revealed her DCN before she identified herself Compliance issues can be reported verbally or in writing to the compliance officer or any member of management. Members, providers, employees or others may report issues anonymously via Missouri Care's compliance hotline.

Analysis of Quality Improvement Process
Missouri Care's process of quality improvement is one of constant evaluation. Missouri Care annually reviews its Quality Management Plan to identify any needed changes to the plan. Changes may include improvements in quality initiatives or follow-though in any instances in which Missouri Care did not adhere to the plan. Missouri Care also develops a quality improvement work plan each year. (See Appendix B for the 2010 Quality Improvement Work Plan). The plan is used to set priorities and to guide new or continuing initiatives. It is referenced and updated as needed throughout the year. The plan is also used at the end of the year to identify quality processes that were successful and processes that need to be changed or replaced in the next year. The Quality Department is responsible for the overall quality plan, but Missouri Care strives to have a quality program that is integrated across departments. Missouri Care also relies on its provider network to evaluate and make recommendations to its' quality improvement process.

Overall Effectiveness of the Quality Improvement Program
Strengths and Accomplishments
Below are the highlights of Missouri Care successes in delivering quality services to members and network providers in SFY 09.

Quality Indicators
• Missouri Care exceeded the National Committee on Quality Assurance's (NCQA) 75th percentile benchmark for Medicaid Managed Care Plans on the following HEDIS measures: Cervical Cancer Screening; Timeliness of Prenatal Care; Postpartum Care; and Well Child Visits in the First 15 months of Life.

• Effectiveness of Care**.** Over the past four years, the health plan significantly improved in, or maintained top state performance in five out of six Effectiveness of Care measures. There were significant rate improvements in Childhood Immunizations (CIS) Combo 3, Follow-up After Mental Health Hospitalization (FUH 7- and 30-day), and Use of Appropriate Medications for People with Asthma (ASM).

• In SFY 09 Missouri Care's performance on two Effectiveness of Care measures remained best-in-state: CIS Combo 3 and Cervical Cancer Screening (CCS). Performance on the CIS Combo 3 measure has steadily improved to 66.23% in HEDIS 2009. Although the CCS rate dipped over the past measurement year to 70.25%, it still matches the national NCQA Medicaid 75th percentile.

• Missouri Care also significantly improved its' Follow-Up After Hospitalization for Mental Health – 7 Day rate, from 30% in HEDIS 2008 to 39.34% in HEDIS 2009.

• Access and Availability of Care. Over the past four years, the health plan significantly improved in, or maintained top state performance in two out of three HEDIS Access and Availability measures. Missouri Care's HEDIS 2009 rate for Timeliness of Prenatal Care (TOPC) was 92.08%, which is statistically equivalent to the national NCQA Medicaid 90th percentile. The HEDIS 2009 Post-Partum Visit (PPV) rate placed the health plan in the top 75th percentile of all Medicaid health plans.

• Use of Services. Since HEDIS 2006, Missouri Care has performed at or above the national 75th percentile on Well Child Visits In the First 15 Months of Life (W15; six or more visits). The HEDIS 2009 rate was 66.93%, which was far above the statewide average of 50.26%. During the same time period, the health plan maintained best-in-state performance on Adolescent Well Care (AWC); in HEDIS 2009 the rate was 43.06%.

• Ambulatory Care is another HEDIS Use of Services measure. Outpatient visits per 1000 member months increased by 17%, or 75 visits per 1000 between HEDIS 2006 and HEDIS 2008, but decreased slightly in HEDIS 2009 (456/1000). During the same period, emergency department visits per 1000 member months have remained relatively unchanged (76/1000). This ratio indicates that ED visits are declining as a percentage of all ambulatory care visits. Although Missouri Care did not observe a significant decrease in ED utilization, an upward trend in use has been avoided for four years.

• Member Satisfaction. For CAHPS 2009, Missouri Care exceeded the CAHPS 2008 MO HealthNet statewide average on all overall performance ratings except Rating of Specialist, for which there was no significant variation. Attesting to the strength of Missouri Care's provider network, members were significantly more likely than the survey vendors' other national plans to report that their PCP spent enough time with their child (Mean rating 91.3% vs. 84.5%). Members also rated Missouri Care highly in the areas of Getting Needed Care and Getting Care Quickly.

Accessibility of Services

• Maintained average speed of answer for phone calls for Prior Authorization, Behavioral Health, and Member Solutions, at 18 seconds, 18 seconds, and 13 seconds respectively. This is below the goal of 30 seconds.

• The average abandonment rate during SFY 09 for Prior Authorization, Behavioral Health and Member Services Departments, was 1.97 percent, 3.69 percent and 1.32 percent,

respectively. All were well below the industry standard of 5 percent.

• Missouri Care has steadily grown its provider network. By June 2009, the network had grown to 678 PCPs, 2.377 specialists, and 644 behavioral health professionals.

• To monitor appointment availability within the provider network, Missouri Care conducts an annual telephonic survey of PCPs and behavioral health professionals. In the most recently completed survey from 2008, 100% of PCPs and 93% of behavioral health providers were found to be compliant with appointment availability standards.

Fraud and Abuse
• The Fraud and Abuse team met state standards in monitoring provider and member complaints, as well as delegation activities. In SF 09 Missouri Care received no state sanctions.

Quality Management
• Biopsychosocial Case Management. Medical Management continued to increase efforts towards integration. Complex cases were presented to an interdisciplinary team consisting of medical and behavioral health professionals. Core biopsychosocial trainings were provided to all clinical staff. Trainings included:
- Introduction to Behavioral Health
- Medication Adherence
- Introduction to Substance Abuse
- Traumatic Brain Injury
- The Biopsychosocial Model
- The Major Psychiatric Disorders
- Engagement and Retention
- Presenting a Complex Case
• Maintained NCQA accreditation of Missouri Care's disease management program.
• Provider Training. Partnered with the University of Missouri's Clinical Simulation Center to provide an educational opportunity to community physicians to improve brief screening and treatment techniques in substance abuse. Each provider assessed four simulated patients and then participated in a debriefing with fellow colleagues.

Performance Improvement Projects (PIPs).
• In SF 09 Missouri Care implemented seven PIPs to improve member health care and outcomes. Four clinical PIPs addressed member adherence with medical recommendations: 1) Medication adherence of members diagnosed with persistent asthma, 2) WIC participation impact on well-child visits, 3) Chlamydia screening, and, 4) Lead screening. Non-clinical PIPs targeted use of services and access to care, including: 1) Adolescent well care visits, 2) Follow-up appointments within 7 and 30 days of mental health hospitalization, and 3) Reduction of inappropriate emergency room visits. Significant improvements in care and service were documented.

Opportunities for Improvement
The following are opportunities for improvement for SFY 10:
• Successfully implementing and reporting effectiveness of Missouri Care's East-West expansion
• Improving EPSDT participation rates
• Improving dental access/annual dental screening rates
• Improving well child visits for members three, four, five, and six years of age
• Increasing lead testing rates
• Decreasing non-urgent emergency department utilization
• Implementing an enhanced Cultural Competency program

Molina Healthcare of Missouri

Quality and Compliance Committee
The Molina Healthcare of Missouri (MHMO) Board of Managers has the ultimate authority and responsibility for the quality of care and service delivered by MHMO. The Board of Managers is responsible for the direction and oversight of the Quality Improvement (QI) Program and delegates authority to the Quality Improvement Committee (QIC), under the leadership of the Chief Medical Officer (CMO) and the plan President.

MHMO's QIC is responsible for the implementation and ongoing monitoring of MHMO's QI program and meets at least quarterly or more if needed. Through the QI sub-committees, the QIC policy decisions, analyzes and evaluates the progress and outcomes of all quality improvement activities, institutes needed action and ensures follow-up. The QI sub-committees include the following:

- Utilization Management Committee (UMC)
- Professional Review Committee (PRC)
- Clinical Quality Improvement Committee (CQIC)
- Member/Provider Satisfaction Committee (MPSC)
- Delegated Oversight Committee (DOC)

The QIC sets the strategic direction for all quality activities at MHMO. The QIC receives reports from all QI sub-committees, advises and directs the committees on the focus and implementation of the QI program and work plan. The QIC reviews data from QI activities to ensure that performance meets standards and makes recommendations for improvements to be carried out by sub-committees or by specific departments.

The QIC is chaired by the CMO and co-chaired by the plan President. It is composed of the Directors and Managers of key health plan functions. The QIC confirms and reports to the Board of Managers that plan activities comply with all state, federal, regulatory and National Committee for Quality Assurance (NCQA) standards. The QIC reports to the Board of Managers any variance from quality performance goals and the plan to correct the variance. The QIC develops and presents an annual QI Program description, work plan and prior year evaluation, as well as quarterly summaries of activities to the Board of Managers**.**

The plan President and CMO are responsible to plan, design, implement and coordinate QI activities. Their combined responsibilities include but are not limited to:

- Reporting to the Board of Managers at the quarterly meetings
- Demonstration and promotion of the QI Program through communication, practice and resource allocation
- Achievement of organizational goals
- Direct involvement in QI activities to include:
    - Analysis of Utilization Management and QI data
    - Serve as chair of QI committees
    - Ensure effectiveness of quality activities and allocate resources

The plan President is responsible for:

- Co-chairing the QIC
- Working with the CMO in the monitoring of the effectiveness of the QI Program, relative to the safety and health status of MHMO members

The CMO is responsible for:

- Supervision of all of Healthcare Services including operational oversight responsibility for the QI, Utilization Management, and Credentialing departments
- Act as the Co-chair of the QI, UMC, CQIC, DOC, PRC and MPSC
- Oversight of development, dissemination, implementation and evaluation of clinical practice guidelines, preventive health guidelines and benefit interpretation guidelines
- Communication of information and decisions to network practitioners and providers, and follow-up on corrective action plans implemented for issues regarding quality of care, patient safety, or service

The Director, QI is under the direction of the CMO, leads the QI function and is responsible to:

- Promote and maintain quality as a priority and guiding principle throughout the organization
- Co-Chair of the PRC
- Make available administrative support for planning, oversight, and allocation of resources to establish and maintain an organization wide system of QI
- Serve as a resource for planning, implementation, and evaluation of the QI Program
- Provide operational oversight of the QI Program and annual work plan, Health Education, Healthcare Effectiveness Data and Information Set (HEDIS), Disease Management, Delegation Oversight, Credentialing, and other clinical measurement processes
- Coordinate health service activities to provide for measurement and analysis, obtaining needed expertise as needed
- Coordinate the organization's NCQA Accreditation preparation
- Coordinate and oversee, with the CMO, annual External Quality Review Organization (EQRO) survey and all Performance Improvement Projects (PIPs)

Analysis of Quality Improvement Process

The QIC delegates QI functions to specific sub-committees. Each of these sub-committees is guided by a description that outlines its composition, meeting frequency, standards and responsibilities. All MHMO Quality Sub-committees meet at least quarterly or more as needed and keep contemporaneous minutes using a standard format.

The following Sub-committees report to the QIC:

- UMC
  - Overall purpose: Develop and maintain the Utilization Management Program
- PRC
  - Overall purpose: Establishment and maintenance of a NCQA compliant credentialing program
- CQIC
  - Overall purpose: Provide clinical oversight of programs such as emergency room utilization as well as monitor PIPs and clinical measures
- MPSC
  - Overall purpose: Monitor member and provider satisfaction issues as identified through various avenues such as the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey and provider satisfaction survey
- DOC
  - Overall purpose: Ensure fulfillment of clinical and contractual obligations by all delegated contractors and compliance with all state and NCQA standards.

To provide for overall quality functioning as a managed care plan, MHMO continuously monitors important aspects of care. These aspects or activities of care/service include, but are not limited to:

- Access/Availability
- Continuity/Coordination of Care
- Disease Management Programs
- Under/Over Utilization
- Behavioral Health Care
- Chronic/Acute Care
- Member Safety/Error Avoidance
- High-Risk/High-Volume/Problem-Prone Care
- Preventive Care and Services
- Member and Practitioner Satisfaction/Dissatisfaction
- Guideline Management; Clinical Practice and Preventive Guidelines
- Health Plan Service Standards
- Quality of Care Complaint Review and Clinical Case Review

QI is a data driven process. MHMO utilizes multiple data sources to monitor, analyze and evaluate the QI program and planned activities. These sources include, but are not limited to the following:

- Encounter data
- Claims data

- Pertinent medical records (minimum necessary)
- Utilization reports and case review data
- Provider and member complaints through call tracking, UM, Provider Services and other sources
- Provider and member satisfaction survey results
- Complaint, Grievance and Appeal data
- Statistical, epidemiological and demographic member information
- Authorization and denial data
- Enrollment; regional, disenrollment trends
- HEDIS and EQRO survey results
- Behavioral Health data
- GeoAccess provider availability data and analysis

A cyclic, continuous and systematic process is used to improve performance and communicate clinical and service quality issues. This process is used throughout the organization to help individuals improve procedures, systems, quality, cost and outcomes related to their areas of responsibility. The model includes the following steps:

- Establish standards and benchmarks
- Identify areas to be measured
- Collect data
- Analyze data and determine performance levels
- Identify opportunities for improvement
- Prioritize opportunities
- Design and implement interventions
- Measure effectiveness via data collection
- Implement successful interventions as policy and/or work processes

Overall Effectiveness of the Quality Improvement Program

MHMO's QI Program has proven its effectiveness through the achievement of Healthcare Effectiveness Data and Information Set (HEDIS) scores, the results of the Performance Improvement Projects (PIPs) and the measurement of performance indicators. The Quality Improvement Committee (QIC) continues to play a positive role in guiding the focus of the QI Program to effectively measure the quality of care and services provided to MHMO's members.

Strengths and Accomplishments

The strengths and accomplishments of MHMO's QI Program throughout the fiscal year include:

- Completion of clinical and non-clinical PIPs
- Continued improvement of HEDIS scores
- Organizational efforts towards achieving state and local regulatory compliance and NCQA accreditation in 2011
- Implementation of programs to address the priority needs associated with the major high-risk, acute and chronic illnesses faced by plan members
    - These programs include preventive health, health education, and disease management guidelines
- Utilization of multi-disciplinary and multi-dimensional teams to address process

improvements that can enhance care and service, including primary, specialty and behavioral health practitioners as appropriate

Opportunities for Improvement

MHMO's QI Program will focus on the following opportunities for improvement:

- Continue to monitor performance measures
- Continue efforts to increase HEDIS scores in areas of cervical cancer screening, childhood immunizations and adolescent well care visits
- Continued effort to increase CAHPS scores
- Continued effort to increase Provider Satisfaction ratings
- Ongoing development and evaluation of PIPs through an analysis of adverse events, member population characteristics, and risk factors

Population Characteristics

The following information was taken from the MO HealthNet Managed Care health plans' SFY 2009 Annual Evaluations:

Blue Advantage Plus of Kansas City

Race/Ethnicity

BA+ is sensitive to the ethnic composition of its members. The following table illustrates the members self-reported race. BA+ does not vary in cultural and ethnic membership compared to the general population demographics of the Kansas City Metro Area.

Race	Count (SFY07)	% of Total (SFY07)	Count (SFY08)	% of Total (SFY08)	Count (SFY09)	% of Total (SFY09)
White (Non-Hispanic)	16,869	60.0%	16,851	59.0%	17,302	58.8%
Black (Non-Hispanic)	10,090	36.0%	10,230	35.8%	10,567	35.9%
Asian or Pacific Islander	220	1.0%	49	0.2%	71	0.2%
Hispanic	327	1.0%	411	1.4%	394	1.3%
Other/Unidentified	780	3.0%	1,025	3.6%	1,098	3.8%
TOTAL	28,286	100%	28,566	100%	29,429	100%

Membership in regards to race and ethnicity has remained virtually unchanged since SFY07.

Special Needs

Introduction

The BA+ Special Programs Coordinator coordinates the flow for referrals made by the MO HealthNet Division for members with Special Health Care Needs, Lead Case Management and Consent Decree. BCBSKC has policies and procedures that outline the processes followed. The process has been enhanced by incorporating reporting and assessment protocols that identifies more information about the special needs member. There are several attempts to reach the members on the list to screen them for potential case management needs. If they meet BCBSKC/BA+ case management criteria, they are further evaluated for case management. Screening tools are included in the policy and procedure. This process is followed by the BCBSKC/BA+ Case Management department. Referrals are made as needed to New Directions Behavioral Health, the High Risk Prenatal program and the Asthma Disease Management program. In addition, PCPs are informed in the Physician's Office Guide that BA+ will assist in coordinating necessary case management services for BA+ members.

BA+ makes it a priority for all members with special health care needs to obtain the services needed. Services can range from seeing a specialist, to entering care management or a disease management program. BA+ has implemented several processes to reach members with special needs. The BA+ Member Handbook informs members to contact BA+ if they have special health care needs. It is a requirement of MHD that BA+ review the special health care needs reports on a monthly basis and refers members to case management as necessary. The table below indicates the special needs statistics for SFY07, SFY08 and SFY09.

SPECIAL NEEDS STATISTICS

Members in Lead Case Management	SFY07	SFY08	SFY09
Lead Level 0-14	36	17	15
Lead Level over 15	0	6	6
Consent Decree	869	NA*	976
Special Health Case Needs Children			
Number on list	582	585	573
Number referred for care management assessment	14	36	5

* *Family Support Division offices were converting to a new reporting system during this measurement period.*

The BA+ Special Programs Coordinator coordinates the flow for referrals made by the MO HealthNet Division for members with Special Health Care Needs, Lead Case Management and Consent Decree. Utilizing the Special Health Care Needs data to identify members with Special Health Care Needs is a requirement of MHD. BCBSKC reviews claim data to identify other members that might require case management services for Special Health Care Needs. BCBSKC continually reviews the screening tool and makes revisions to questions as deemed necessary.

LEAD TESTING

BA+ recognizes that in order to maintain and improve a healthy environment among the BA+ population, intervention is important. BA+ utilizes various interventions to make sure parents of young members of BA+ are educated and informed about elevated lead levels and lead screenings. Details of interventions include:

1. PrevenTrac – BA+ mails out reminder letters to parents of BA+ children to remind them of their upcoming EPSDT exam. One of the screenings that is included in the EPSDT exam is the lead screening. In addition, an appointment planner is sent to all PCPs informing them of members that are due for their annual EPSDT exam.

2. *Well-Aware* – Four times annually, BA+ sends out a publication titled *Well Aware* to BA+ members. In this publication, BA+ periodically includes educational information on lead poisoning in an attempt to raise awareness of lead poisoning and to provide parent education. Articles included in *Well Aware* during SFY09 include:
    - *Well Aware* (Summer 2008) – Lead Poisoning: Protect your child
    - *Well Aware* (Spring 2009) – Keep Children Safe From Lead

3. Physician Office Guide – BCBSKC distributes a Physician's Office Guide (POG) to the office managers of providers with whom we contract. This Guide serves as a reference manual for BCBSKC practitioners. This Guide contains information that discusses the requirement of lead screening and treatment for Medicaid members and the childhood

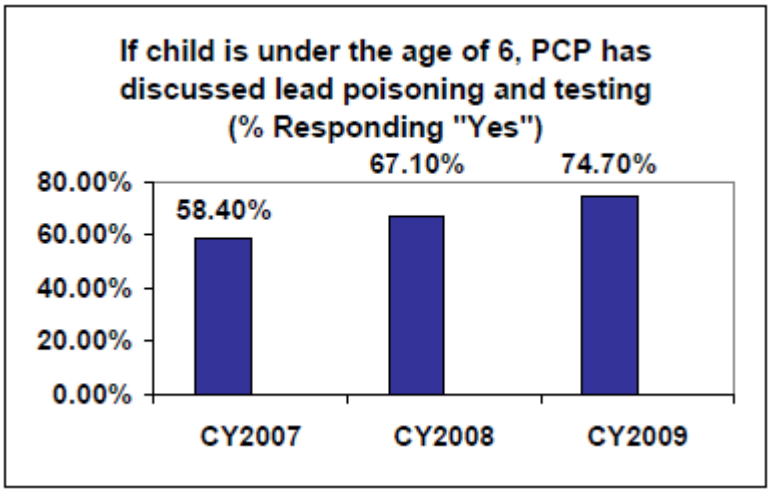
blood lead testing and follow-up guidelines. The POG also contains maps of lead testing areas in Missouri, Kansas City, and Jackson County.

Health Risk Assessments (HRA) from State When a new BA+ member indicates on this HRA they require help getting lead screening, the Health Information Coordinator will create a case and assign to the appropriate case manager and save as a potential, initial referral to case management.

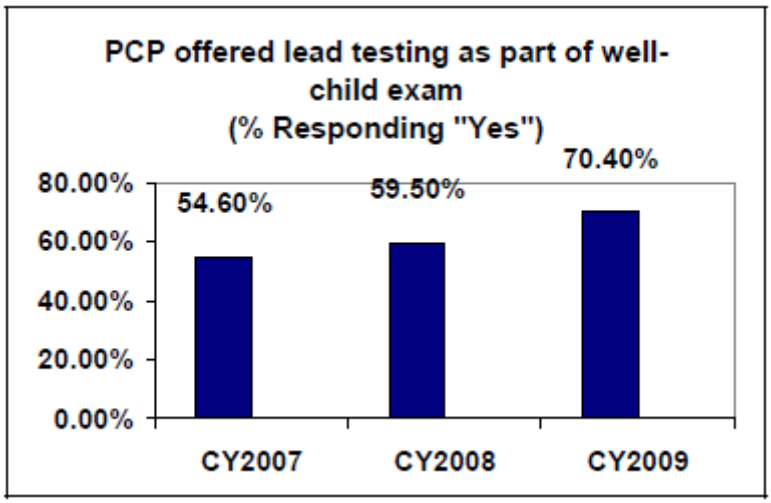
In addition, the Special Programs Coordinator sends educational materials on lead are sent to the member. The approved information that members received include:

a. Leadosaurus says…be alert Lead Can Hurt (Activity Book)
b. Leadosaurus says: Spin the wheel see where lead may be hiding
c. Lead Flyer
d. Lead Packet Letter
e. Protect your family from lead in your home – pamphlet

BA+ adds a supplemental question to the annual CAHPS® survey to measure PCPs discussions with parents/guardians of children under the age of six, regarding lead poisoning and testing.



While CY2009 result (74.7%) indicates more PCPs have discussed lead poisoning and testing, there has not been any significant change in comparison to CY2007 (58.4%) and CY2008 (67.1%) results.



The number of PCPs offering lead testing as a part of well-child exams increased significantly in comparison to CY2007 and CY2008.

Languages Identified

During the BA+ enrollment process with the state, each member's primary language is selfreported. This information is updated into FACETS. This informs any BCBSKC staff who communicates with the member, the preferred language of the member. BA+ provides interpretative services to assist members in communicating with BA+. The use of the AT&T language line provides an alternative for communication when language differences exist. Ongoing monitoring of the language line usage provides a mechanism for evaluating significant differences in BA+ member's needs.

Measurement is conducted on a quarterly basis to determine what languages are spoken by members. The following is an analysis of the information provided through the State Eligibility File transmission. Even though we have not exceeded the contract requirement of 200 members or five percent of membership who speak a single language other than English as a primary language (contract requirement 2.8.2), BA+ does provide some materials in Spanish.

Language Spoken

	3Q08	4Q08	1Q09	2Q09
Blank	12,373	12,359	12,362	9,153
American	10	10	15	2
Arab	-			
Chinese	1	1	1	2
English	14,790	15,011	15,341	17,157
No Response	-			
Other	97	90	102	425
Polish	1			
Russian	1	1	1	1
Spanish	98	154	195	131
Vietnamese	17	19	20	168
LAOT	1	1	0	0
Total	27,389	27,646	28,036	26,889

Opt-Outs
According to the termination information provided by the State of Missouri MO HealthNet Division, two members opted out of BA+ for SSI in SFY2009.

Children's Mercy Family Health Partners

Race/Ethnicity
Race and ethnicity are data elements that we just began receiving in our data from the State; therefore we are unable to report on race and ethnicity for 2009 fiscal year. We will however add this to a list of things to follow up on and work on obtaining from the state data as well as with member interactions.

Special Needs
CMFHP has a dedicated full-time Outreach Coordinator to identify and screen our Special Health Care Needs population.

In Fiscal year 2009, through monthly excel spread sheets from the State, Children's Mercy Family Health Partners Special Health Care Needs Outreach Coordinator identified the following number of individuals within our membership that had special health care needs:

Year	Identified SHCN members	Number of SHCN members already in CM when identified	Number of SHCN members screened	Number in Consent Decree
FY 2009	**1188**	**46**	**906**	**236**

The Special Health Care Needs Coordinator identifies members who are not already in Case Management, attempts to screen the member through outreach phone calls or letters.

If Case Management services are indicated, the member is referred to a CMFHP Pediatric or Lead Care Manager, Asthma Health Coach or Health Lifestyles Health Coach.

Languages Identified
Children's Mercy Family Health Partners membership consists of individuals who have a variety of primary languages. The following is a breakdown of our membership in 2008 and 2009 and the primary languages spoken:

Language	FY 2008 Members	FY 2009 Members
American Sign	26	21
Arabic	17	41
Bosnian	1	2
Chinese	8	4
Cambodian	1	0
Danish	0	4
English	46,732	52,611
French	0	1
Gujarathi	0	1
Haitian	0	1
Hmong	0	1
Korean	2	1
Laotian	0	3
Polish	0	1
Romanian	2	6
Russian	1	1
Somali	0	3
Spanish	1,194	1,585
Tagalog	42	181
URDU	0	9
Vietnamese	48	50
Other	95	92
TOTAL	48,169	54,619

Summary by language of translation services:
Based on the numbers above, CMFHP has a large Hispanic population. 30% of the CMFHP Customer Service representatives speak Spanish who are available from 7am to 6pm Monday through Thursday and 7am to 6pm on Friday to assist the Hispanic community. CMFHP also employs two full time Hispanic Community Outreach Representatives who answer questions and provide outreach activities to those who are prospective members. These representatives can also provide back-up to Customer Service in answering questions for members if needed.

CMFHP also has access to a language line that can be used to assist non-English speaking members with translation services. CMFHP contracts with Propio Language Services, a local corporation, for member and provider translation services. Along with this agreement, we secured translators for languages that were not available with a previous vendor.

In Fiscal Year 2009, CMFHP did not identify anyone who needed communication accommodations outside of the services described above.

Summary of services to members with visual or hearing impairments or disabilities:
Children's Mercy Family Health Partners members have access to a toll free TDD line. When requested, copies of printed materials are available and provided via cassette, CD or in large print versions. In addition, upon request, CMFHP has a list of sign language interpreters who are available if needed to assist members in provider offices.

Inventory by language of member materials translated:
The following materials are provided in English and Spanish:

- Quarterly member newsletter the "Connection"
- Quarterly Teen newsletter "Your Space"
- Member brochures
- Non-Emergency Transportation brochure
- Member Handbook
- CMFHP
- First Touch OB Case Management brochure
- Urgent care brochure
- Disease management brochures

Inventory of member materials available in alternative formats:
CMFHP utilizes access to a toll free TDD line. When requested, copies of printed materials are provided via cassette or in large print versions. In addition, an audio version of our member handbook is available on line.

Audio Podcasts:
In order to increase communication with members and educate them on how to lead healthier lives, CMFHP recorded several podcast with information on the following topics. These podcasts are available on a CD and on the CMFHP website at www.fhp.org. These podcasts also assist in providing education for members who need assistance with health literacy.

- First Touch Maternity Care
- HeLP (Healthy Lifestyles Program) for health and physical education with Health Coaching
- Lead Care Management
- Non-Emergent Medical Transportation (NEMT)
- Asthma Care Management and Health Coaching

Opt-Outs
In FY 2008, CMFHP had 17 members opt out of managed care. In FY 2009, we had 37 members opt out of managed care. The following describes the types of "Opt Outs" for these 2 years:

	FY 2008	FY 2009
DSS Opt-Out	1	1
Alternative Care Opt-Out	12	6
SSI Opt Out	24	14
Total	**37**	**21**

Harmony Health Plan of Missouri

Race/Ethnicity
Harmony Health Plan has the ability to report the number of members by sex, age and area however due to reporting constraints and validity of State file data relative to ethnicity HHP does not have the ability to report by ethnicity at this time.

Harmony has identified this as an area of opportunity for 2009-2010.

Special Needs
It was estimated that 18 million children in the United States have special health needs. In Missouri, the number of children with special health care needs was around 300,000 or 21% (data from 2007, Kids Care Data Center). For Harmony the number of special health care needs children identified in 2009 was 322.

Harmony Health Plan of Missouri
Children with Special Health Care Needs Enrollment Report

	Jul 09	Aug 09	Sept 09	Oct 09	Nov 09	Dec 09	Jan 09	Feb 09	Mar 09	Apr 09	May 09	Jun 09
Starting Census	9	16	14	20	20	22	23	37	41	18	56	46
Referrals	72	32	7	5	7	49	57	68	54	128	74	52
Opened Cases	7	3	7	4	7	4	22	23	3	43	24	9
Closed Cases	8	5	1	4	5	3	8	19	26	5	34	26
Ending Census	16	14	20	20	22	23	37	41	18	56	46	29

Differences by Gender

According to Kids Care Data Center males are more likely than females to have special health care needs (in 2005). Fifty-three percent of Harmony's special care needs population was male while 47% were female.

Differences by Age
According to Kids Care Data Center children ages 6 to 11 and 12 to 17 were about twice as likely as young children ages 0 to 5 to have special health care needs (16 and 17 percent versus 9

percent, in 2005). Harmony's data showed that children ages 0-5 and 6-11 had about the same percentage of children with special health care needs while children ages 12-17 had a slightly higher percentage than the two younger age groups.

Harmony's Special Health Care Needs Population by Age Group

Age	0 - 5	6-11	12-17	18-21
Rate	23%	27%	36%	13%

Languages Identified

Harmony identified three languages (Arabic, Spanish and Vietnamese) other than English that were primarily spoken by our members. However the percentage of members primarily speaking non-English languages was less than 1 percent of the Harmony's total membership. The grid below shows the languages and percentage of members who primarily use a language other than English. There was very little change in primary languages spoken compared to the 2007-2008 contract year.

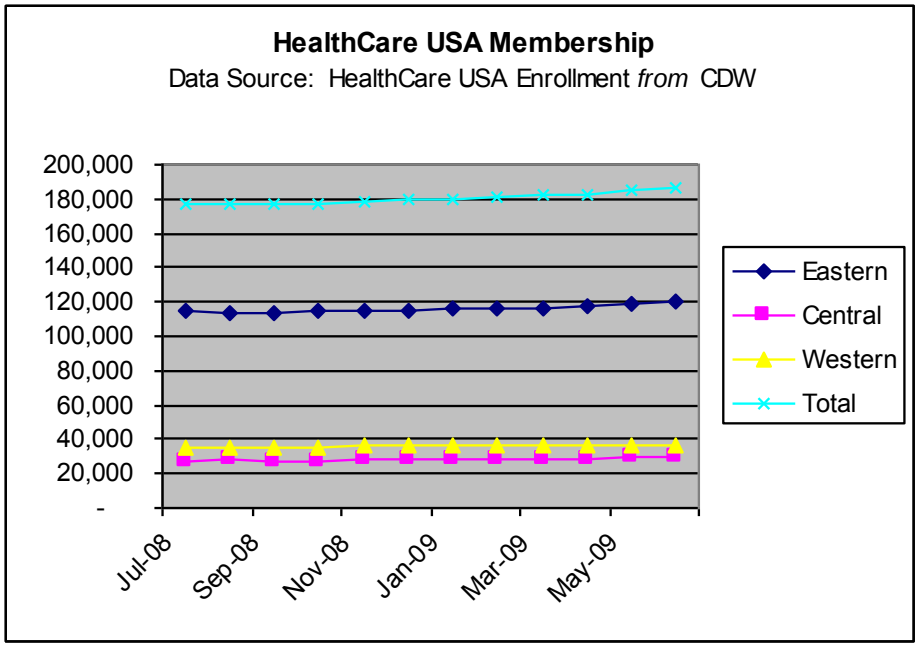
Languages	2007-2008	2008-2009
Arabic	0.23%	0.12%
English	99.03%	99.08%
Spanish	0.67%	0.71%
Vietnamese	0.07%	0.10%

Opt-Outs

Harmony Health Plan received 3 approved opt outs from DSS from July 1, 2008 through June 30, 2009, significantly lower than the previous year. The opt outs covered 4 members. The reasons for opting out of the Plan were to return to the fee-for-service plan and "no reason given". We believe opportunities exist to further reach out to members and providers to educate them on the benefits of the MO HealthNet managed care program and, more specifically Harmony.

HealthCare USA

HealthCare USA's population has continued to increase through FY 2009, with about 7000 additional members added. The expansion counties increased membership about 4000 members, with the additional 3000 members slowly being added over the first half of 2009, most likely a reflection of the economy.



Race/Ethnicity

HealthCare USA has established strong partnerships with agencies and organizations dedicated to improving the lives of minority cultures and disparate populations in Missouri. Some of the agencies are: Black Health Care Coalition, Hispanic Chambers of Commerce, Mexican Consulate, Urban League of Metropolitan St. Louis, 27th Ward Infant Mortality Reduction Initiative, Maternal Child and Family Health Coalition, Minority Health & Health Equity Committee, Teen Pregnancy Prevention Partnership, Minority Health Alliance Eastern Region, Big Brothers Big Sisters of Eastern Missouri, Boys and Girls Clubs and Caring Communities.

Some of the largest ethnic events that HealthCare USA has either sponsored or participated in include:

- 11th Annual Male Leadership Conference (African American)
- Sai Medical Camp (Hispanic)
- Bike Safety Rodeo (Hispanic)
- Fiesta in Florissant (Hispanic)
- Binational Health Fair (Hispanic)
- Take Your Loved One to the Doctor Day (African American)
- Kansas City School District Double Dutch Contest (African American)
- Guadalupe Center Health Fair Cinco de Mayo (Hispanic)
- Multicultural Fall Festival (All)
- Cole County Hispanic Family Fun Day (Hispanic)
- Pettis County Back to School Fair (Russian and Bosnian)
- Parents as Teachers Spring Carnival (Hispanic, Asian, Bosnian, Russian)

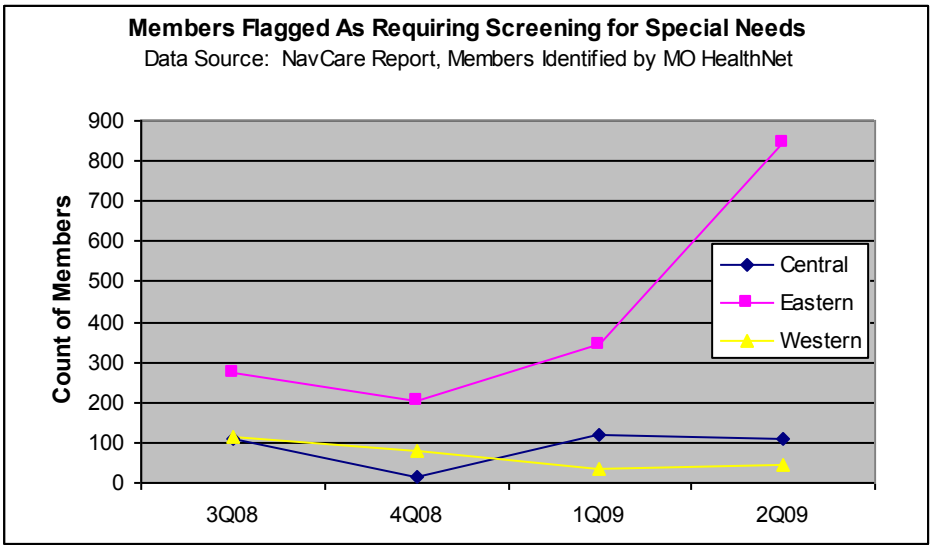
Not only do we recognize and support ethnic communities within our regions, but we also acknowledge the differences between urban and rural communities. We have strengthened our

partnerships in many rural areas by regularly attending monthly community action agency meetings and participating in their local events such as:

- Cole County Back-to-School fair
- Boone County Back-to-School Fair
- Jefferson County Back-to-School Fair
- Pike County Back-to-School Fair
- Warren County Dental Fairs

Special Needs

Members with special needs continue to be identified primarily by MO HealthNet at the time of enrollment. The majority of members identified are less than 21 years old. Others are identified and referred through sources such as readmissions data, outcomes of the internal SynCare health risk assessment, concurrent review, PCP referrals and even member self-referrals.



The Eastern region comprises the bulk of the referrals, consistent with membership. While it appears as if there was a significant increase in the volume on the special needs disc from MO HealthNet in the Eastern region during the second quarter of 2009, this is not the case. One of the special needs coordinators was unexpectedly out for an extended period of time and the remaining coordinators were not able to complete discharges from the system during this time, which makes the run chart appear as it does during this quarter. All members received the services they needed during this time. The issue was a data entry issue.

Languages Identified

HealthCare USA membership is comprised of individuals who may declare a language other than English as their primary language (upon their enrollment) and those members with visual or hearing impairment. The principal languages as defined by the State contract are English and Spanish. Other languages with a significant membership include, Arabic, Vietnamese, Chinese Mandarin, and Russian. Bosnian is not a choice for the State enrollment language declarations and is grouped as "undetermined."

Members' Declaration of Primary Language Spoken		
Language	**Count**	**Rate**
English	128, 914	65.27%
Undetermined	65,043	32.93%
Other	2,229	1.12%
Spanish	967	.48%
Arabic	120	.06%
Vietnamese	95	.05%
Russian	70	.04%
Chinese	34	.02%
Cambodian	4	.00%
Romanian	4	.00%
Polish	3	.00%
Sign	2	.00%
Tagalog	1	.00%

This diverse membership requires both translation of written materials and oral interpreter services. HealthCare USA employs Spanish speaking staff in the customer service department. HealthCare USA provides telephonic interpretation services through Language Line and face-to-face services throughout all three regions by contracting with the following agencies: Language Access Metro Project (LAMP), Jewish Vocational Services, International Institute, A-Z Translating Services, and AAA Translation. Interpreter services for hearing impaired members are provided through Deaf Inter-Link, Deaf Expression, Inc. and DEAF Way. Some documents, including the member handbook, are made available in Braille upon request. In the first six months of 2009, there were 1660 requests for face-to-face language assistance services. The number of requests in the last six months of 2008 was 1265. A breakdown of face-to-face language service requests is shown below.

Face to Face Language Service Requests		
Language	**Q3/Q4 2008**	**Q1/Q2 2009**
Arabic	66	132
Bosnian	104	110
Burmese	31	47
Chinese	5	22
Dari	60	53
French	3	7
Hindi	0	0
Portuguese	0	2
Kunama	0	2
Russian	43	42
Somali	93	130
Romanian	0	1
Spanish	786	991
Swahili	7	11
Turkish	0	0
Uzbek	3	9
Urdu	0	2
Vietnamese	67	97
Nepali	0	1
Kirundi	2	1
Bengali	1	0
Persian	1	0
Total	**1265**	**1660**

HealthCare USA contracts with Language Line for telephonic language assistance services. The following languages were requested in order of frequency through August 2009: Spanish, Arabic, Burmese, Vietnamese, Somali, Chinese, Bosnian, Russian, Nepali, Karen, Korean, and Albanian.

HealthCare USA's 24-hour nurse line employs bilingual staff supplemented as needed by a third party language assistance service. They also support members needing TDD/TTY services via a local TTY access number.

Upon request, HealthCare USA offers the member handbook and other member materials in other languages to meet the needs of our non-English speaking members. "Noodle Soups", one-page educational handouts targeting specific health-related topics, are distributed to members through events and meetings. Our current topics translated in Spanish include:

- La importancia de Lavar tus manos (Importance of Hand Washing)
- Sea sabia(o), vacune a sus hijos! (Be Wise, Immunize)
- Controlando el peso de su nino (Controlling Your Child's Weight)
- Despues de las vacunas (After vaccinations)
- Servicios De Un Ineprete (Language Access Services) Also available in Bosnian (Prevodilia Ke Uslage)

Other HealthCare USA translated materials are Los Ninos Saludables Son Nuestro Negocio (Healthy Kids Are Our Business), Servicios de un Interprete Prevodila Ke Usluge (Language Assistance Services), and Las primeras semanas de su bebe (Baby's First Weeks). A lead poisoning prevention coloring book is written in Bosnian.

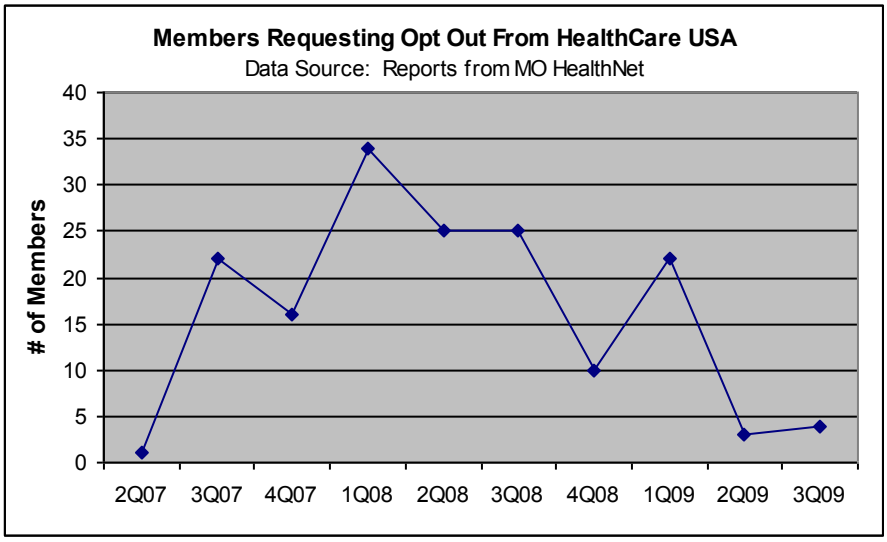
HealthCare USA's website offers interactive educational health and wellness-related program, *Kid's Health*®, to anyone with access to a computer. *Kid's Health*® offers a variety of physician approved articles such as: Managing Home Health Care for Children in Wheelchairs, Camping for Special Needs Children, Bullying, Everyday Illness and Injuries, and Dealing with Feelings. There are special sections dedicated to parents, teens and younger children. The site contains hundreds of timely, age appropriate articles, interactive games and healthy recipes. In addition, there are 1325 articles translated into Spanish.

In accordance with our Oct. 1, 2009 contract, a language block has been added to all member literature. This block reads: To receive a translated copy of this document, call Member Services at 1.800.566.6444. Para recibir una copia traducida de este documento, llame al servicio para miembros al 1.800.566.6444.

To meet the needs of our speech, hearing and visually impaired members the member handbook is also offered in Braille and audio upon request. There have been no requests in the past four quarters for these alternative versions.

There have been no grievances related to language services submitted over the past year.

Opt-Outs
Members requesting to opt out from the plan are forwarded to HealthCare USA from MO HealthNet. A HealthCare USA case manager contacts the member to inquire about their request to opt out. They then assist the member in solving the barriers leading to the opt out request. A few examples include finding a PCP or specialist, securing therapy visits, and/or assisting with filling medications. A member may be enrolled in case or disease management if needed. All members receive a follow-up visit to make sure their healthcare needs are being met.



There was a spike in opt out requests at the beginning of 2008 because of the First Guard membership acquisition. Since that time the count has continued to trend down.

Missouri Care

Race/Ethnicity
The State provides Missouri Care with race and ethnicity data on enrolled members. Missouri Care does not fully utilize this information because it is not captured in QNXT, our data management system. This will be a primary area of focus in 2010, as Missouri Care enhances its' cultural competency initiatives. Currently, the health plan's case managers address cultural needs on a one-to-one basis.

Special Needs
Missouri Care's services for children with special health care needs are available to all enrolled Title XIX members from birth to age 21. Missouri Care recognizes the challenges that families of children with special health care needs (CSHCN) confront when navigating the health care system. These children often have complex physical and/or behavioral health care needs and multiple social issues requiring professional assistance from an array of specialists, subspecialists and community-based organizations. Missouri Care has partnered with the Thompson Center for Autism and Neurodevelopmental Disorders at the University of Missouri since its launch in 2005. Missouri Care refers our members with suspected developmental disabilities to

the Thompson Center, which provides families with diagnostic, assessment and treatment services for children, youth and young adults. Our care managers work with their staff to emphasize individualized services that are comprehensive, coordinated, and caring.

In conjunction with the University of Missouri Hospitals and Clinics, Missouri Care contracts with specialists capable of providing an effective health care home for CSHCN. Missouri Care's services for CSHCN promote the early identification of physical, behavioral and developmental problems; preventive health services; and outreach and education, in accordance with MO HealthNet program requirements. Our goal has been, and remains, to improve the quality and cost effectiveness of Medicaid managed care, particularly for vulnerable and high need populations.

Missouri Care recognizes the critical importance of maintaining the continuity of medically necessary physical, occupational and speech therapy for CSHCN. To this end, we coordinate service delivery with the public school systems and therapy providers through the Individual Family Service Plan (IFSP) and Individual Education Plan (IEP) processes. This entails assembling all staff involved in the member's care to review medical necessity and prioritize a plan of care, thereby improving the chance that the child and family will receive seamless care coordination services across all relevant agencies.

The system of care for children and young adults with special health care needs involves:
- An expeditious and coordinated process for identification and referral of children and young adults with special health care needs for assessment and development of a plan of treatment
- Having specialists serving as the child's PCP, if acceptable to the child's caregivers
- Active involvement of the child's PCP and specialists in the treatment planning process
- Specialized prior authorization procedures
- Direct access to a specialist(s), as appropriate
- Ongoing assessment to identify any special conditions that require a course of treatment or regular care monitoring Missouri Care's services for children with special health care needs are available to all enrolled Title XIX members from birth to age 21.

In 2003, Missouri Care began collaborating with the Missouri Partnership for Enhanced Delivery of Services (MO-PEDS), a project of the University of Missouri based on a health care home model of care, to help identify and coordinate the services and support for families of CSHCN. The objective was to improve quality of care by increasing the availability of comprehensive care coordination in 18 counties in central Missouri. A key feature of this program was the MOPEDS family support specialist, who partners with the member and family, primary care provider, specialists and Missouri Care's nurse case manager to ensure the timely and efficient delivery of needed physical, behavioral and social support services.

Parents and families served by the partnership report significant increases in satisfaction with care coordination and access to behavioral health services. They also note improvements in family burdens, caregiver strain, and parents' missed days at work, children's school absences and the utilization of ambulatory services.[2] In SFY 09 Missouri Care continued to provide financial support for the program (now known as the Family Resource Services program) in

collaboration with the University Of Missouri Department Of Child Health, and the Thompson Center for Autism and Neurodevelopmental Disorders. The Thompson Center is the only autism center in the Missouri and currently the home of Family Resource Services. In CY 08, Missouri Care and Family Resource Services cocase managed 75 children with special health care needs.

[2] Farmer, JE, Clark, MJ, Sherman, A, Marien, W.E., & Selva, TJ, "Comprehensive Primary Care for Children with Special Health Care Needs in Rural Areas," Pediatrics 116 (2005): 649-656.

Identification of Children with Special Health Care Needs

In addition to the identification of CSHCN through the Title V program, Missouri Care employs a variety of additional strategies:

Health Risk Assessments

In 2008 Missouri Care conducted 1,693 health risk assessments with children that MO HealthNet identified as CSHCN. Following completion of the assessment and the identification of any gaps in the children's care, the health plan enrolled 588 of these children in our pediatric case management program.

Predictive Modeling

Missouri Care employs a proprietary risk assessment application called Predictive Pathways™, a proven technology for identifying members who currently have or are at risk of developing complex and/or chronic health care needs. Predictive Pathways™ accomplishes this task through an internal diagnostic grouping process that evaluates over 15,000 ICD-9 codes and identifies specific chronic and acute conditions having long recovery timeframes (such as spinal cord injuries) or commonly recurrent conditions (such as respiratory infections). The grouping logic ranks members according to the type of claim, the frequency of the diagnosis, the provider specialty and other relevant data. The goal is to accurately identify a primary condition for each member.

Member Outreach

Missouri Care sends materials to all enrolled members that provide detailed information about services available to CSHCN, including member newsletters, the Member Handbook, EPSDT and other preventive health reminders, and case and disease management materials. In addition, Missouri Care's Welcome Call service informs caregivers with special needs children about available programs, provides assistance in accessing needed services, and refers caregivers or members to case management for follow-up. Caregivers are also encouraged to call Missouri Care's Member Services Department if they have a child in need of such services or suspect they may have a need.

Network Providers

Missouri Care's network providers are active partners in identifying and managing the care of CSHCN. We educate our providers about CSHCN through newsletters and special educational forums, including information about the referral process and the responsibility of the provider in caring for these members.

Missouri Care also makes a focused effort to include specialists with particular medical expertise and interest in caring for CSHCN in our provider network. The health plan provides covered,

out-of-network specialty services, as appropriate, for the member's condition and identified needs. This includes coordinating transportation (if necessary) and supporting the member and the member's caregiver during the process.

Languages Identified
Missouri Care tracks the number of members who speak a language other than English. During SFY 09, approximately 2% of members were identified as speaking a language other than English. The majority of these members, 80%, identified Spanish as their primary language. Interpreter services are available for all members regardless of their native language, and written materials are available to members in Spanish. Members are informed of these options in the member handbook. Missouri Care also attempts to call all new members. If during a new member call, a member or household identifies Spanish as his/her primary language, a Spanish translated member handbook is mailed to the member.

Opt-Outs
During SFY 09, five opt outs were reported to the health plan by the Department of Medical Services (MO HealthNet). The reasons for disenrollment were non-classified.

Molina Healthcare of Missouri

Race/Ethnicity
All members will be treated equally, fairly and provide covered services without regard to race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual preference, health status, income status, program membership, or physical or mental disability, except where medically indicated.

Special Needs
Members with special needs are identified through various avenues. One of those avenues is through the monthly state Special Needs list. Members that are in foster care, who have applied for or are receiving SSI (disability), or have mental health issues may be identified on this report. Molina Healthcare of Missouri's (MHMO) Utilization Management Specialist attempts to contact every member on the list to evaluate their current needs, ensure members are connected with community resources, and make members aware of the benefits available through MHMO. Some of the community resources shared with members include: WIC, Parents as Teachers, First Steps/IFSP/IEP, MPACT, and the Regional Centers. The Specialist also attempts to connect the members with major support groups for any identified disease processes if needed. If ongoing needs are identified at the time of the evaluation, the member is referred to the Complex Case Managers for further assessment, intervention and evaluation. Special Needs Resource letters are also sent out to these members regarding community resources.

Other members with special needs are identified through durable medical equipment (DME) and therapy requests. Depending on the severity of the case, members may be transitioned to a Complex Case Manager for coordination of services required beyond their DME and therapy needs. Special Needs Resource letters are sent out to the families of these members when appropriate. The Utilization Management Specialist and Complex Case Manager communicate

the member's current needs and pertinent medical history to all caregivers involved, including their primary care provider (PCP), specialists, therapists and parent/guardians, in order to help determine any needs identified and assist in transitioning them through the continuum of care.

Another method of identifying children with special needs is via the MHMO Clinical Case Management staff. Hospitalized children who develop special needs through illness, injury or premature birth are identified by Clinical Case Managers and referred to the Complex Case Management staff. The intent of this program is to identify members with special needs, coordinate services, ensure that quality care is provided and initiate case management services. The Complex Case Managers are responsible for the evaluation and management of complicated medical cases, high risk social situations and those members with unique medical needs.

Languages Identified

Access to care is a key component of creating positive health outcomes. MHMO has implemented the following to eliminate barriers to care:

- Member Services bi-lingual translators – Bosnian and Spanish
- Community Outreach and Education services such as:
    - MHMO hosts baby showers, back to school fairs, and educational presentations in highly populated Hispanic and Bosnian communities. MHMO has developed its Germbusters and health and fitness presentations in Spanish.
    - MHMO has a Hispanic outreach representative who is present at community events to assist with language barriers and also rotates throughout the Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC) and other high volume clinics to provide health education and answer frequently asked questions about the health plan. These efforts allow MHMO to effectively communicate the services provided by MHMO to its members who do not speak English as their primary language.
    - Translators through Language Access Metro Project (LAMP) on site and Language Line via the telephone. MHMO members who do not speak English as a first language can visit their PCP with confidence that their needs will be communicated through LAMP on site translators. MHMO utilizes LAMP for providing these services. All appointments are coordinated in advance and the translator arrives at the physicians or specialists office to effectively communicate on behalf of the member. New MHMO members have called to express their gratitude for this extra service. Often times our Spanish and Bosnian speaking members are unfamiliar with the MO HealthNet Division processes and need some extra assistance understanding their benefits while at their appointments. The translators used by LAMP are familiar with the MO HealthNet Managed Care program and can relay information to the providers to ensure members have a clearer understanding of the services they are receiving.
- Spanish and Bosnian prompts are part of the telephone in bound queues and members are given the option of speaking with a representative in their primary language. Member Services representatives who speak English as their primary language have

been trained to offer to transfer members to a Spanish or Bosnian speaking representative using a phrase in the requested language.

- Marketing and educational materials translated into Spanish and Bosnian. Members can request member materials printed in their primary language. MHMO currently stocks Spanish and Bosnian marketing and educational materials, but can order and expeditiously receive materials printed in other languages upon members' request.

MHMO examines opportunities for continuously improving multilingual services offered to its members with English language barriers. MHMO tracks data on the volume of members who have been identified as speaking a language other than English. On June 1, 2009, MHMO's membership reports reflected a total of 670 eligible members who speak Spanish and 167 who speak Bosnian. Incorporated into MHMO's practitioner orientation program is education on processes to access interpreters for members.

Foreign Primary Language 06/01/2009

Primary Language	Members	% of Total Members	Total Membership
ASL	2	0.003%	77582
Arabic	72	0.093%	77582
Bosnian	167	0.215%	77582
Chinese	47	0.061%	77582
Hindi	2	0.003%	77582
Laotian	1	0.001%	77582
Other	411	0.530%	77582
Romanian	3	0.004%	77582
Russian	28	0.036%	77582
Spanish	670	0.864%	77582
Tagalog	1	0.001%	77582
Turkish	2	0.003%	77582
Vietnamese	115	0.148%	77582
Totals:	1521	1.961%	77582

Opt Outs

The data below reflects the members who were approved for opt out from MHMO as reported to MHMO by the MO HealthNet Division. MHMO will continue to track and manage the member opt out information.

Opt Outs	3QFY08	4QFY08	1QFY09	2QFY09	FYTD
	14	27	16	17	74

Community Outreach/Marketing
MHMO's Community Outreach Department provides the community served with quality education, information and necessary resources. The Community Outreach Department is committed to educating the community on managed care, healthy behaviors, use of benefits, access to PCPs, and other health information, through health presentations, resource fairs, and health focused events. In an effort to maintain visibility to both members and potential members, the Community Outreach Department always represents MHMO visually and verbally in and throughout the community. MHMO prides itself in making sure its members know about the care that they can receive through MHMO.

Below is an overview of activities that the Community Outreach Department offers:

- MHMO Health Presentations
    - Germbusters (hand washing)
    - Dental Hygiene
    - Bicycle Safety
    - Health & Nutrition (with Hip-Hop workout)
    - Lead Awareness
    - Head Lice Prevention
    - Stranger Danger
    - MHMO sponsored events
    - Baby Showers
    - Back to School Fairs
    - Safety Days
- MHMO informational sessions
    - Department of Health
    - Family Support Division
    - FQHCs
    - Parents as Teachers
- MHMO's "Dr. Cleo's *Cool* Cat Club"
    - Gift Cards for Good to Progressive Report Cards & *Purrfect* Attendance
    - Treats for Birthdays
    - School, Camp, Daycare Appearances with Dr. Cleo the cat

From July 2008 to June 2009, MHMO has participated in over 300 events throughout the state of Missouri**.**

Region	Number of Events
Eastern	203
Central	42
Western	93

Below are events that MHMO have sponsored or participated in, to provide the community with awareness about several health initiatives.

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

- Dr. Cleo's Guide to Health and Nutrition Presentations
    - Food and Activity Log
- Jennings School District "Healthy Kids Days"
    - Providing BMI, height, vision, hearing screenings
- People's Health Center: Healthy Cooking Family Days

Childhood Immunization

- Immunization Days with FQHCs
    - EPSDT Community Health Initiatives at Health Care for Kids Myrtle Hilliard Davis Back to School Health Fair
    - People's Health Center Back to School Fair
    - Lane Tabernacle Health Fair

Lead Screenings

- Myrtle Hilliard Davis Comprehensive Health Center Back to School Fair
- MHMO and St. Louis Housing Authority Job and Wellness Fair
- Healthy Baby Fair
- MHMO and Alpha Phi Alpha Back to School Fair
- St. Louis University Health Resource Center Health Fair
- MHMO Launch Event
- St. Louis Housing Authority and MHMO Back to School

Cancer Awareness

- RYP Missions & Cancer Health Fair
- Prostate Cancer Rally Breast Cancer Lunch and Learn
- People's Health Center PSA testing day

Dental Hygiene Awareness

- Dental Fair with Bridgeport Dental
- Give Kids a Smile Day

Cultural Awareness

- Festival of Nations Hispanic Festival
- Bi- National Fair (St. Louis and Kansas City)
- Guadeloupe Church Health Information Day
- St. Cecilia Health and Career Fair
- Day of the Child (St. Louis and Kansas City)
- Cinco de Mayo educational day (St. Louis and Kansas City)

Outreach Activities	July 2008 – June 2009
School Presentations	154
Students Reached	11,491
WIC Presentations	25
WIC Sit- Ins	60
Cultural Festivals	30
OB Presentations	25
Baby Showers	11
Women's Shelters and Group Homes	25
# of high volume on-site delivery locations	22
FSD presentations	36

New Mom Outreach

In addition to educating the community through various programs and events, the MHMO Community Outreach Department has an entire program dedicated to the new mothers that are members of the plan. Through MHMO's BABY CARE program, mom's can be assured that they have the help they need to start off their new venture. Once a new mom delivers a baby, she receives personal contact from a MHMO Outreach Coordinator. This is either by a new mom visit from a BABY CARE coordinator or telephonically from a Member Services Representative. When the new mom is contacted, she receives pertinent information that insures her and her baby receive quality healthcare and resources.

New Mom Report
July 2008 – June 2009

Month	# of Deliveries	New Moms Visited
July	429	237
August	449	254
September	462	283
October	415	214
November	378	240
December	373	181
January	311	176
February	320	89
March	384	122
April	395	80
May	357	197
June	348	180
TOTAL	4621	2253

Partnerships
Strong relationships with community facilities, organizations, and agencies anchor MHMO to the communities that we serve. These agents recognize the need for dual partnerships for the purposes of recruitment as well as the efforts involved to inform, and educate the community, and assess and address the needs. MHMO's main goal for developing partnerships throughout the community is to have MHMO represented even when there is not an Outreach Coordinator present. When MHMO develops strong relationships with complimenting agencies, MHMO educate their clients, members, and populations about benefits and resources.

Partnerships in the Eastern, Central, and Western Regions include the following:

- FQHCs
- RHCs
- Departments of Health
- Boys and Girls clubs
- Clinics
- School Districts
- Hospitals
- FSD offices
- Churches
- Unemployment agencies
- WIC offices
- Jobs Corps agencies
- SIDS agencies
- Father's Support Center, St. Louis
- Get Healthy DeSoto
- St. Louis Housing Authority
- Linwood YMCA
- Samaritan Center
- Youth in Need
- Women's Safe House
- Lincoln University
- March of Dimes
- Hispanic Chamber of Commerce
- North East Community Action Agency (NECAC)
- Missouri Community Action Agency (MOCAA)
- Community Council of St. Charles County
- Kingdom House
- "Let's Start"
- Jammaa Learning Center
- Heat Up/Cool Down St. Louis

Community Giving
MHMO is proud of its commitment to donating not only nominal resources, but also employee volunteer time. Through a "Helping Hands" initiative, MHMO volunteers choose to invest time

and energy with local organizations. Over the past year MHMO has volunteered its time with numerous organizations such as: Habitat for Humanity, Heat Up / Cool Down St. Louis, March of Dimes, Youth in Need, and the Samaritan Center. On "Make a Difference Day," MHMO provided 60 coats to the Youth and Family Center after school program for children.

MHMO Community Champion Awards
MHMO relies heavily on its community relationships. Therefore MHMO has established an award to acknowledge its partners for all of their dedication to the community that MHMO serves.

MHMO solicits nominations from different community organizations of the "unsung heroes" across the state of Missouri. These "heroes" can be volunteers, service providers, or employees who demonstrate selfless dedication to improving the quality of life in the community they serve. Each year, a recognition dinner is held to honor the Community Champion Award winners and a $1,000 donation is made to each winner's agency of choice. During MHMO's first event MHMO awarded over a total of $10,000 for the awardees to present to their respective agencies.

Quality Indicators

The following information was taken from the MO HealthNet Managed Care health plans' SFY 2009 Annual Evaluations:

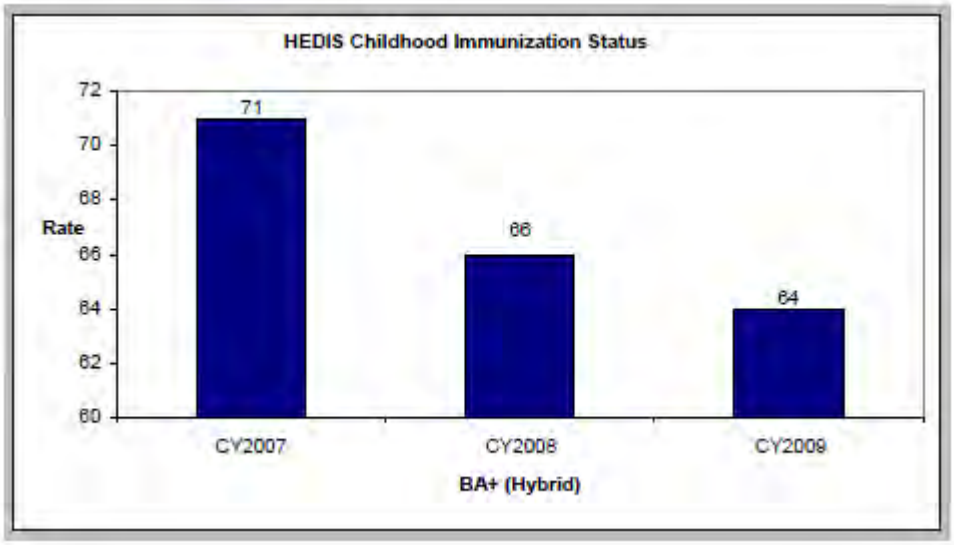
Blue Advantage Plus of Kansas City

Performance Measures

Trends in Missouri Medicaid Quality Indicators

Effectiveness of Care - Childhood Immunization Status

Childhood immunizations are one of the earliest preventive measures that can be done to greatly reduce illnesses such as polio, hepatitis, tetanus, chicken pox, whooping cough, measles, and meningitis. The HEDIS Combo 2 measure includes IPV, Hep B, DTaP, MMR, Hib, and VZV and is the measure that counts for NCQA points. It is expected that in the future Combo 3, which includes the addition of the pneumococcal vaccine, will replace Combo 2.



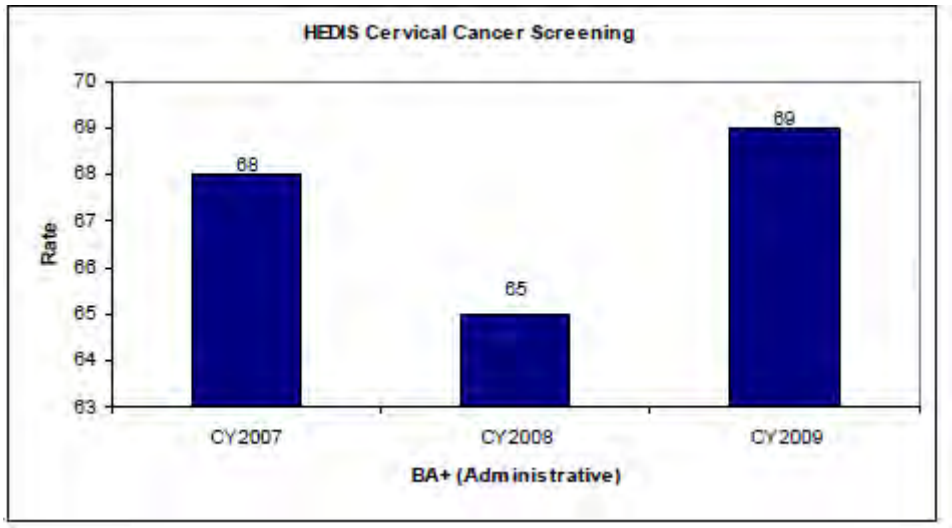
Interventions

- On Track at Two – An immunization reminder program for members 2 years old and younger. The goal of this program is to increase the rate at which our members are receiving the complete series of childhood immunizations. An introductory letter is sent to the parents of the identified member welcoming them to the Program. Reminders are then sent to the parents at 4, 6 and 12 months to advise them that recommended immunizations are due. If we do not have record of the child receiving the appropriate immunizations at 21 months, an additional letter is mailed identifying the child as being tardy for recommended immunizations. A final program completion letter is mailed when the member reaches 24 months of age and has completed all the recommended vaccinations.

- PrevenTrac BA+ mails out reminder letters to parents of BA+ children to remind them of their upcoming EPSDT exam. The letter includes the immunization schedule for the recommended ages. In addition, an appointment planner is sent to all PCPs informing them of members that are due for their annual EPSDT exam.

Outcomes
In CY2009, there was no statistical change in comparison to CY2008. In CY2009 BA+ ranked 7th out of 10 state MO HealthNet Plans (consideration provided for those plans who are in multiple regions).

Cervical Cancer Screening
According to the American Cancer Society (2009) it is estimated that there will be 11,270 new cases of cervical cancer and 4,070 deaths in 2009. The Pap test is a simple procedure to detect cervical cancer. This measure reflects the percentage of women between the ages of 21 and 64 who had a Pap test within the last three years.

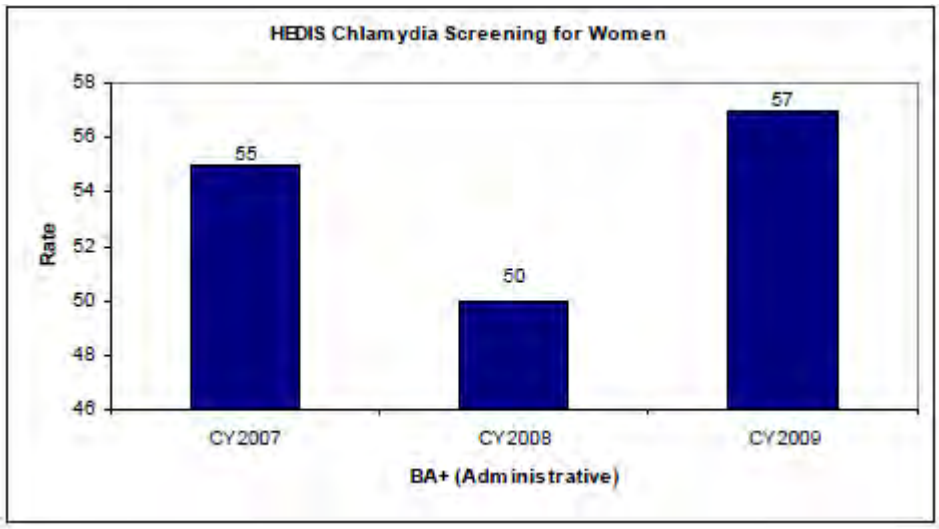


Interventions
- All women between the ages of 18 and 69 receive an annual mass mailing containing educational material related to cervical cancer and encouragement to the member to get a Pap test.
- The PCP physician profile reports the percentage of their patients that are compliant with having a Pap test in the last three years. A list of women that need a Pap test is included in the profile. Physicians are encouraged to report compliance for which BCBSKC has no data for inclusion in the EDW as a pseudo claim.

Outcomes
- In CY2009 BA+ ranked 2nd out of 10 state MO HealthNet Managed Care Plans (consideration provided for those plans who are in multiple regions).
- In CY2009, there was significant statistical change (favorable) in comparison to CY2008.

Chlamydia Screening for Women
Chlamydia is a common sexually transmitted disease (STD) caused by a bacterium which can damage a woman's reproductive organs. Even though symptoms of Chlamydia are usually mild or absent, serious complications that cause irreversible damage, including infertility, can occur "silently" before a woman ever recognizes a problem. Chlamydia is the most frequently reported bacterial sexually transmitted disease in the United States. In 2006, 1,030,911 Chlamydia

infections were reported to CDC. (CDC, 2009)

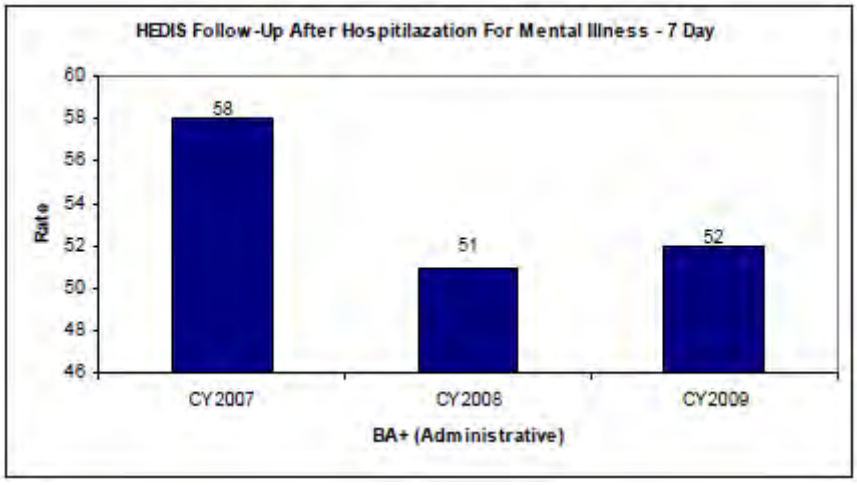


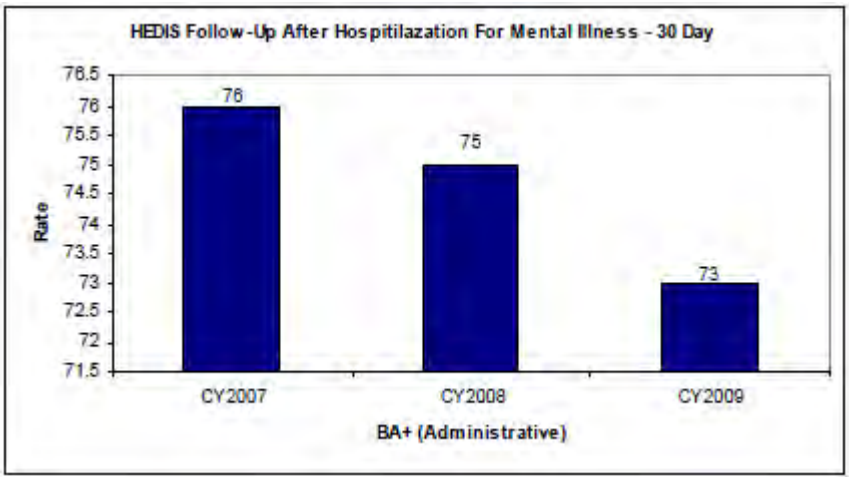
Outcomes

- In CY2009, there was statistical improvement on the Chlamydia Screening Rate in comparison to CY2008.
- In CY2009 BA+ ranked 4th among MO HealthNet Managed Care Plans in Missouri.

Follow-up After Hospitalization for Mental Illness (FUH)

The success of the member after a behavioral health hospitalization is to connect with a behavioral health provider within a week of discharge. FUH measures the percentage of members that completed a visit with a behavioral health provider within 7 days and 30 days of discharge.





Interventions

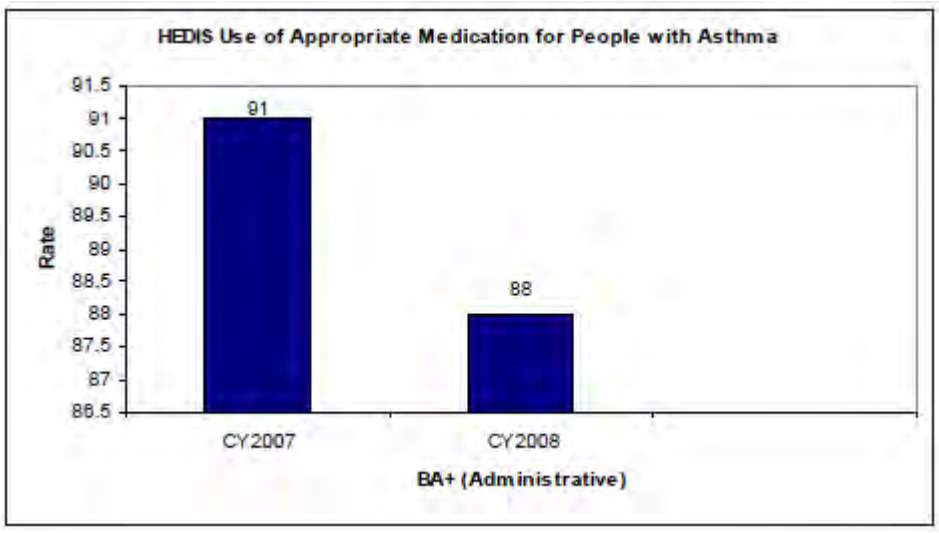
- New Directions Behavioral Health has a mature on-going performance improvement project for BA+ members to meet the 7- and 30-day timeframes for this measure. NDBH works with facility staff to set an appointment prior to discharge; members are contacted by NDBH clinical staff; and/or home visits are arranged through their Personal Transition Services program.

Outcomes

- In CY2009, there was no statistical change in rates in comparison to CY2008.
- BA+ ranked 1st among all MO HealthNet Managed Care Plans for 7-Day and 30-Day Followup.

Use of Appropriate Medications for People with Asthma (ASM)

Asthma is a chronic lung disease that inflames and narrows the airways and affects more than 22 million people in the United States (NIH, 2009). Appropriate treatment of the members with asthma includes prescribing a medication that controls or helps to prevent symptoms. This measure reports the percentage of members between 5-56 years of age who were appropriately prescribed a controller medication.

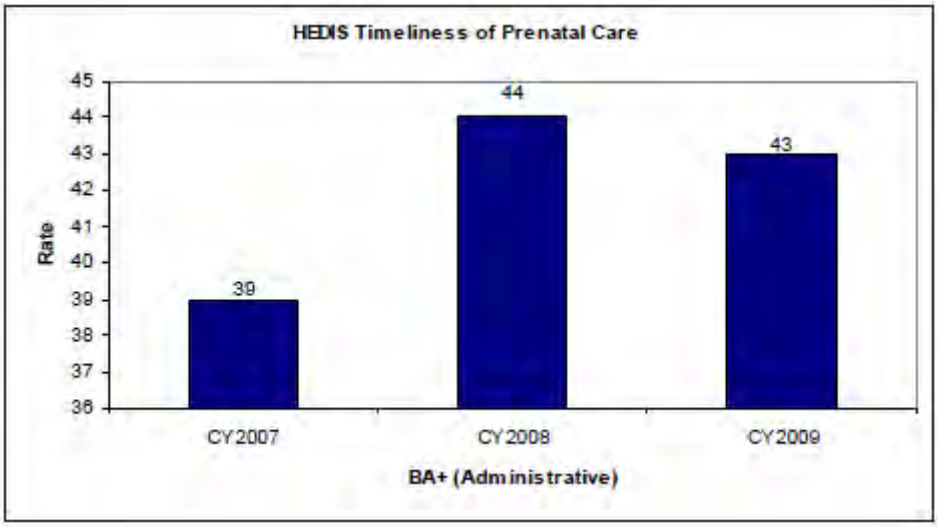


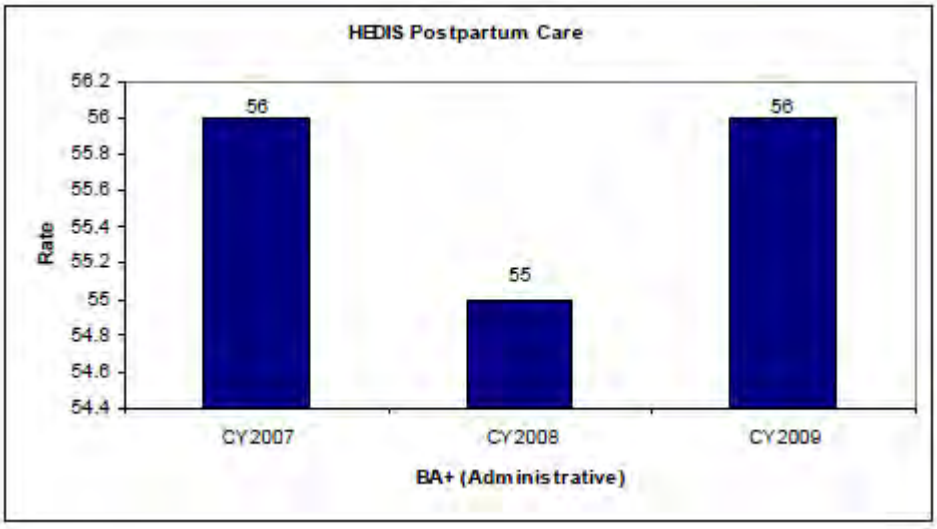
Outcomes

- In CY2008, there was no statistical change in the ASM rate in comparison to CY2007.
- BA+ did not report the ASM rate in CY2009 due to programming priorities.

Access/Availability of Care - Prenatal and Post-Partum Care (PPC)

The American College of Obstetricians and Gynecologists (ACOG) establish guidelines for the care of women during pregnancy and after delivery. Prenatal and post-partum visits help to ensure the health of the fetus and the mother. PPC measures the percentage of women who have received at least one prenatal visit within the first trimester and a post-partum visit at least forty-two days after delivery.



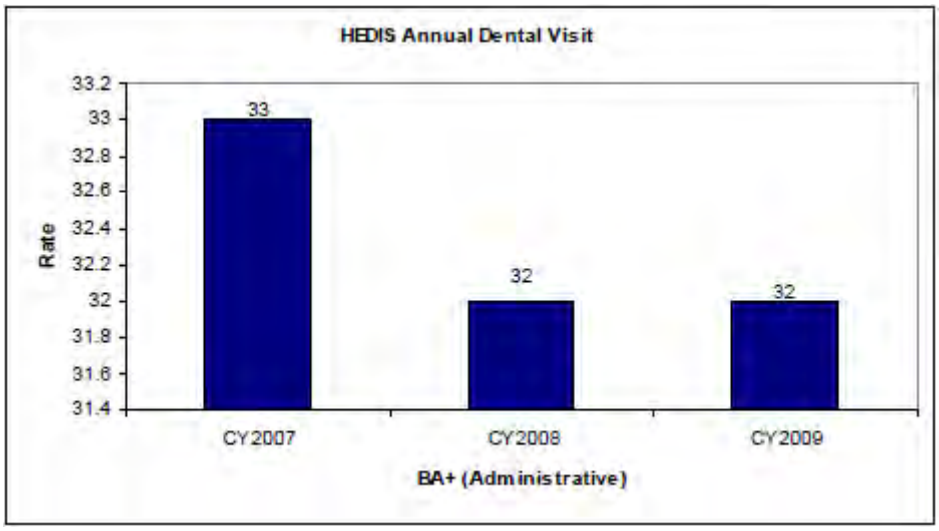


Outcomes

- In CY2009, BA+ experienced an increase in the postpartum care rates.
- There was no statistical change in the prenatal care rate.
- BA+ ranked last among all MO HealthNet Managed Care Plans.

Annual Dental Visit

The percentage of members 2 – 21 years of age who had at least one dental visit during the measurement year is the requirement for the Annual Dental Visit measure.



Outcomes

- In CY2009, there was no statistical change in rates in comparison to 2008.
- BA+ ranked 5th out of 10 state MO HealthNet Plans (consideration provided for those plans who are in multiple regions).

SATISFACTION WITH THE EXPERIENCE OF CARE

Below is a table providing responses to the Child CHAPS survey questions for CY2004 through CY2009. In CY2009, there were no statistical improvements in any of the results in comparison to CY2008. There was a statistical significant decrease in one measure: Rating of Health Care.

			2009	2008	2007	2006	2005	2004
9	(H) CAHPS Child Survey	Getting Needed Care*	75%	82%	80%	81%	84%	81%
		Getting Care Quickly**	90%	79%	78%	80%	79%	79%
		How well Doctors Communicate	90%	90%	89%	92%	90%	90%
		Courteous and Helpful Office Staff	NA	91%	90%	92%	91%	90%
		Customer Service*	84%	74%	64%	77%	77%	72%
		Rating of Personal Doctor	79%	83%	80%	78%	78%	79%
		Rating of Specialist	78%	81%	79%	77%	86%	80%
		Rating of Health Care	74%	84%	82%	80%	76%	82%

* Composite not trendable to 2008 due to changes in question wording and/or response choices of component questions in 2009.

**Component questions were added to and/or deleted from the composite calculations as defined by NCQA in 2009.

Use of Services - Well Child Visits
The following table provides the HEDIS rates for Well Child Visits and Adolescent Well Care Visits for CY2007 through CY2009.

	2007	2008	2009
(H) Well Child Visits in the First 15 Months of Life (W15)			
0 visits	2%	2%	3%
1 visits	4%	4%	4%
2 visits	5%	6%	6%
3 visits	8%	9%	10%
4 visits	15%	16%	14%
5 visits	23%	23%	23%
6 or more visits	40%	39%	39%
(H) Well Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life (W34)	56%	56%	56%
(H) Adolescent Well-Care Visits (AWC)	33%	34%	35%

Interventions

- PrevenTrac - BA+ mails out reminder letters to parents of BA+ children to remind them of their upcoming annual well child exam. In addition, an appointment planner is sent to all PCPs informing them of members that are due for their annual well child exam.

Outcomes

- In comparison to 2007 and 2008, there has been no statistical change in all three measures.
- BA+ ranked 1st in 5 Well Child Visits and 8th in 6 or More Well Child Visits among all MO HealthNet Managed Care Plans (considering Plans who are in multiple regions).
- BA+ ranked 5th in Adolescent Well Care Visits.

Mental Health Utilization

	2007	2008	2009
(H) Mental Health Utilization – Percentage of Members Receiving Inpatient, Intermediate Care and Ambulatory Services (MPT)	Not Reported	Not Reported	Not Reported

Identification of Alcohol and Other Drug Services (IAD)
Below is table providing the HEDIS rates for Identification of Alcohol and Other Drug Services for CY2007 through CY2009

(H) Identification of Alcohol and Other Drug Services	Inpatient Chemical Dependency Services		Intensive Outpatient/Partial Hospitalization		Outpatient/ED	
CY2007	Number	Percent	Number	Percent	Number	Percent
	132	0.51%	0	0.00%	194	0.75%
CY2008	Number	Percent	Number	Percent	Number	Percent
	158	0.60%	17	0.06%	233	0.88%
CY2009	Number	Percent	Number	Percent	Number	Percent
	121	0.45%	6	0.02%	265	0.98%

Outcomes

- In comparison to the CY2008 result (0.60%)), there was a statistical decrease in inpatient chemical dependency services for 2009 (0.45%).
- There was a decrease in the CY2009 inpatient outpatient/partial hospital result (0.02%). In comparison to CY2008 (0.06%), the decrease is statistically significant.
- The CY2009 outpatient/ED rate (0.98%) also increased significantly in comparison to CY2008 (0.88%).

Ambulatory Care

Below are three tables that indicate the HEDIS rates for Ambulatory Care for FY2007 through FY2009.

	(H) Ambulatory Care (AMB) 2007	Ambulatory Care (Total)		Outpatient Visits		Emergency Room Visits		Ambulatory Surgery/Procedures		Observation Room Stays Resulting in Discharge	
		Age	Member Months	Visits	Visits/ 1000 Member Months	Visits	Visits/ 1000 Member Months	Procedures	Procedures / 1000 Member Months	Stays	Stays/ 1000 member Months
		<1	23,498	19,428	826.79	2,126	90.48	102	4.34	36	1.53
		1--9	132,581	38,707	291.95	5,922	44.67	440	3.32	43	0.32
		10--19	97,431	18,994	194.95	4,220	43.31	211	2.17	106	1.09
		20--44	52,769	15,383	291.52	5,848	110.82	550	10.42	419	7.94
		45--64	3,660	1,367	373.5	295	80.6	72	19.67	4	1.09
		65--74	4	4	1,000	0	0	1	250	0	7.64
		75--84	0	0	NA	0	NA	0	NA	0	1.09
		85+	0	0	NA	0	NA	0	NA	0	0.00
		Unknown	0	0		0		0		0	
		Total	309,943	93,883	302.9	18,411	59.4	1,376	4.44	608	1.96

	(H) Ambulatory Care (AMB) 2008	Ambulatory Care (Total)		Outpatient Visits		Emergency Room Visits		Ambulatory Surgery/Procedures		Observation Room Stays Resulting in Discharge	
		Age	Member Months	Visits	Visits/ 1000 Member Months	Visits	Visits/ 1000 Member Months	Procedures	Procedures / 1000 Member Months	Stays	Stays/ 1000 member Months
		<1	25,217	20,999	832.73	2,564	101.68	131	5.19	55	2.18
		1--9	138,392	41,786	301.94	6,945	50.18	564	4.08	77	0.56
		10--19	99,652	20,077	201.47	4,821	48.38	338	3.39	172	1.73
		20--44	50,819	14,110	277.65	6,503	127.96	568	11.18	453	8.91
		45--64	3,080	1,224	397.40	342	111.04	71	23.05	14	4.55
		65--74	13	11	846.15	5	384.62	0	0.00	0	0.00
		75--84	2	2	1,000.00	0	0.00	0	0.00	0	0.00
		85+	0	0	NA	0	NA	0	NA	0	NA
		Unknown	0	7		0		0		0	
		Total	317,175	98,216	309.66	21,180	66.78	1,672	5.27	771	2.43

	(H) Ambulatory Care (AMB) 2009	Ambulatory Care (Total)		Outpatient Visits		Emergency Room Visits		Ambulatory Surgery/Procedures		Observation Room Stays Resulting in Discharge	
		Age	Member Months	Visits	Visits/ 1000 Member Months	Visits	Visits/ 1000 Member Months	Procedures	Procedures / 1000 Member Months	Stays	Stays/ 1000 member Months
		<1	26,729	20,791	777.84	3,083	115.34	222	8.31	46	1.72
		1--9	145,436	42,677	293.44	8,589	59.06	887	6.1	84	0.58
		10--19	100,426	21,251	211.61	5,316	52.93	884	8.8	212	2.11
		20--44	49,896	16,716	335.02	6,835	136.98	1,803	36.14	547	10.96
		45--64	2,923	1,226	419.43	254	86.9	61	20.87	8	2.74
		65--74	1	0	0.00	0	0.00	0	0.00	0	0.00
		75--84	4	0	0.00	0	0.00	0	0.00	0	0.00
		85+	0	0	NA	0	NA	0	NA	0	NA
		Unknown	0	0		0		0		0	
		Total	325,415	102,661	315.48	24,077	73.99	3,857	11.85	897	2.76

Outcomes

Year-over-year results for ambulatory care appear to be trending upward in the following categories.

- Outpatient Visits
- Emergency Room Visits
- Ambulatory Surgery/Procedures
- Observation Room Stays Resulting in Discharge

Quality Indicators

	2007		2008		Significant
	Births	*Percent*	*Births*	*Percent*	*Change*
Birth weight (grams) – total number of births by weight category for each live birth					
< 1500 Grams	15	1.30%	10	0.80%	No
1500-2499 Grams	3	0.30%	1	0.10%	No
2500+ Grams	1141	98.40%	1255	99.10%	No
Total	1159		1266		
Gestation Age (Weeks)					
< 33 weeks	39	3.40%	28	2.20%	No
33-36 weeks	31	2.70%	33	2.60%	No
Total	70		61		
Method of Delivery					
C-Section	1435	99.60%	1417	99.60%	No
VBAC	6	0.40%	7	0.40%	No
Birth to Mothers < 18 years of age	84	7.20%	86	6.80%	No
Births to mothers aged 35 or more	49	4.20%	62	4.90%	No
	Number	*Rate*	*Number*	*Rate*	*Change*
Asthma Admission under age 18, Inpatient admission rate per 1000 Population	56	2.08	66	2.4	No
Asthma admission 4-14 Inpatient admissions Per 1000 Population	35	1.3	36	1.31	No
Asthma emergency room visits 0-3	84	-	94	-	No
Asthma emergency room visits 4-17	191	-	214	-	No
Asthma admissions age 18 – 64 Per 1000 Population	9	0.33	7	0.3	No
Emergency room visits age 0-19 per 1000 Population	14,330	54.4	16,988	62.3	Yes
Emergency room visits age 20 – 64 Per 1000 Population	6,845	127	7,089	134.2	Yes

Outcomes

- In comparison to 2007, BA+ has not seen any significant changes in the majority of the BA+ Quality Indicators listed above.
- BA+ experienced significant change in both of the Emergency Room quality indicators:
  1) Emergency room visits age 0-19 and
  2) Emergency room visits age 20-64.
- ER utilization for BA+ is increasing significantly. BA+ has implemented several one-on-one interventions and population wide interventions to decrease ER utilization. (See Attachment 13 for details on the BA+ ER Pilot project.)

HEDIS Indicators by MO HealthNet Managed Care Health Plans Within Regions, Live Births

				Significantly different from			2007
	2007	2006	2005	MEDICAID	State		Total
Indicator Name	Rate*	Rate*	Rate*	Managed Care	Rate	Number	Deliveries
Cesarean Sections	23.5	23.0	23.3	Low	Low	435	1,849
Vaginal Birth After Cesarean (vbac)	9.6	15.2	4.8	***	***	17	177
Adequacy Of Prenatal Care	↓80.6	84.9	86.8	No	Low	1,399	1,736
Early Prenatal Care	77	76.7	81.7	No	Low	218	296
Low Birth Weight (lbw, Less Than 2500 G)	10.8	12.4	7.2	No	No	30	277
Low Birth Weight (lbw, Less Than 2500 G) Delivered In Level Ii/Iii Hospitals	88.4	89.9	84.0	No	No	137	155
Very Low Birth Weight (vlbw, Less Than 1500 G) Delivered In Level Ii/Iii Hospitals	76.9	90.6	76.7	Low	Low	20	26
Smoking During Pregnancy	27.4	30.2	28.4	No	High	506	1,849
Spacing Less Than Eighteen Months	↑21.0	15.8	15.9	High	High	215	1,024
Births To Mothers Less Than 18 Years	5.8	5.8	5.1	No	High	108	1,849
Repeat Births To Teen Mothers (Less Than 20 Years)	4.4	3.4	3.8	No	High	82	1,849
Prenatal WIC Participants	77.8	77.7	74.8	High	High	1,435	1,845

*Per/1000
↓ Indicates a significant decrease from 2006 rate.
↑ Indicates a significant increase from 2006 rate

Outcomes

- The majority of the HEDIS Indicators (CY2007) listed above for BA+ has remained unchanged.
- Compared to previous years, BA+ experienced a decrease in the "Smoking during Pregnancy" HEDIS indicator (30.2 to 27.4).
- There was also improvement in rates for all three "Low Birth Rate" HEDIS indicators.
- The CY2007 rate for the "Very Low Birth Rate" HEDIS indicator was decreased (90.6 to 76.9)
- There was significant increase in the "Spacing Less Than Eighteen Months" indicator.
- CY2007 "Adequacy of Prenatal Care" indicator was significantly different (unfavorable) than CY2006.

Children's Mercy Family Health Partners

Performance Measures

HEDIS (Healthcare Effectiveness Data & Information Set)

Trends in Missouri Medicaid Quality Indicators

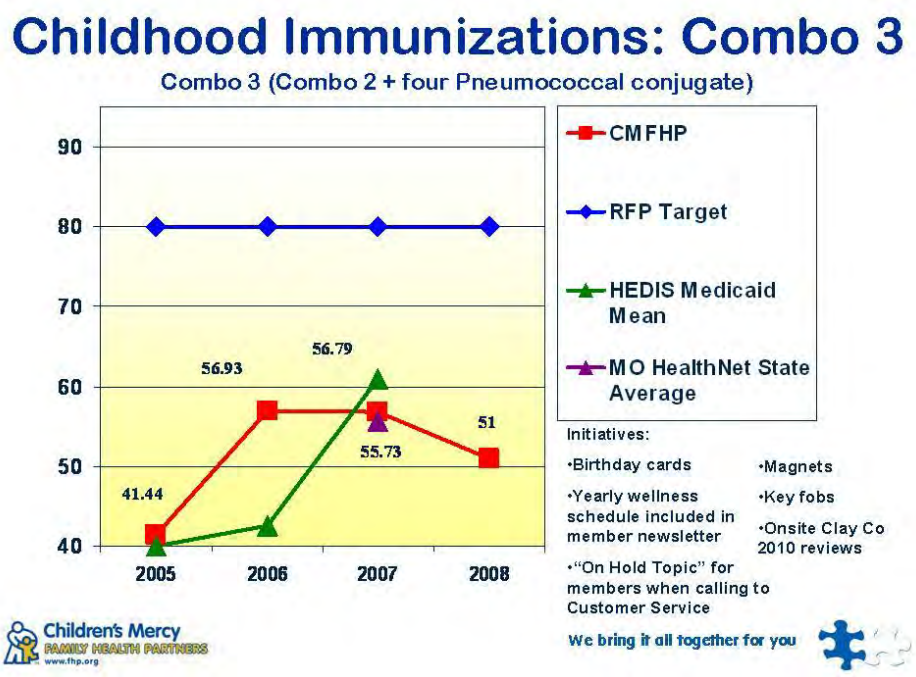
Program Review

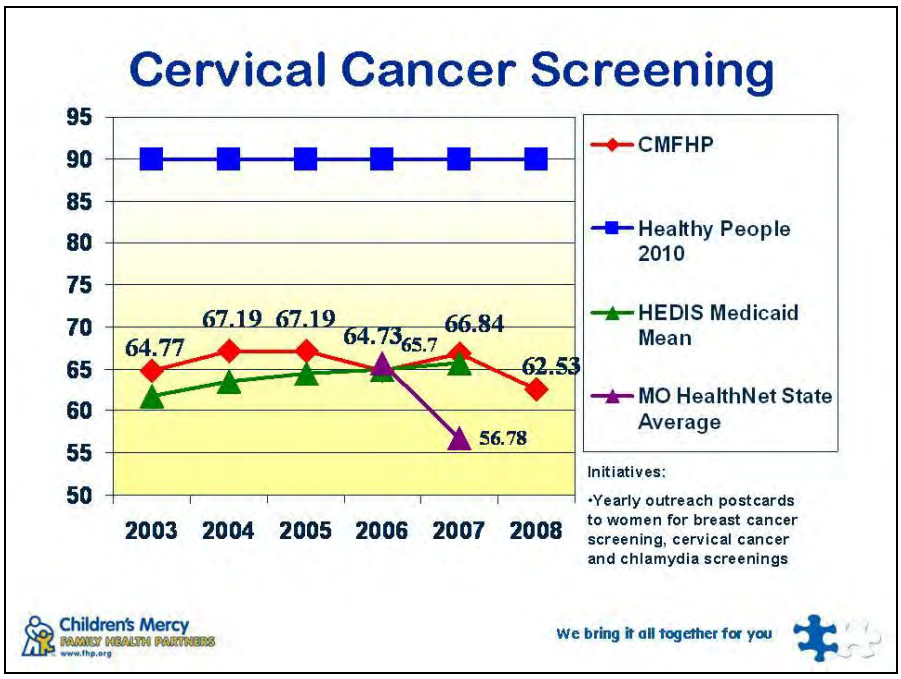
Children's Mercy Family Health Partners (CMFHP) actively measures, monitors, and reports HEDIS Quality Indicators as part of our overall quality improvement program. All reportable HEDIS measures are presented to the Administrative Oversight and Medical Oversight Committees (AOC/MOC) and the Board of Directors (Governing Body). In addition, the measures are reported annually to the State of Missouri in accordance with the state contract. HEDIS rates are plotted over time and compared with State and National benchmarks. The trends and comparative results are shared with both the AOC and the Health Improvement Committee for oversight and improvement recommendations.

Data and Trends
The following graphs demonstrate how CMFHP trends and monitors our HEDIS performance. In the following graphs, several abbreviations are used:

CMFHP	Children's Mercy Family Health Partners
HP	Healthy People 2010
RFP	MO HealthNet Contract - Request for Proposal

All vertical axis numbers represent the percentage of the population receiving services, except for the Ambulatory Care Measures which are per 1000 member months.




Cervical Cancer Screening
95
90
85
80
75
70
65
60
55
50
2003
2004
2005
2006
2007
2008
64.77
67.19
67.19
64.73
65.7
66.84
62.53
56.78
CMFHP
Healthy People 2010
HEDIS Medicaid Mean
MO HealthNet State Average
Initiatives:
•Yearly outreach postcards to women for breast cancer screening, cervical cancer and chlamydia screenings
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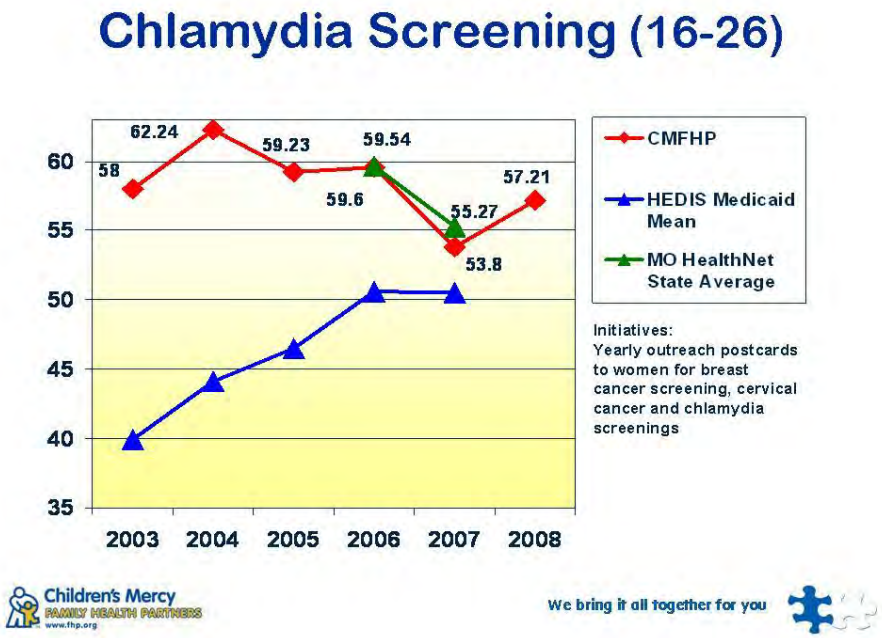
Chlamydia Screening (16-26)
60
55
50
45
40
35
2003
2004
2005
2006
2007
2008
58
62.24
59.23
59.54
59.6
55.27
53.8
57.21
CMFHP
HEDIS Medicaid Mean
MO HealthNet State Average
Initiatives:
Yearly outreach postcards to women for breast cancer screening, cervical cancer and chlamydia screenings
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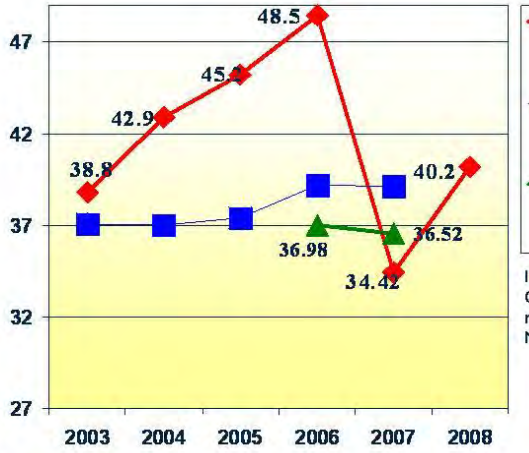
Mental Health Follow Up after Hospital (7 days)



CM FHP

HEDIS Medicaid Mean

MOHealthNet State Average

Initiatives:
Continue claim reconcile process with New Directions

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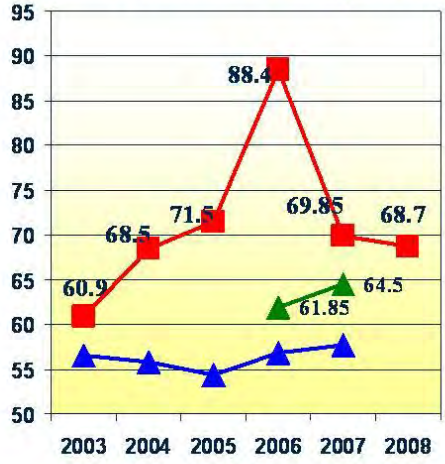
Mental Health Follow Up after Hospital (30 days)



CMFHP

HEDIS Medicaid Mean

MO HealthNet State Average

Initiatives:
Continue claim reconcile process with New Directions

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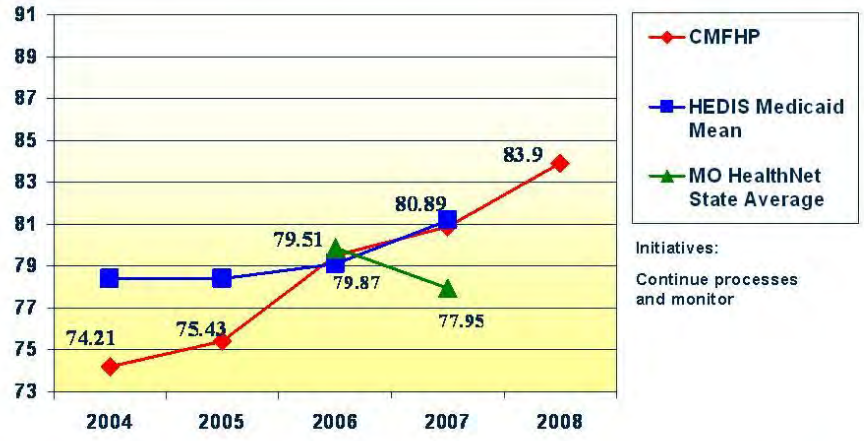
Timeliness of Prenatal Care



Initiatives:

Continue processes and monitor

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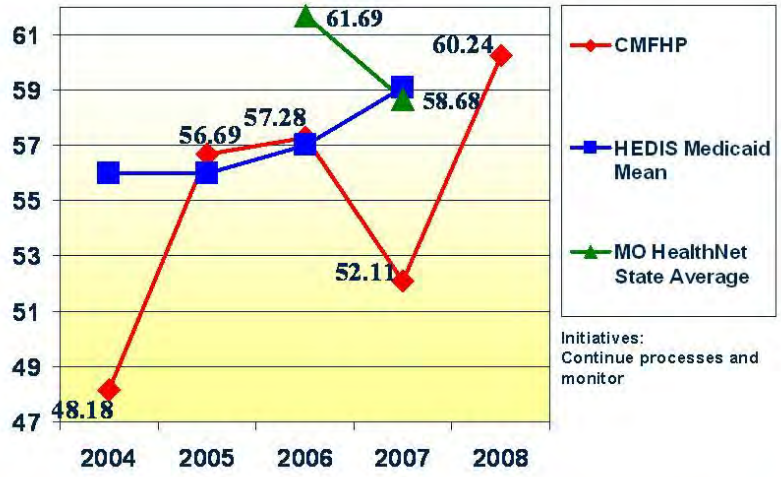
Postpartum Care



Initiatives:
Continue processes and monitor

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Annual Dental Visits

Initiatives:

- Dental PIP 2008;
- Postcards to all members who have not had an annual dental screening
- Dental QI Team in place 2009
- Statewide PIP 2009

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Well Child Visits
(six or more in 1st 15 months of life)

Initiatives:

*Newborn Cards for 0-11 mo. – includes periodicity schedule

*Birthday Cards for 1-11 yrs. – includes periodicity schedule

*All periodicity schedules include dental, lead immunizations and well care information.

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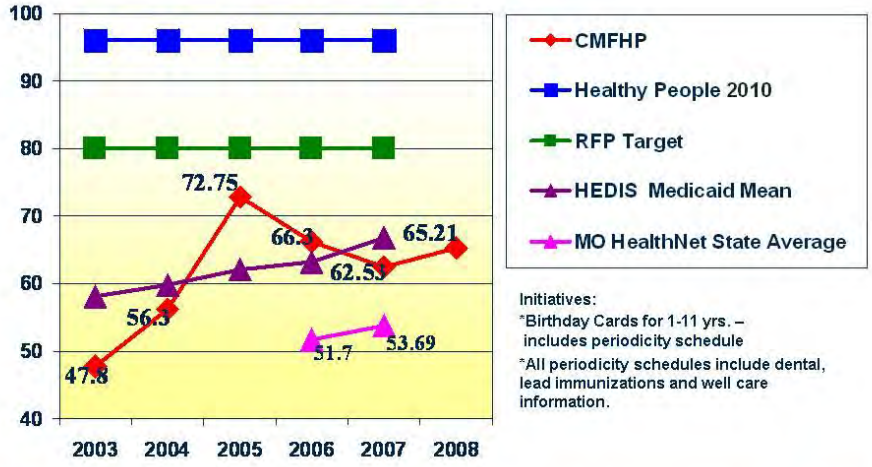
Well Child Visits
3-6 years



Initiatives:

*Birthday Cards for 1-11 yrs. – includes periodicity schedule

*All periodicity schedules include dental, lead immunizations and well care information.

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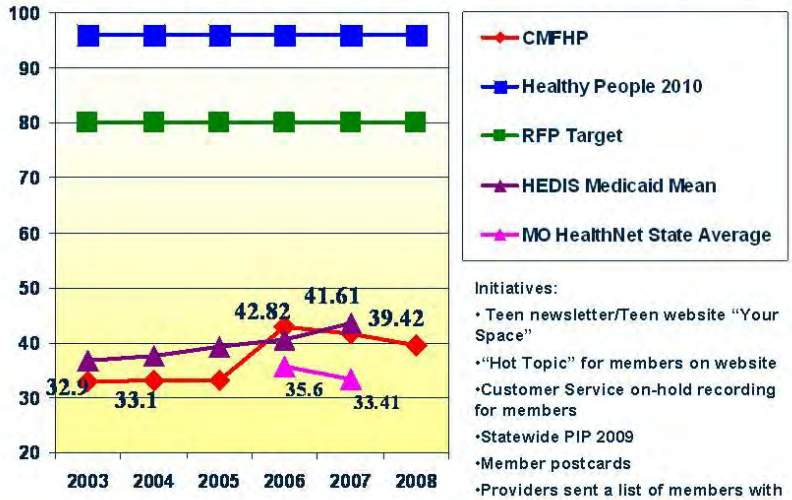
Adolescent Well Care



Initiatives:

- Teen newsletter/Teen website "Your Space"
- "Hot Topic" for members on website
- Customer Service on-hold recording for members
- Statewide PIP 2009
- Member postcards
- Providers sent a list of members with out an annual visit

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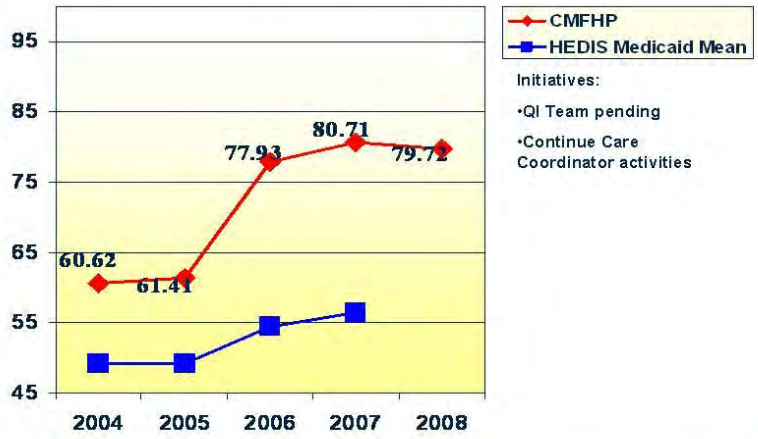
Ambulatory Care
(ER visits / 1000 member months)



Initiatives:

- QI Team pending
- Continue Care Coordinator activities

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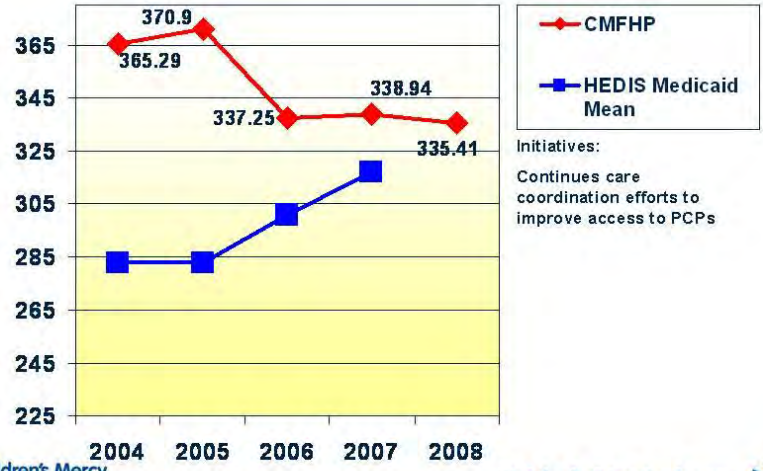
Ambulatory Care
(outpatient visits / 1000 member months)



Initiatives:

Continues care coordination efforts to improve access to PCPs

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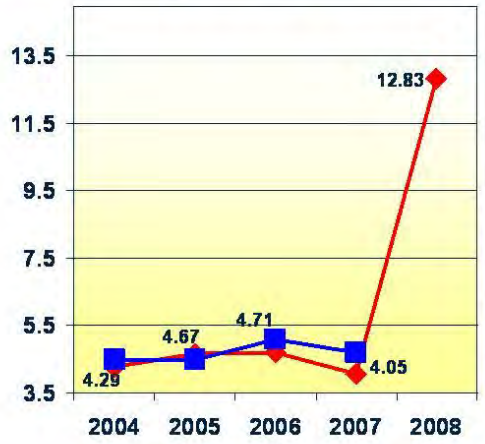
Ambulatory Care
(Amb Surg Proc / 1000 member months)



Initiatives:

- Continue to monitor based on new code specifications below
- The increase outcome is identified as a result of code changes in the technical specifications, an additional 1023 codes were added in 2009. The additional codes included ICD-9 and CPT codes.

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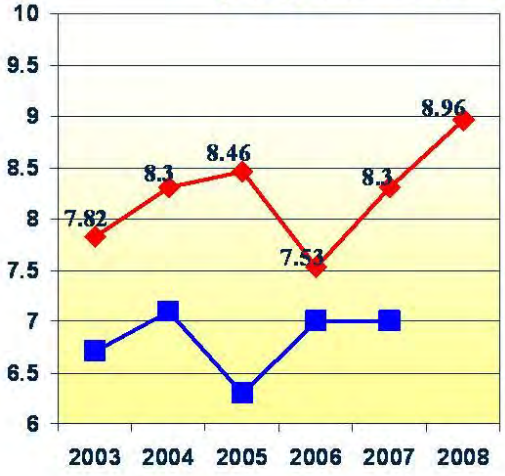
Mental Health Utilization
(any MH service)



Initiatives:

- Collaboration with State QA&I Subgroup for tracking and trending of access
- Collaboration with New Directions

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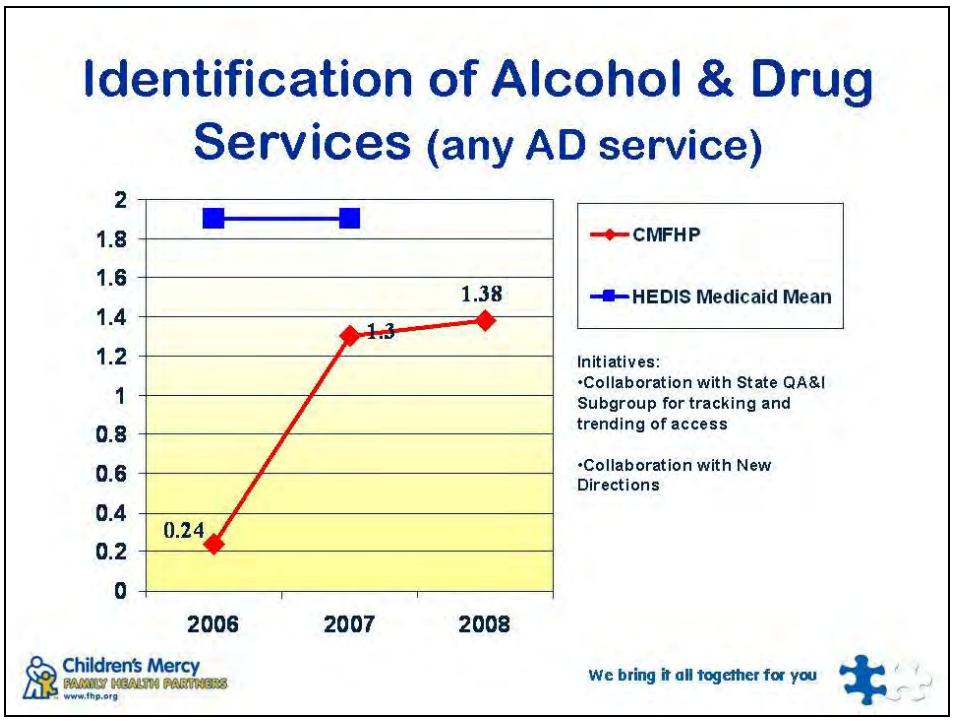


Analysis
Considering all measures, CMFHP's HEDIS rates compare favorably to the Missouri State averages on the most recent comparison available. Of the eleven Effectiveness of Care measures presented, CMFHP rates higher than the State Average on eight; of the three that were below, all of the CMFHP rates improved in the subsequent year. Regarding Access to Care and Dental Visits, CMFHP again rated higher than the State Average.

When the comparison shifts to National Averages, however, CMFHP rates higher on only 5 of 11 Effectiveness of Care measures presented; in addition, CMFHP also rates lower on the Dental Visit measure. As part of the overall quality improvement program, the National benchmarks will become more prominent comparison points for evaluating our progress.

Strengths
CMFHP does well with Cervical Cancer and Chlamydia Screenings, Appropriate Medication for Asthma, Mental Health Follow-up (30 days), and Well Child Visits (0-15mths). CMFHP tends to be above National and State averages for these measures. CMFHP has also made significant improvement over time with the Timeliness of Prenatal Care measure which now exceeds the State Average and is very close to the National Average.

Weaknesses
CMFHP is lagging the National Average in Childhood Immunizations (Combo3), Mental Health Follow-up (7 days), and Postpartum Care. For Dental Visits and Well Child Visits (3-6 years), we are below the National Average but above the State Average.

Opportunities
Improvement initiatives implemented based on Children's Mercy Family Health Partners' HEDIS Indicator results included:

Yearly wellness reminders and schedules are mailed to members for children, adolescents, women and men (including Breast Cancer and Prostate Cancer screening reminders). These reminders are also posted on our website. In addition, Newborn Cards (0-11 mths) and Birthday Cards (1-11 yrs) are being sent to members and include Immunization Periodicity, Lead Screening, Dental Visit, and Well Child Visit schedules.

Cervical Cancer and Chlamydia screening letters were sent to identified members and their providers to promote increased screening rates.

Plan-level Performance Improvement Project (PIP) for annual dental visits was completed. A dental QI team is in place and the Statewide Dental PIP activity has begun.

A periodic Teen Newsletter has been developed which specifically addresses adolescent health concerns and encourages well care visits as part of a healthy lifestyle. The information is also available on our website under the "yourspace teen magazine".

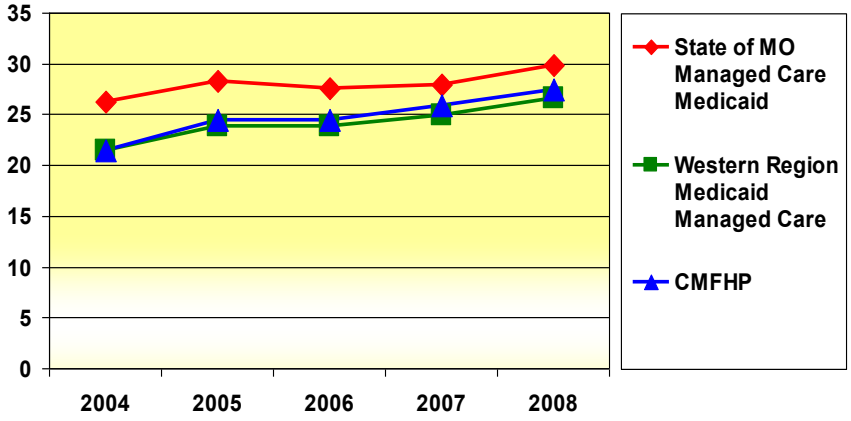
Coordination and collaboration with behavioral health subcontractor to assess decreased rates and improve rates in the Mental Health Follow up in 7 and 30 days post-hospitalization measures.

HEDIS Indicators by MO HealthNet Managed Care Health Plans Within Regions, Live Births
HEDIS Indicators MO HealthNet Maternal Outcomes for Western Region
Children' Mercy Family Health Partners (CMFHP) actively participates in the State of Missouri, MO HealthNet Division's Managed Care Quality Assessment and Improvement Advisory Group (QA & I). The purpose of the QA&I is to impact service utilization through collaborative monitoring and continuous quality improvement activities. The Missouri Department of Health and Senior Services calculates and reports Maternal Health Indicators based on data from birth certificate information annually to the QA & I. The Maternal Health Indicators were distributed to CMFHP via the QA&I. The outcomes were reviewed and trended to past reports. After analysis the indicators were reported to the Health Improvement Committee for oversight and recommendations.

Data and Trends
Please see the following graphs for demonstration of CMFHP tracking and trending of maternal health indicators.

Maternal Health Indicators

Cesarean Section Deliveries
(Based on DHSS Data)



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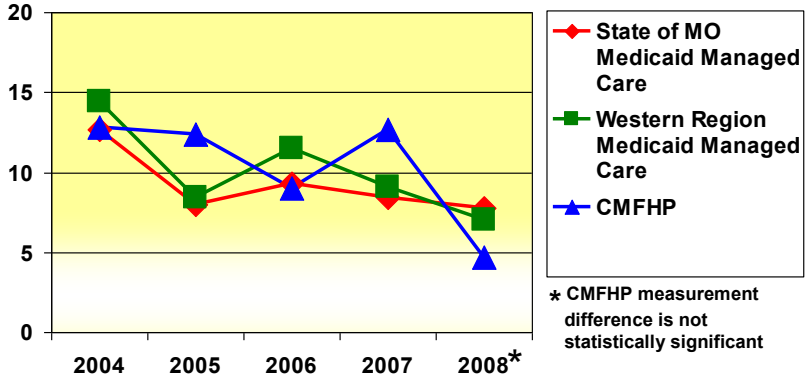
Maternal Health Indicators

Vaginal Deliveries After C/S (VBAC)

Total Deliveries = Total Live Births with VBAC or Repeat C-Section noted
Based on DHSS Data



* CMFHP measurement difference is not statistically significant

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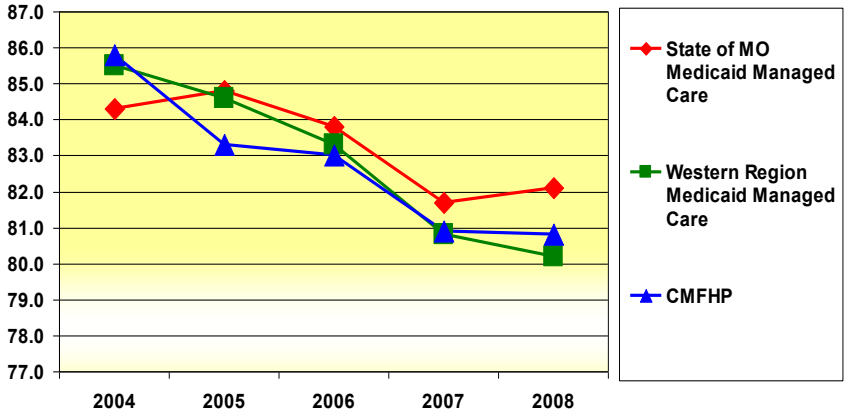
Maternal Health Indicators

Percent of Women with Adequate Prenatal Care



Based on DHSS Data
Total deliveries = Total live births to women with known prenatal care

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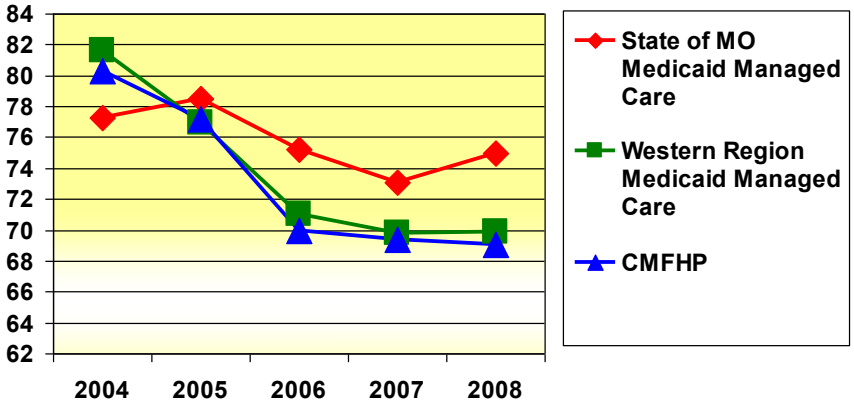
Maternal Health Indicators

Percent of Women Receiving Early Prenatal Care
(Based on DHSS Data – Total Deliveries = Total live births to continuously enrolled women for 280 days prior to delivery)



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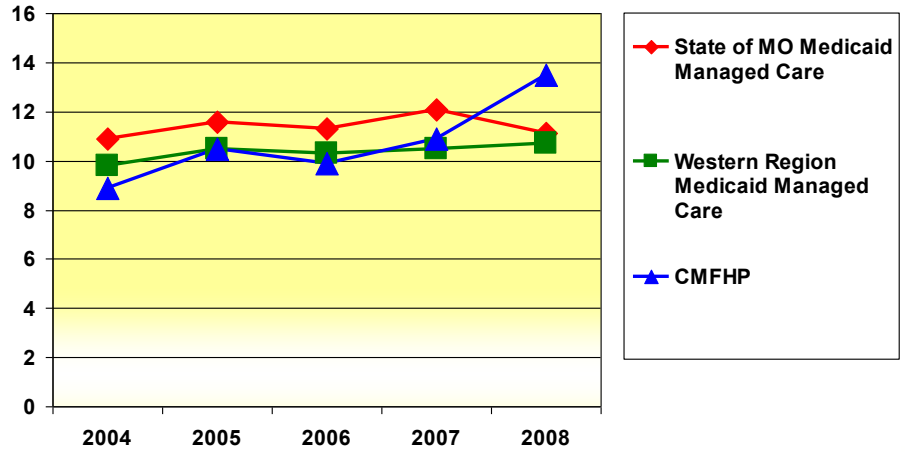
Maternal Health Indicators

Percent of Low Birth Weight Deliveries (< 2500 Grams) (Based on DHSS Data)



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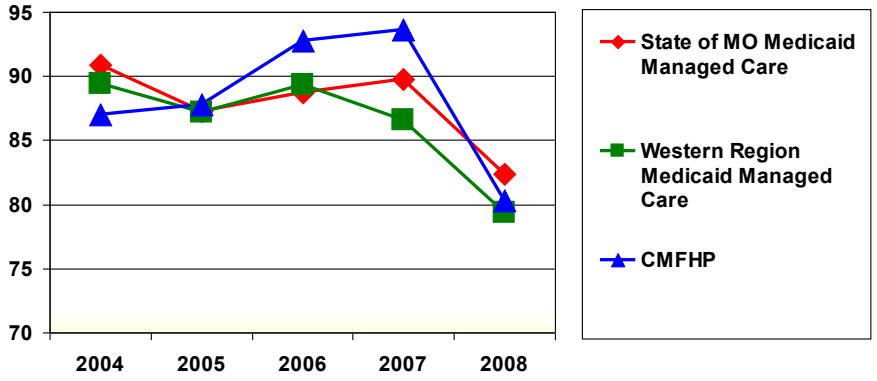
Maternal Health Indicators

Percent of Low Birth Weight Deliveries in Level II/III Hospitals (< 2500 Grams) (Based on DHSS Data)



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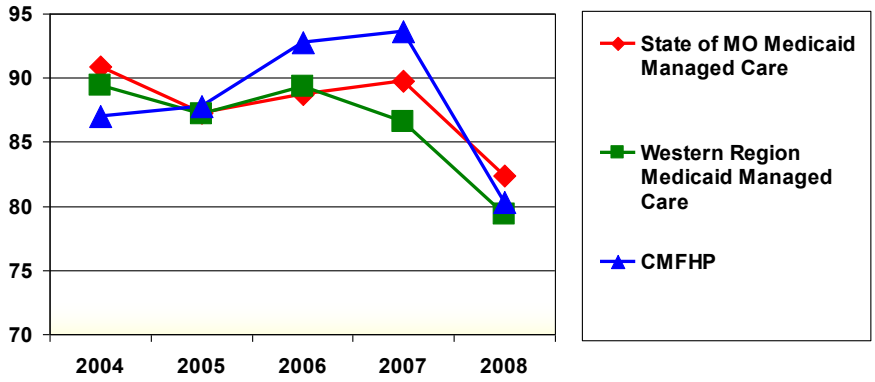
Maternal Health Indicators

Percent of Low Birth Weight Deliveries in Level II/III Hospitals (< 2500 Grams) (Based on DHSS Data)



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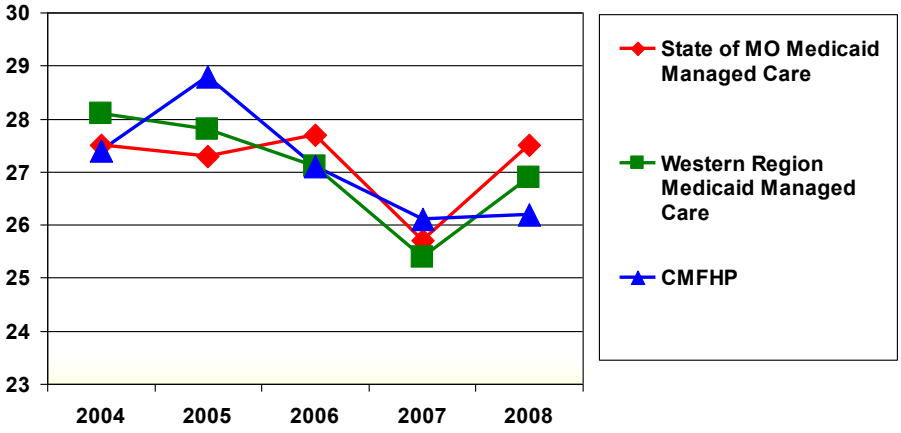
Maternal Health Indicators

Percent of Women Smoking During Pregnancy (Based on DHSS Data)



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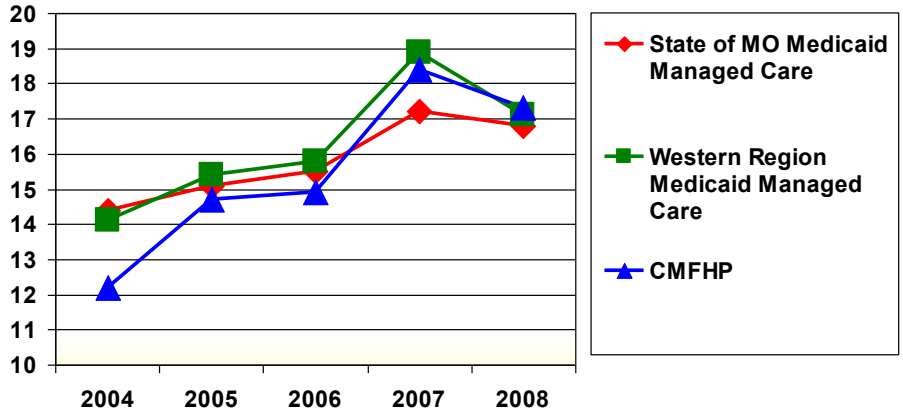
Maternal Health Indicators

Percent of Women with Birth Spacing < 18 Months
(Based on DHSS Data)



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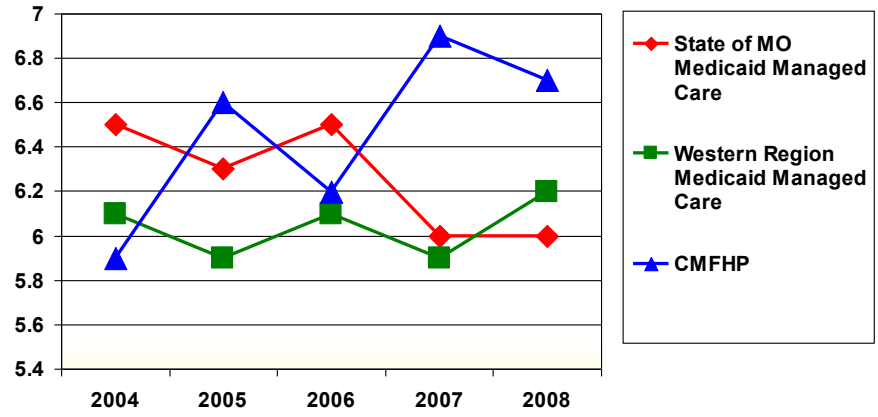
Maternal Health Indicators

Percent of Births to Mothers less than 18 years of age
(Based on DHSS Data)



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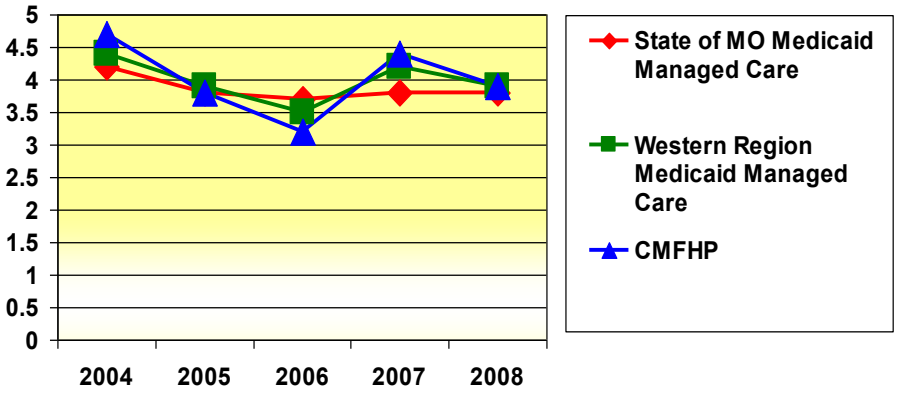
Maternal Health Indicators

Percent of Repeat Births to Women < 20 years
(Based on DHSS Data)



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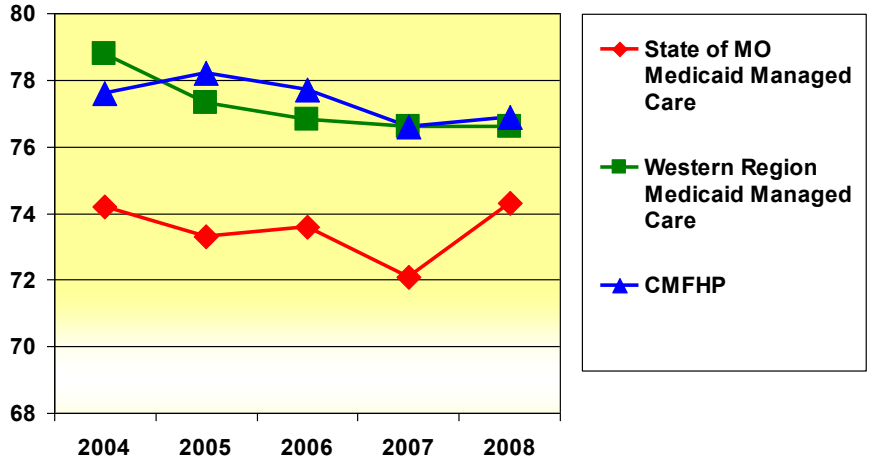
Maternal Health Indicators

Percent of Prenatal WIC Participants
(Based on DHSS Data)



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Analysis
CMFHP's trended cesarean sections indicator demonstrates a statistically significant lower rate compared to both the State Medicaid Managed Care and the Western Region averages. The DHSS reported rate of 27% is comparable to CMFHP's ongoing tracking of cesarean section rates. CMFHP's indicator for vaginal birth after cesarean has a denominator too small to calculate with statistical significance.

CMFHP's trended adequacy of prenatal care indicator demonstrates no statistically significant change compared to both the State Medicaid Managed Care and the Western Region averages. CMFHP's trended early prenatal care indicator demonstrates a statistically significant lower rate compared to both the State Medicaid Managed Care and the Western Region averages. CMFHP compared this rate to our Healthcare Effectiveness Data and Information Set (HEDIS) and note that this self-reported birth certificate data is lower than our HEDIS prenatal care rate which is 83.9%.

CMFHP's trended low birth weight indicators demonstrate no statistically significant changes compared to both the State Medicaid Managed Care and the Western Region averages. CMFHP speculates that the higher incidence of low birth weight infants may indicate adverse selection by members with high risk pregnancies.

CMFHP's trended smoking during pregnancy indicator demonstrates no statistically significant change compared to both the State Medicaid Managed Care and the Western Region averages. The 2008 incidence of members smoking during pregnancy is less than both the State Medicaid Manage Care and the Western Region averages.

CMFHP's trended spacing less than eighteen months indicator demonstrates no statistically significant change compared to both the State Medicaid Managed Care and the Western Region averages.

CMFHP's trended births to teen mothers indicator demonstrates no statistically significant changes compared to both the State Medicaid Managed Care and the Western Region averages. CMFHP theorizes the higher incidence of members with births to mothers less than 18 years of age may indicate adverse selection by members with high risk pregnancies.

CMFHP's trended prenatal participants in Women, Infants and Children's (WIC) indicator demonstrates a statistically significant higher rate compared to both the State Medicaid Managed Care and the Western Region averages.

Strengths
CMFHP's lower rate of cesarean sections should also correlate to lower post-delivery surgical complications.

CMFHP's outcome for delivery of very low birth weight babies in Level II/III hospitals is 100%. This increases the opportunity for highest level of care for at risk infants and decreases the likelihood for unexpected death.

CMFHP's rate of women smoking during pregnancy although not statistically significant is mathematically lower than both the State Medicaid Managed Care and the Western Region averages. A lower rate of women smoking during pregnancy increases the likelihood that more infants will be born at average birth weights and at expected gestational age.

CMFHP's trended prenatal participants in Women, Infants and Children's (WIC) indicator demonstrates a statistically significant higher rate compared to both the State Medicaid Managed Care and the Western Region averages. This higher rate demonstrates the consistent intervention for health promotion from CMFHP's OB Care Management Program and increases the numbers of women and children receiving the nutritional support required for growth and development.

Weaknesses
CMFHP's trended indicator, percent of births to mothers less than 18 years of age, compared to both the State Medicaid Managed Care and the Western Region averages although is not statistically significant, it is mathematically higher.

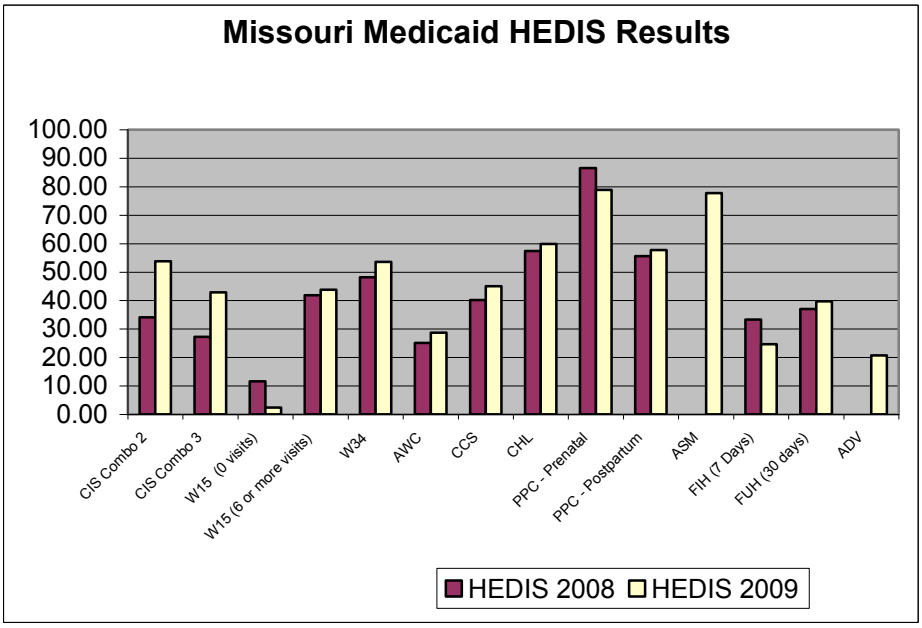
Opportunities
Improvement initiatives implemented based on CMFHP's Maternal Health indicator results include:

- Outreach to members and providers to increase the rate of prenatal care initiation in the first trimester of pregnancy,
- Targeted OB Education to high volume provider offices to increase the rate of prenatal care initiation in the first trimester of pregnancy and notification to the health plan for assessment and case management services,
- Continued targeted OB care management to outreach to high risk pregnant women for improved birth outcomes,
- Continued OB care management to all members regarding: community services; WIC services; risks of smoking during pregnancy and risks related to second hand smoke; risks of drug and alcohol use; risks of lead exposure; signs and symptoms of premature labor; primary care providers for mother and infant; anticipated well child visits for infants and children; child birthing classes; behavioral health access and benefits; transportation options; nurse line access; advance directives; Parents as Teachers; and patient safety.
- Continued post delivery care and education to all members regarding: family planning; birth spacing; contraception; folic acid supplements prior to next pregnancy; and initiation of early prenatal care for future pregnancies.

Harmony Health Plan of Missouri

Performance Measures
Trends in Missouri Medicaid Quality Indicators
In an effort to support Missouri HealthNet quality initiatives, ensure network quality compliance, improve overall plan satisfaction and support network relationships, provider and member outreach activities continue to be focused on achieving statistically significant HEDIS results

with a focal point on achieving results in equal to or greater than the 75th percentile on the National Committee for Quality Assurance Benchmarks.



Analysis

There are thirty-eight HEDIS® an HEDIS like measures being reported in this evaluation. Harmony Health Plan had a goal to achieve statistically significant improvement in a net of 33% of all reported HEDIS® measures for Missouri Medicaid. Of the thirty-eight measures, eleven were not measured in 2008 due to insufficient plan membership size and are not available for year to year comparison.

Of the remaining twenty-seven measures, twenty-two (81%) showed improvement when comparing HEDIS 2009 to HEDIS 2008 results. Statistically significant improvement was observed in six of these twenty-one measures. One measure showed a statistically significant decrease when comparing HEDIS 2009 results to HEDIS 2008.

Thirty seven measures are available for comparison to the NCQA HEDIS benchmarks. Lead Screening is a HEDIS like measure and does not have a benchmark for comparison. The majority (77%) of these thirty six measures fall below the 50th percentile in comparison to NCQA benchmarks. Four of the six measures that fall above the 50th percentile are for Well Child Visits 15 months.

HEDIS Measure	Rate 2008	Rate 2009	% Change	Sig
Adolescent Well Care Visits	25.06%	28.71%	+3.65%	NS
Annual Dental Visits: 2-3 Years	N/A	6.99%	N/A	N/A
Annual Dental Visits: 4-6 Years	N/A	18.82%	N/A	N/A
Annual Dental Visits: 7-10 Years	N/A	30.31%	N/A	N/A
Annual Dental Visits: 11-14 Years	N/A	25.19%	N/A	N/A
Annual Dental Visits: 15-18 Years	N/A	20.92%	N/A	N/A

Annual Dental Visits 19-21 Years	N/A	9.90%	N/A	N/A
Annual Dental Visits: Combined Total	N/A	20.68%	N/A	N/A
Use of Appropriate Medications for People with Asthma 5-9 years old	N/A	83.33%	N/A	N/A
Use of appropriate Medications for People with Asthma 10-17 Years Old	N/A	75.00%	N/A	N/A
Use of Appropriate Medications for People with Asthma 18-56 Years Old	N/A	75.00%	N/A	N/A
Use of Appropriate Medications for People with Asthma : Combined All Ages	N/A	77.78%	N/A	N/A
Cervical Cancer Screenings	40.20%	45.01%	+4.81%	NS
Childhood Immunization Status: DTP	36.36%	61.34%	+24.98	SSI
Childhood Immunization Status: IPV	52.27%	78.15%	+25.88	SSI
Childhood Immunization Status MMR	70.45%	82.35%	+11.9	NS
Childhood Immunization Status: HIB	56.82%	82.35%	+25.53	SSI
Childhood Immunization Status: HEP	56.82%	81.09%	+24.27	SSI
Childhood Immunization Status: VZV	63.64%	73.95%	+10.31	NS
Childhood Immunization Status: Pneumococcal Conjugate	36.36%	53.36%	+17.0	SSI
Childhood Immunization Status: Combo 2	34.09%	53.78%	+19.69	SSI
Childhood Immunization Status: Combo 3	27.27%	42.86%	+15.59	NS
Chlamydia Screening in Women 16-20 years	57.28%	57.49%	+0.21%	NS
Chlamydia Screening in Women 21-25 years	57.43%	62.59%	+5.16%	NS
Chlamydia Screening Combined	57.5%	59.80%	+2.45	NS
Follow-Up for Hospital for Mental Illness (FUH) – 7 Days	33.33%	24.66%	-8.67	NS
Follow Up for Hospitalization for Mental Illness (FUH) 30 Days	37.04%	39.73%	+2.69	NS
Lead Screening in Children	50.00%	62.18%	+12.18%	NS
Timeliness of Prenatal Care	86.51%	78.83%	-7.68	SSD
Postpartum Care	55.56%	57.66%	+2.1%	NS
Well Child Visits in First 15 Months: 6 or more visits	41.86%	43.75%	+1.89	NS
Well Child Visits in First 15 Months: 5 visits	16.28%	15.89%	-.039	NS
Well Child Visits in First 15 Months: 4 visits	10.47%	17.97%	+7.5%	NS
Well Child Visits in First 15 Months: 3 visits	9.30%	8.07%	-1.23%	NS
Well Child Visits in First 15 Months: 2 visits	2.33%	5.99%	+3.66%	NS
Well Child Visits in First 15 Months: 1 visits	8.14%	2.34%	-5.8%	SSD
Well Child Visits in First 15 Months: 0 visits	11.63%	5.99%	-5.64%	NS
Well Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	48.18	53.53	+5.35	NS

Harmony Health Plan supports Department of Health and Senior Services 2009 Quality Targets in measures that specifically represent the HHP Medicaid population demographic. Targets for improvement include:

- Effectiveness of Care
  - Childhood Immunization Status
  - Cervical Cancer Screening
  - Chlamydia Screening in Women
  - Follow-up After Hospitalization For Mental Health Disorders (FUH)
  - Use of Appropriate Medications for People with Asthma

- Access/Availability of Care
    - Prenatal and Postpartum Care
    - Annual Dental Visit
- Use of Services
    - Well Child Visits in the First 15 Months of Life
    - Well Child Visits in the third, fourth, Fifth and Sixth Year of Life
    - Adolescent Well-Care Visits
    - Ambulatory Care
    - Mental Health Utilization – Percentage of Members Receiving Inpatient, Intermediate Care and Ambulatory Services
    - Identification of Alcohol and Other Drug Services
- Satisfaction with the Experience of Care
    - CAHPS 4.OH Child Survey

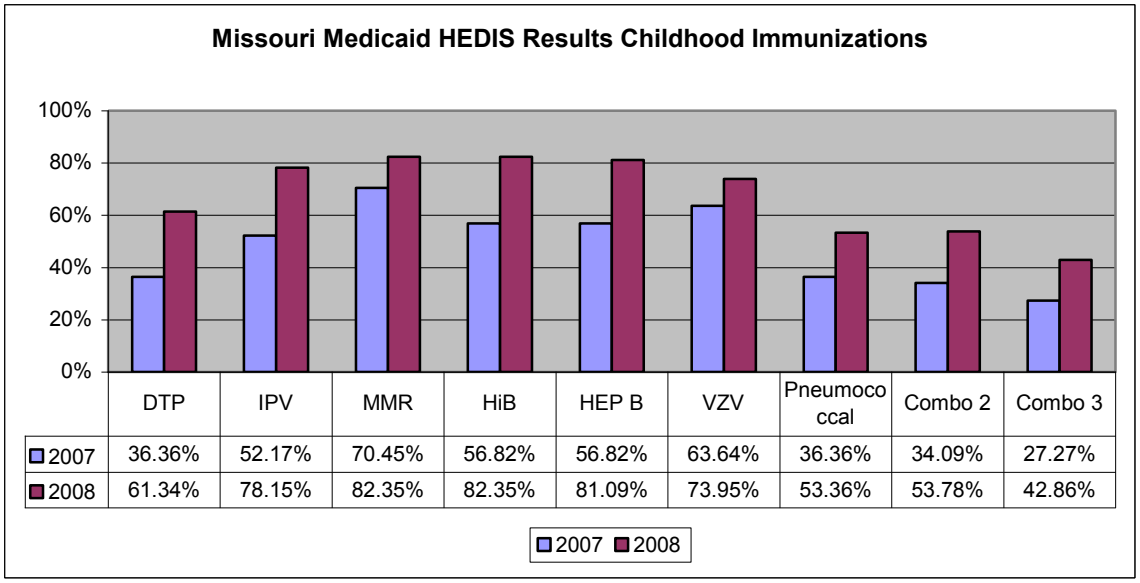
Opportunities for improvement remain in all measures, however, year over year improvements were noted in Adolescent Well Care, Cervical Cancer Screenings, Childhood Immunization Status, Chlamydia Screenings, Lead Screenings in children, Well Child Visits in the First 15 Months (6 or more visits) and Well Child Visits in the Third, Fourth, Fifth and Six Years of Life.

Effectiveness of Care Measures
In the Effectiveness of Care category, four of seven measures (57%) showed improvement when comparing 2009 to 2008 results and one measure had a statistically significant increase.

Childhood Immunizations

Measure	Num	Den	2008	Num	Den	2009	Chi	P Value	Sig
CIS Childhood Immunizations Combo 2	16	44	34.09%	128	238	53.78%	4.5085	0.0337	SSI
CIS Childhood Immunizations Combo 3	12	44	27.27%	102	238	42.86%	3.7449	0.0530	NS

The 2009 HEDIS® Childhood Immunization Status (CIS) combo 2 measure had a statistically significant 19.69% increase in comparison to the 2008 rates. Similarly, CIS combo 3 results increased 15.59% in comparison to the 2008 rates. Both of these measures rank below the tenth percentile in comparison to the National Committee for Quality Assurance (NCQA) HEDIS® Benchmarks.



Well Woman Care – Cervical Cancer and Chlamydia Screening

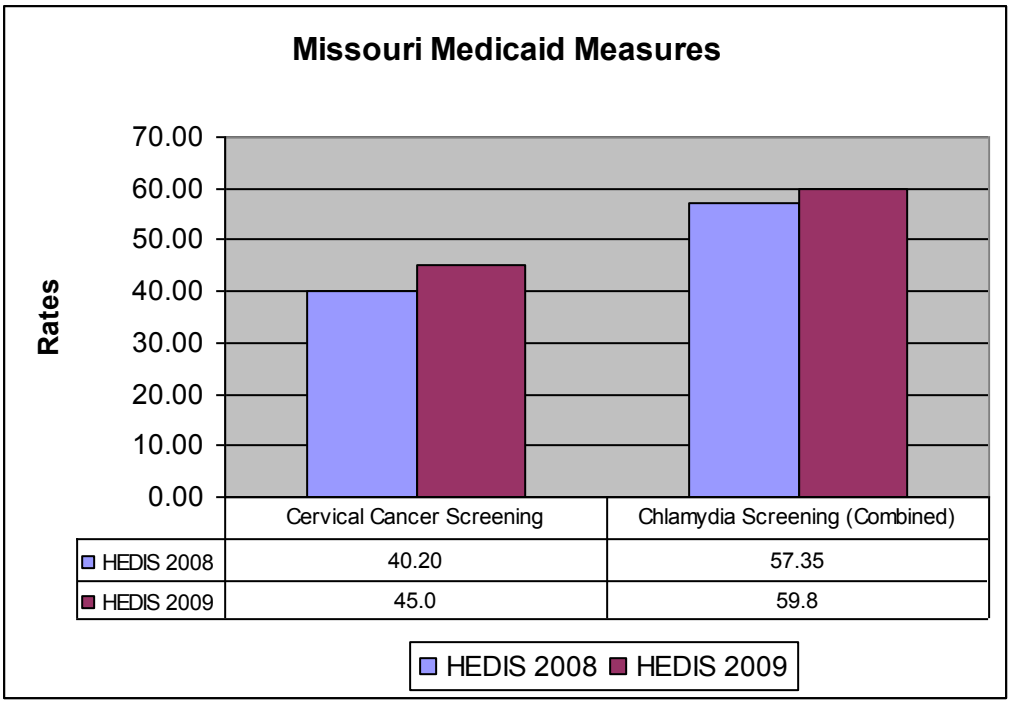
Measure	Num	Den	2008	Num	Den	2009	Chi	P Value	Sig
CCS Cervical Cancer Screening	119	296	40.20%	185	411	45.01%	0.4963	0.4811	NS
CHL Chlamydia Screening in women	117	204	57.35%	183	306	59.80%	03036	0.5871	NS

Cervical Cancer Screening

The 2009 HEDIS Cervical Cancer Screening (CCS) measure had a non statistically significant increase of 4.81% in comparison to the 2008 rate. This result ranks below the 10th percentile in comparison to NCQA HEDIS Benchmarks.

Chlamydia Screening in Women (CHL)

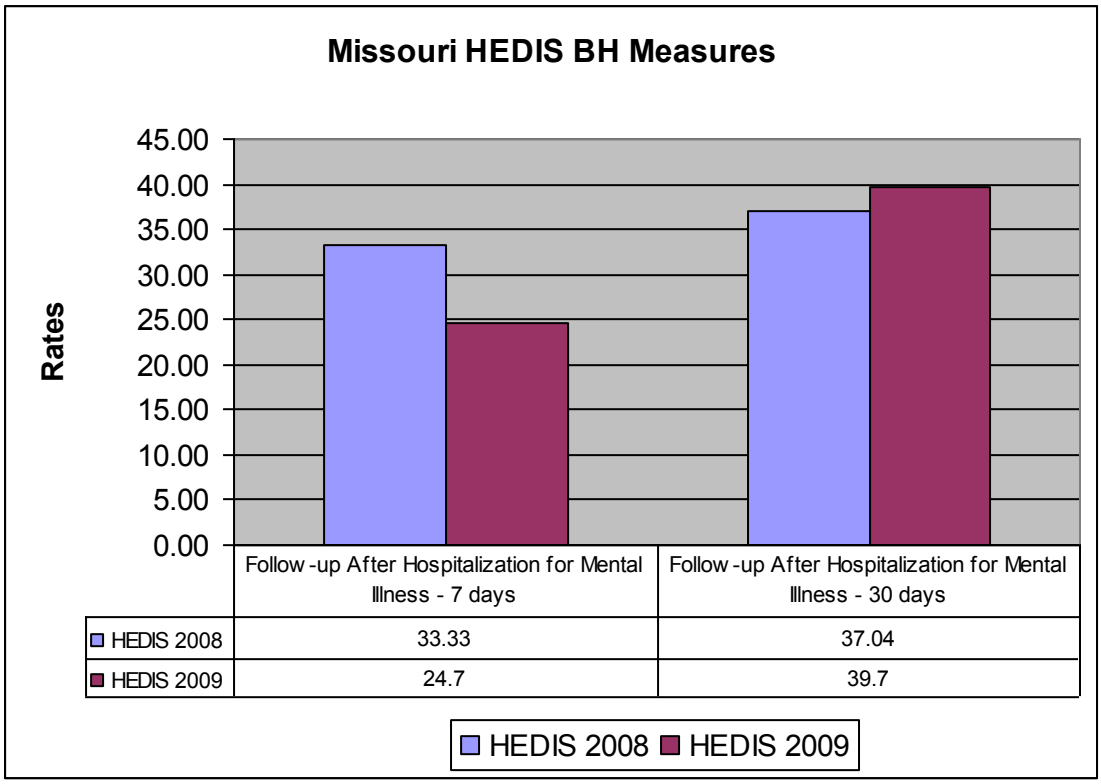
The 2009 HEDIS Chlamydia Screening in Women (CHL) measure had a non statistically significant increase of 2.45% in comparison to the 2008 rate. This result ranks between the 50th and 75th percentile in comparison to NCQA HEDIS Benchmarks.



Follow-Up After Hospitalization for Mental Health Disorders (FUH)

Measure	Num	Den	2008	Num	Den	2009	Chi	P Value	Sig
FUH Follow Up After Hospitalization for Mental Health Disorders – 7 days	9	27	33.33%	18	73	24.66%	.07527	0.3856	NS
FUH Follow Up After Hospitalization for Mental Health Disorders –30 days	10	27	37.04%	29	73	39.73%	0.0599	0.8066	NS

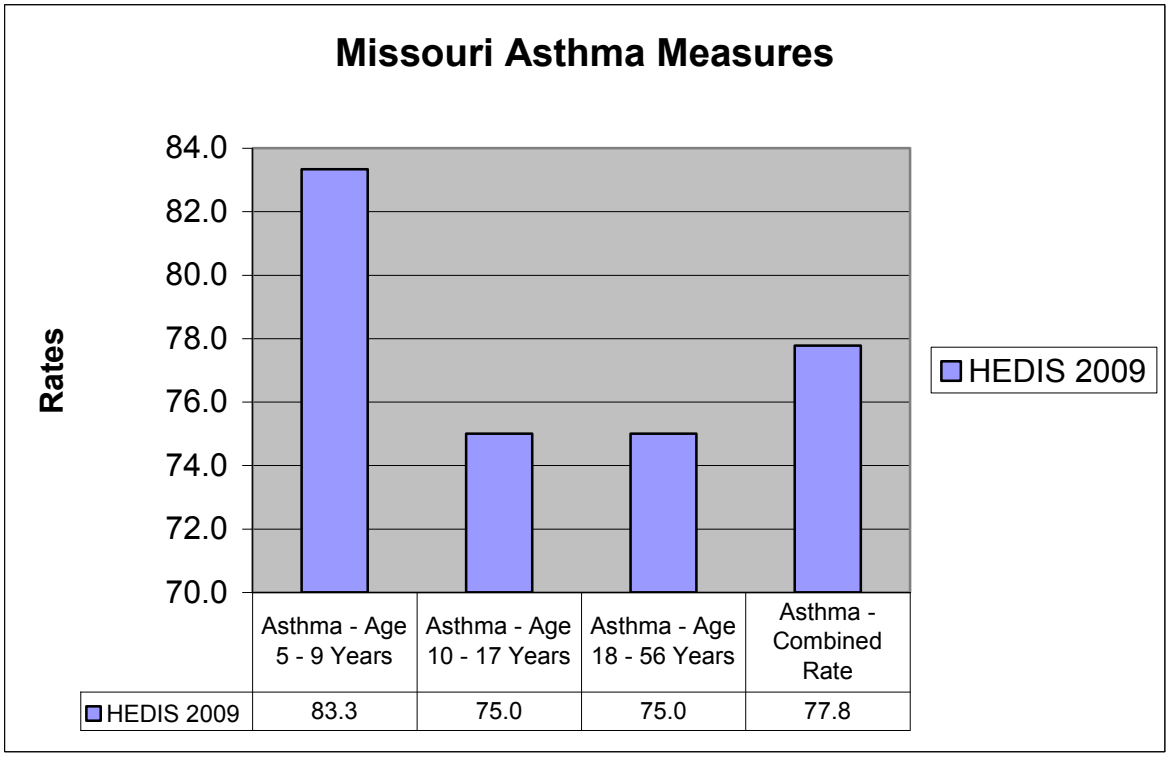
The 2009 HEDIS Follow-Up After Hospitalization for Mental Health Disorders (FUH) results for 7 days showed a non statistically significant decrease of 8.67% from 33.33% to 24.66% in comparisons to the 2008 rates. The measure for 30 day follow up showed a 2.69% slight increase from 37.04% to 39.73%. Both of these results rank below the 25th percentile in comparison to the NCQA HEDIS Benchmarks.



Use of Appropriate Medications for People with Asthma (ASM)

Measure	Num	Den	2008	Num	Den	2009	Chi	P Value	Sig
ASM Use of Appropriate Medications for People with Asthma	N/A	N/A	N/A	14	18	77.78%	N/A	N/A	N/A

The combined rate for the 2009 HEDIS measure Use of Appropriate Mediations for People with Asthma (ASM) was 77.78%. This result ranks below the 10th percentile in comparison to the NCQA HEDIS Benchmarks. These results were not measured by Harmony Health Plan of Missouri in 2008 and therefore, there is no data to complete a year to year comparison.



Access/Availability of Care

Of the three HEDIS measures falling under the category of Access/Availability of care, one measure, Post Partum Care had a statistically significant increase. Timeliness of Prenatal Care had statistically significant decrease. The membership of the plan was not large enough to report Annual Dental Visits in 2008; therefore, that measure is not trend able year over year.

Prenatal Care and Post Partum Care

Measure	Num	Den	2008	Num	Den	2009	Chi	P Value	Sig
PPC: timeliness of Prenatal Care	327	378	86.51%	324	411	78.83%	8.0390	0.046	SSD
PPC Postpartum Care	210	378	55.56%	237	411	57.66%	0.3565	0.5504	NS

Prenatal Care

The rate for the 2009 HEDIS measure Timeliness of Prenatal Care was 78.83%, which represents a statistically significant decrease of 7.68% from the 2008 results of 86.51%. This result ranks below the 50th percentile in comparison to the NCQA HEDIS Benchmarks.

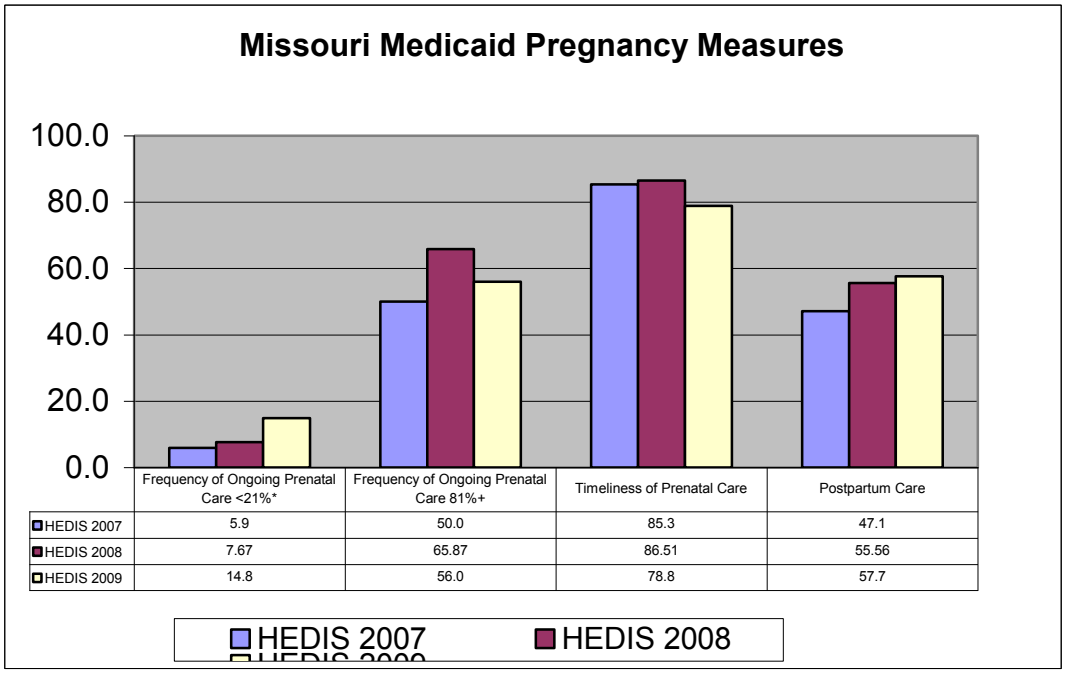
The rate for the 2009 HEDIS measure Frequency of Ongoing Prenatal Care less than 21% of expected visits had a statistically significant increase of 7.17% in comparison to 2008 results. In this category, a smaller number is desired

The rate for the 2009 HEDIS measure Frequency of Ongoing Prenatal Care 81% or more of expected visits was 55.96%, which represents a 10.65% statistically significant decrease in

comparison to 2008 results. This results ranks below the 50th percentile in comparison to the NCQA HEDIS Benchmarks.

Post Partum Care

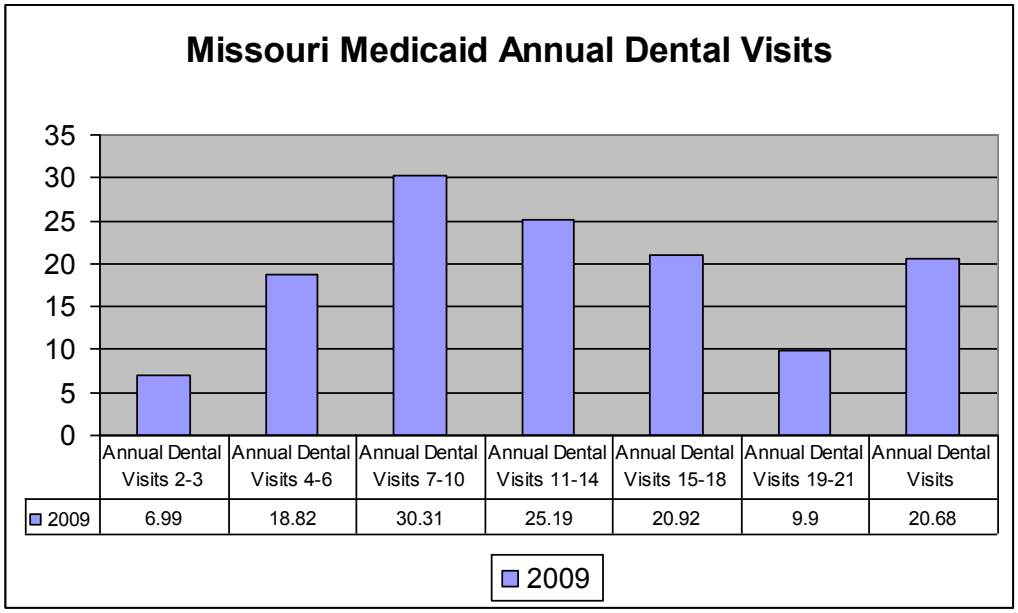
The rate for the 2009 HEDIS Postpartum care was 57.66% representing a non-statistically significant change of 2.10% in comparison to 2008 results. This result ranks below the 50th percentile in comparison to the NCQA HEDIS Benchmarks.



Annual Dental Visits

The rate for the 2009 HEDIS measure Annual Dental Visits – Combined was 20.86%. This rate results ranks below the 10th percentile in comparison to the NCQA HEDIS Benchmarks. These results were not measured by Harmony Health Plan of Missouri in 2008 and therefore, there is no data to complete a year to year comparison.

Measure	Num	Den	2008	Num	Den	2009	Chi	P Value	Sig
ADV Annual Dental Visit	N/A	N/A	N/A	729	3525	20.86%	N/A	N/A	N/A



Use of Services

All measures falling under the category of Use of Services showed a non statistically significant increase in 2009 when compared to 2008 results.

Well Child Visits

Measure	Num	Den	2008	Num	Den	2009	Chi	P Value	Sig
WCV Well child Visit in the First 15 months of Life (6 or more visits	36	86	41.86%	168	384	43.75%	0.1021	0.7493	NS
W34 Well child Visits in the Third, Fourth, Fifth and Sixth Years of Life	198	411	48.18%	220	411	53.53%	2.3559	0.1248	NS
AWC Adolescent Well Care	103	411	25.06%	118	411	28.71%	1.3925	0.2380	NS

Well child Visits in the First 15 Months of Life (W15)

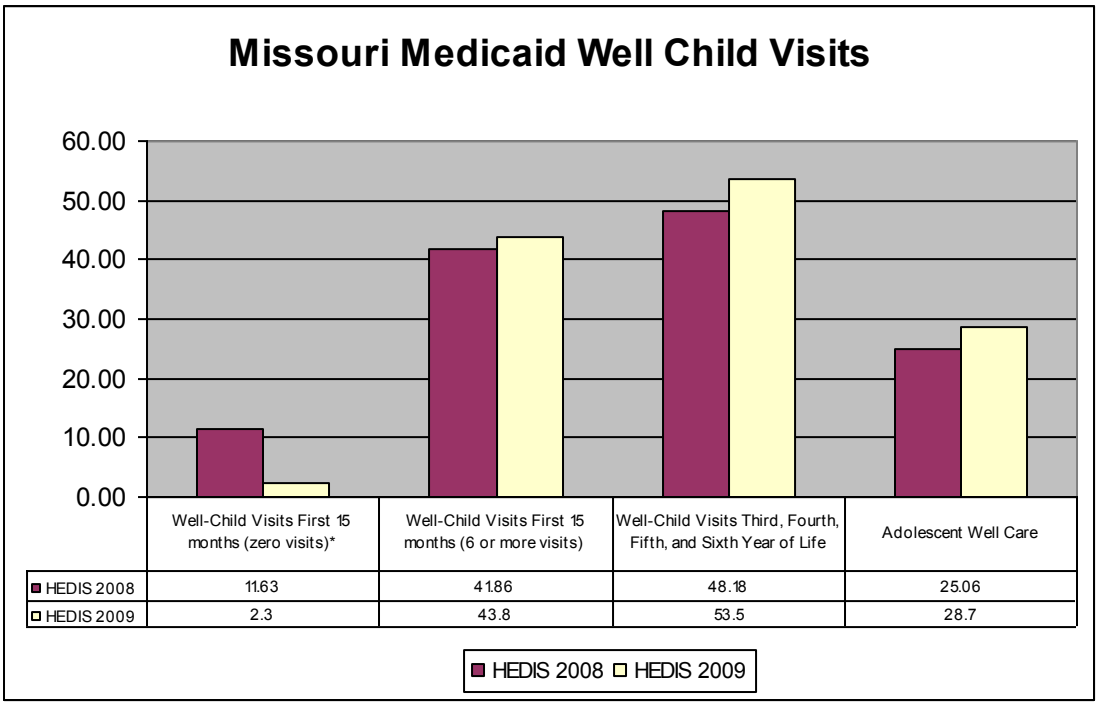
The rate for the 2009 HEDIS measure Well Child Visits in the First 15 Months of Life (W15) six or more visits was 43.75%, which represents a 1.89% non statistically significant increase in comparison to 2008 results. This results ranks below the 25th percentile in comparison to the NCQA HEDIS Benchmarks.

Well child Visits in the Third, fourth, Fifth and Sixth Year of Life (W34)

The rate for the 2009 HEDIS measure Well child Visits in the Third, Fourth, Fifth and Sixth Months of Life (W34) was 53.53%, which represents a 5.35% non statistically significant increase in comparison to 2008 results. This results ranks below the 25th percentile in comparison to the NCQA HEDIS Benchmarks.

Adolescent Well Care

The rate for the 2009 HEDIS measure Adolescent Well Care Visits (AWC) was 28.71%, which represents a 3.65% non statistically significant increase in comparison to 2008 results. This result ranks below the 25th percentile in comparison to the NCQA HEDIS Benchmarks.



Ambulatory Care

	Outpatient Visits	Outpatient Visits/1000 Member Months	ED Visits	ED Visits/1000 Member Months	Ambulatory Surgery Procedures	Ambulatory Surgery Procedures per 1000 Member Months	Observation Room Stays Resulting In Discharge	Observation Room Stays per 1000 member Months
2008	14380	191.85	5717	76.27	169	2.25	140	1.87
2009	28961	215.58	11062	82.34	687	5.11	163	1.21

In the category of Ambulatory Care, the overall number of Outpatient visits, Emergency Department Visits, Ambulatory surgery Procedures and Observation Room Stays Resulting in Discharge increased when comparing HEDIS 2008 to HEDIS 2009 data. This is consistent with the increase in growth of the plan. Furthermore, the total member months increased 79% from 74,955 to 134,343.

Mental Health Utilization

	Any Services Number	Any Services Percent	Inpatient Number	Inpatient Percent	Intensive Outpatient/Partial Hospitalization Number	Intensive Outpatient/Partial Hospitalization Percent	Outpatient/ED Number	Outpatient/ED Percent
2008	186	2.98%	19	0.30%	9	N/A	174	2.79%
2009	564	5.04%	97	0.87%	13	0.12%	508	4.54%

For Mental Health Utilization, the overall number of Inpatient visits, Intensive Outpatient/Partial Hospitalization and Outpatient /Emergency Department Visits increased when comparing HEDIS 2008 to HEDIS 2009 data. This is consistent with the increase in growth of the plan. Furthermore, the total member months increased 79% from 74,955 to 134,343.

Identification of Alcohol and Other Drug Services Total

	Any Services Number	Any Services Percent	Inpatient Number	Inpatient Percent	Intensive Outpatient/Partial Hospitalization Number	Intensive Outpatient/Partial Hospitalization Percent	Outpatient/ED Number	Outpatient/ED Percent
2008	95	1.52%	39	0.62%	2	N/A	67	1.07%
2009	155	1.38%	82	0.73%	4	0.04%	92	0.82%

The overall number of Inpatient visits, Intensive Outpatient/Partial Hospitalization and Outpatient /Emergency Department Visits for Identification of Alcohol and Other Drug Services increased when comparing HEDIS 2008 to HEDIS 2009 data. This is consistent with the increase in growth of the plan. Furthermore, the total member months increased 79% from 74,955 to 134,343.

Barriers

Member Barriers:

Lack of knowledge of needed testing and treatment.
Transportation issues.
Lack of understanding of the value and long term benefit of preventative health services and screenings.
Lack of knowledge of the frequency and necessary follow up regimens.
Value immediate access to care and do not want to wait for services that are scheduled in the future.

Physician Barriers:

Lack of knowledge of transportation assistance for members.
Members do not necessarily keep appointment that is made during outreach.
Difficulty outreaching to members due to telephone and address changes.
Time constraints.

Health Plan:

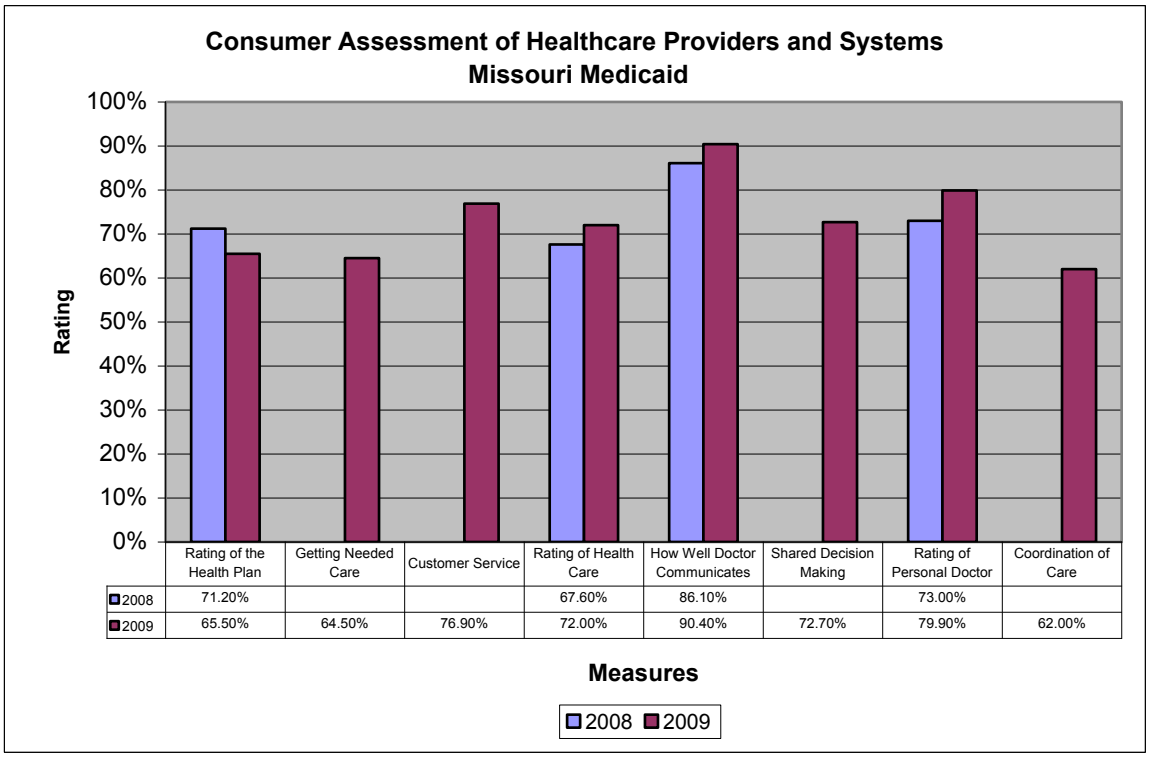
Non-compliant member outreach lists are not provided to physicians on consistent basis.

Recommendations:

Continue interventions listed on the HEDIS 2009-2010 Work Plan.
More concentrated efforts for one-on-one with the Harmony QI Nurses will occur with focus on discussing results, providing information on physician performance, clinical practice guidelines and the member outreach (non-compliant list).

Satisfaction with the Experience of Care

The Consumer Assessment Healthcare Providers and Systems Report provides information on member's satisfaction with the Health Plan. The information reported in this section relates to the 4.OH Child Satisfaction Survey. Performance Improvement Plan is to improve Member Satisfaction with the Health Plan.



Analysis/Results: The results reported by The Meyer Group include information on the trending between current and previous year's results and significance testing is performed at the 95% confidence level. On the 2009 survey, four measures had non-significant decreases and four were untrendable due to a significant change in responses on the CAHPS Survey tool.

CAHPS Measures	Baseline Rate CY 2008	Rate CY 2009	Significant Increase (SI), Decrease (SD) or No Difference (NSD)
Rating of the Health Plan	71.2%	65.5%	NSD
Getting Needed Care	N/A	64.5%	Not Trendable
Customer Service	N/A	69.2%	Not Trendable
Rating of Health Care	67.6%	72.0%	NSD
How Well Doctors Communicate	86.1%	90.4%	NSD
Shared Decision Making	N/A	72.7%	Not Trendable
Rating of Doctor	73.0%	79.9%	NSD
Coordination of Care	N/A	62.0%	Not Trendable

Barrier/Root Cause:

Member:

Member knowledge of what to expect during interaction

Physician:

Physician knowledge of CAHPS rates, member satisfaction.

Health Plan:

QI department without key personnel to complete tasks.

Plans for 2009/2010: Based on the above findings there are significant opportunities to improve all CAHPS areas. Harmony implemented revised interventions for all key CAHPS drivers. For example, the physician education programs now place special emphasis on education related to CAHPS rates and interventions for improving areas that are less than the tenth percentile. Additionally, physicians will be educated on referrals for case management for better coordination of care. The one-on-one meetings with physicians will be more robust and include specific detailed information about CAHPS rates and member satisfaction. Furthermore, Harmony staff will utilize Member newsletters and welcome packets to educate on what to expect at visits and encourage partnership with physicians.

HEDIS Indicators by MO HealthNet Managed Care Health Plans Within Regions, Live Births

Overview of the HEDIS Indicator Summary: 2008 Live Births

Although our membership has grown, Harmony Health Plan did not have enough members in several categories to be valid for comparison. These categories are:

- Vaginal births after Cesarean Section
- Low birth weight
- Very low birth weight delivered in a level 11/111 hospital

However, in the categories where our membership was adequate for analysis, our rates in general were not statistically different from the Mo Health Care Managed Care rate for the majority of the indicators.

Our rate was not statistically different from the Mo Health Net rate in the following categories:

- C-sections as a percentage of total births
- Early pre-natal care
- Spacing less than eighteen months
- Births to mothers less than 18 years
- Repeat births to teen mothers

In all of these categories the rate was also not statistically different from the State rate except for the category of early pre-natal care.

Our network and the impact of our Harmony Hugs program are the keys to our high rate of low birth rate babies being delivered in level 2 or level 3 hospitals.

On the other hand, the Plan's low rate of adequacy of pre-natal care (although it has increased each year) and WIC participation in our Plan compared to other MCOs is a surprising area of opportunity. We anticipated that these rates would be the highest rate given our one-on-one outreach and interaction with our pregnant members. Our Harmony Hugs program, described below, counsels all pregnant women on the importance of adequacy of pre-natal care and WIC participation. These are big components of the program and the focal point of the interventions. We call members at least quarterly to help ensure they are making all their appointments and remove any barriers. We inform them how and where to obtain WIC services. We will continue to monitor these rates.

Overview of the Harmony Hugs Program:

Purpose: Harmony Hugs is a support and education program for pregnant Harmony Health Plan members in Missouri. Harmony Hugs is designed to improve care management of pregnant women by starting early in their pregnancy providing educational information and support. The program will also identify members with potential risk factors that may adversely affect the outcome of their pregnancy. Hugs will encourage pregnant women to practice good prenatal care through direct mailings of educational materials, availability of a Harmony Hugs social services specialist for questions and concerns who also advocates for consistent follow up with their provider, and appropriate referral into OB case management.

Goals: The Harmony Hugs Program goals are to identify all pregnant members, more specifically the high risk members, and identify these members early in pregnancy. Harmony Hugs will outreach and enroll these members into the Harmony Hugs Program. Once identified, the program will advocate, intervene, coordinate services and educate members through comprehensive follow ups based on pregnancy risk level regarding their prenatal, peri-natal and postnatal states. The Hugs program will contribute toward improving pregnancy outcomes through coordination of care, education, and appropriate referrals to OB case management for members with high risk medical complications.

Program Benefits to Member:

- Educational materials and advise regarding fetal development, breastfeeding, substance use and pregnancy, teen pregnancy, child development, nutrition as well as other pregnancy related topics.
- Follow-up at least once per trimester or as needed, with a short assessment to identify any new concerns or needs
- Home visits for moderate or high risk members or upon request of the member.
- Information on WIC and other community resources and important Harmony numbers
- Coordination of care with PCP, OB provider, Medical Group, OB case management staff for high-risk pregnancies
- Support through pregnancy and post delivery
- Upon delivery, conducts post partum and well-child visit reminders to Hugs member, conducts the Edinburgh Postnatal Depression Screening (EPDS) and makes appropriate referrals based on the depression score
- Diaper bag upon enrollment and nursery kit upon delivery

Program Benefits to Physician/Medical Groups

- Better outcomes for their patients
- Support in managing pregnant patients
- Appropriate and timely utilization of medical services
- Pay for Quality incentives based on achieving HEDIS targets

The Harmony Hugs program has increased our effectiveness in achieving better birth outcomes. See the summary of the Hugs program under case management.

HealthCare USA

Performance Measures

HEDIS

HealthCare USA continues to calculate the MO HealthNet Managed Care Performance Measures as required by the State contract. The measures are calculated and reported in accordance with NCQA specifications. Reported measures are calculated using NCQA certified software and results are audited by an NCQA certified auditor. HEDIS rates are reported for Central, Eastern, and Western Missouri.

HEDIS reports are used as a means to identify opportunities for improvement related to services for our members and identify successful interventions intended to improve HEDIS measures. The goal has been to achieve the HEDIS Medicaid mean or better for each measure. Having achieved this for many measures, the goal in 2010 was increased to the HEDIS National Medicaid 75th percentile or better for each measure.

HealthCare USA utilizes an interdepartmental committee that meets monthly to discuss EPSDT and HEDIS measures. The committee analyzes results and brainstorms ideas to improve each indicator, including revising educational information and implementing incentive programs for our membership to increase adherence to well care and preventive services and educational programs for providers about HEDIS measures and what they can do to help improve the reports.

HEDIS results and initiatives are also reported to the Quality Management Committee, Executive Quality Committee and Board of Managers. Feedback from these committees, which includes network providers, is requested.

HealthCare USA recognizes the unique membership and outcomes in each region. The results are analyzed for each region independently for variations and particular challenges within each region. All rates are compared for statistically significant change from the previous year using a chi-square analysis. Rates are also compared to the goal, the NCQA Medicaid 50th percentile.

In anticipation of NCQA Accreditation, HealthCare USA added a "fourth region" for State-Wide HEDIS results. This region includes the entire eligible population of HealthCare USA, and is not a combined average of the three regions. Therefore, medical record review took a sample across all three regions. The measures required for NCQA Accreditation have some crossover

with State required measures, but many are reported and analyzed for the first time by HealthCare USA. Medical record review was completed for the State-Wide measures Childhood Immunizations, Prenatal/Postpartum Care, Controlling High Blood Pressure, and Comprehensive Diabetes Care. No trending is available because these are first year measures for the State-Wide region.

Childhood Immunizations

Central Region

	NCQA Medicaid 50th Percentile	HEDIS Results	
Immunization Submeasures	**2008**	**2009**	**2008**
Dtap	80.50	75.69	79.86
IPV	90.00	90.74	90.97
MMR	91.90	88.19	89.35
Hib	90.70	94.91	91.67
Hep B	90.30	92.59	92.59
VZV	90.00	89.12	89.82
PCV	76.40	75.23	77.78
Combo 2	75.40	71.30 ↓	77.08
Combo 3	68.60	65.28 ↓	72.45

↑ or ↓ indicates a statistically significant change from the previous year's plan rate.
Green: ≥95% of goal Yellow: 85%-94% of goal Red: <85% of goal
Goal is NCQA Medicaid 50th Percentile

Combinations 2 and 3 both declined a statistically significant amount but remain within 95% of goal. Overall, Central region has the best results for immunizations, with all being within 95% of goal. In addition, Central region's Well Child Visits in First 15 Months of Life is also substantially above the other regions and the goal. An increase in adherence to 6 or more well child visits for those 2 and under in the other 2 regions may lead to a concurrent increase in the immunizations as well. Dtap and PCV are the two immunizations that declined, resulting in the decline in the combos 2 and 3. It is unclear at this time what caused or contributed to the decline in these two immunizations. Additional investigation is underway.

Eastern Region

	NCQA Medicaid 50th Percentile	HEDIS Results	
Immunization Submeasures	**2008**	**2009**	**2008**
Dtap	80.50	67.82	70.14
IPV	90.00	84.95	85.88
MMR	91.90	91.90 ↑	88.66
Hib	90.70	93.52 ↑	86.11
Hep B	90.30	85.19	87.73
VZV	90.00	87.73	86.34
PCV	76.40	67.13	68.98
Combo 2	75.40	59.95	64.12
Combo 3	68.60	52.55	57.41

↑ or ↓ indicates a statistically significant change from the previous year's plan rate.
Green: ≥95% of goal Yellow: 85%-94% of goal Red: <85% of goal
Goal is NCQA Medicaid 50th Percentile

Combinations 2 and 3 declined from the previous year's rates, but not significantly. However, both combinations 2 and 3 are less than 85% of goal. Dtap, IPV, Hep B, and PCV all declined. HiB and MMR increased, the Hib increasing a significant amount.

Western Region

	NCQA Medicaid 50th Percentile	HEDIS Results	
Immunization Submeasures	**2008**	**2009**	**2008**
Dtap	80.50	65.28	69.91
IPV	90.00	84.03 ↓	88.89
MMR	91.90	85.65	88.90
Hib	90.70	90.97 ↓	85.88
Hep B	90.30	88.89	89.35
VZV	90.00	83.56	87.50
PCV	76.40	59.72	64.12
Combo 2	75.40	61.11	65.05
Combo 3	68.60	52.31	55.56

↑ or ↓ indicates a statistically significant change from the previous year's plan rate.
Green: ≥95% of goal Yellow: 85%-94% of goal Red: <85% of goal
Goal is NCQA Medicaid 50th Percentile

Combinations 2 and 3 both declined from 2008 results, but not significantly. Combo 2 is within 85% to 94% of goal, and combo 3 less than 85% of goal. All immunizations declined, IPV a significant amount, except for the Hib (change in specifications).

State-Wide

Immunization Submeasures	NCQA Medicaid 50th Percentile	2009 State-Wide Rate
Dtap	80.50	71.06
IPV	90.00	86.11
MMR	91.90	89.12
Hib	90.70	93.52
Hep B	90.30	87.27
VZV	90.00	87.04
PCV	76.40	70.37
Combo 2	75.40	64.58
Combo 3	68.60	57.87

Green: ≥95% of goal Yellow: 85%-94% of goal Red: <85% of goal
Goal is NCQA Medicaid 50th Percentile

Combination 3 is less than 85% of the goal. DtaP, PCV, and combination 2 are all 85-94% of goal.

Overall

There are some patterns in immunizations. Hib increased in all three regions, significantly in two. NCQA changed the HEDIS technical specifications for this one immunization from 3 to 2 by 2 years of age in response to a shortage in the vaccine. Dtap decreased in all 3 regions, with Eastern and Western regions less than 85% of goal. The polio vaccine remained fairly stable, except in the Western region where it decreased a significant amount. Eastern and Western regions are 85-94% of goal.

Interventions include member reminders for well visits with immunization information sent on the birthday month. HealthCare USA uses MOHSAIC and the hybrid method to increase completion of the data. In addition, immunization records are collected during on-site provider audits and from hospital discharge summaries.

Breast Cancer Screening

State-Wide

	NCQA Medicaid 50th Percentile	2009 State-Wide Rate
Breast Cancer Screening	50.10	31.19

Green: ≥95% of goal Yellow: 85%-94% of goal Red: <85% of goal
Goal is NCQA Medicaid 50th Percentile

Breast cancer screening is less than 85% of goal. Education regarding routine mammograms have been added to the quarterly women's health flyer sent to women without a claim for mammography. The effectiveness of this intervention alone will be measured.

Cervical Cancer Screening

Central Region

	NCQA Medicaid 50th Percentile	HEDIS Results	
	2008	2009	2008
Cervical CA Screening	67.00	63.72	66.85

↑ or ↓ indicates a statistically significant change from the previous year's plan rate.
Green: ≥95% of goal Yellow: 85%-94% of goal Red: <85% of goal
Goal is NCQA Medicaid 50th Percentile

There was a decrease in the screening rate from 2008 to 2009; however, the rate remains within 95% of goal. Medical record review raised the rate from 62.34% to 63.72%. Hybrid was completed because the rate decreased, and the proposed reason for the decrease was due to members in the denominator new to the plan because of the county expansion. The measure looks at Pap smears from the measurement year and the year prior. New members could have Pap smears completed but the plan did not receive a claim. Hybrid review did not raise the rate as expected.

Eastern Region

	NCQA Medicaid 50th Percentile	HEDIS Results	
	2008	2009	2008
Cervical CA Screening	67.00	66.85	57.41

↑ or ↓ indicates a statistically significant change from the previous year's plan rate.
Green: ≥95% of goal Yellow: 85%-94% of goal Red: <85% of goal
Goal is NCQA Medicaid 50th Percentile

The administrative percentage decreased less than a percentage point from 2008 to 2009. The percentage is within 95% of goal.

Western Region

	NCQA Medicaid 50th Percentile	HEDIS Results	
	2008	2009	2008
Cervical CA Screening	67.00	59.93	55.22

↑ or ↓ indicates a statistically significant change from the previous year's plan rate.
Green: ≥95% of goal Yellow: 85%-94% of goal Red: <85% of goal
Goal is NCQA Medicaid 50th Percentile

The percentage increased from 2008 to 2009. The result is within 85-94% of goal. The percentage reported is an administrative rate.

State-Wide

	NCQA Medicaid 50th Percentile	2009 State-Wide Rate
Cervical Cancer Screening	67.00	65.38

Green: ≥95% of goal Yellow: 85%-94% of goal Red: <85% of goal
Goal is NCQA Medicaid 50th Percentile

Result is within 95% of goal. Result is administrative.

Overall
Interventions: All women identified as in the denominator for this measure receive a flyer ~~–~~Staying Healthy: A Guide For Women." Included in the flyer is education on Pap smears per CDC recommendations.

Chlamydia Screening
Central Region

	NCQA Medicaid 50th Percentile	HEDIS Results	
By Age Stratification	2008	2009	2008
All Ages	51.90	54.36	51.98
Ages 16-20	48.80	53.03	50.80
Ages 21-25	56.40	58.59	54.55

↑ or ↓ indicates a statistically significant change from the previous year's plan rate.
Green: ≥95% of goal Yellow: 85%-94% of goal Red: <85% of goal
Goal is NCQA Medicaid 50th Percentile

Percentage has increased from 2008 to 2009, and is within 95% of goal. Age stratifications 16 to 20 and 21 to 25 also are within 95% of goal.

Eastern Region

	NCQA Medicaid 50th Percentile	HEDIS Results	
By Age Stratification	**2008**	**2009**	**2008**
All Ages	51.90	73.32 ↑	70.65
Ages 16-20	48.80	67.75 ↑	68.36
Ages 21-25	56.40	66.81	62.68

↑ or ↓ indicates a statistically significant change from the previous year's plan rate.
Green: ≥95% of goal Yellow: 85%-94% of goal Red: <85% of goal
Goal is NCQA Medicaid 50th Percentile

Eastern – There was a statistically significant increase from 2008 to 2009, and all age stratifications remain within 95% of goal.

Western Region

	NCQA Medicaid 50th Percentile	HEDIS Results	
By Age Stratification	**2008**	**2009**	**2008**
All Ages	51.90	65.21↑	59.10
Ages 16-20	48.80	62.31↑	54.81
Ages 21-25	56.40	69.98↑	63.77

↑ or ↓ indicates a statistically significant change from the previous year's plan rate.
Green: ≥95% of goal Yellow: 85%-94% of goal Red: <85% of goal
Goal is NCQA Medicaid 50th Percentile

There was a statistically significant increase from 2008 to 2009, and all age stratifications remain within 95% of goal.

Overall
Interventions: All women identified as in the denominator for this measure receive a flyer ~~–~~Staying Healthy: A Guide For Women." Included in the flyer is education on chlamydia screenings. In 2008 drilldown analysis identified an error in billing by the Missouri State Laboratory. The lab was educated and new claims are now billed correctly. In addition, the NCQA auditor allowed a one-time patch for the incorrectly billed claims to be numerator-adherent. This has resulted in the increases seen in all 3 regions.

Respiratory Conditions
State-Wide

Measure	NCQA Medicaid 50th Percentile	2009 HEDIS Result
Appropriate Testing for Children with Pharyngitis	62.50	74.42
Appropriate Treatment of Children with URI	84.30	84.34
Avoidance of Antibiotic Tx in Adults with Acute Bronchitis	25.00	16.19
Use of Spirometry Testing in the Assessment and DX of COPD	27.50	34.38

Green: ≥95% of goal Yellow: 85%-94% of goal Red: <85% of goal
Goal is NCQA Medicaid 50th Percentile

Antibiotic mis-utilization measures are within 95% of the goal for the pediatric measures, but less than 85% of goal for the adult measure of avoidance of antibiotic treatment in adults with acute bronchitis. HealthCare USA in response to the results completed member and provider education on antibiotic utilization and approved a clinical practice guideline as well. Use of Spirometry Testing is within 95% of goal. The denominator is very low at 32.

Use of Appropriate Medications for People with Asthma

Central Region

	NCQA Medicaid 50th Percentile	HEDIS Results	
By Age Stratification	**2008**	**2009**	**2008**
Ages 5-9	91.80	95.88	89.41
Ages 10-17	89.50	84.83	91.67
Ages 18-56	85.80	73.81	67.50
All Ages Combined	88.70	86.97	87.36

↑ or ↓ indicates a statistically significant change from the previous year's plan rate.
Green: ≥95% of goal Yellow: 85%-94% of goal Red: <85% of goal
Goal is NCQA Medicaid 50th Percentile

Age stratification 18-56 only percentage not within 95% of goal. Denominator is 42 for this age group.

Eastern Region

	NCQA Medicaid 50th Percentile	HEDIS Results	
By Age Stratification	**2008**	**2009**	**2008**
Ages 5-9	91.80	88.35	87.75
Ages 10-17	89.50	86.67	86.88
Ages 18-56	85.80	81.31	83.46
All Ages Combined	88.70	86.75	86.87

↑ or ↓ indicates a statistically significant change from the previous year's plan rate.
Green: ≥95% of goal Yellow: 85%-94% of goal Red: <85% of goal
Goal is NCQA Medicaid 50th Percentile

All age stratifications and the combined percentage are within 95% of goal.

Western Region

	NCQA Medicaid 50th Percentile	HEDIS Results	
By Age Stratification	**2008**	**2009**	**2008**
Ages 5-9	91.80	92.11	94.87
Ages 10-17	89.50	92.90	81.25
Ages 18-56	85.80	80.00	63.64
All Ages Combined	88.70	90.64	85.37

↑ or ↓ indicates a statistically significant change from the previous year's plan rate.
Green: ≥95% of goal Yellow: 85%-94% of goal Red: <85% of goal
Goal is NCQA Medicaid 50th Percentile

All age stratifications except 18-56 are within 95% of goal. Denominator for this age bracket is 70.

State-Wide

By Age Stratification	NCQA Medicaid 50th Percentile	2009 HEDIS Result
Ages 5-9	91.80	89.50
Ages 10-17	89.50	87.22
Ages 18-56	85.80	80.30
All Ages Combined	88.70	87.33

Green: ≥95% of goal Yellow: 85%-94% of goal Red: <85% of goal
Goal is NCQA Medicaid 50th Percentile

All ages stratifications within 95% of goal.

Overall

HealthCare USA continues interventions to increase asthma medication utilization as prescribed. Members in asthma disease management who did not get their asthma prescription(s) filled receive a reminder call from their disease management nurse. A member incentive called Asthma Around the World encourages medication refills and is available to any member with asthma. Provider charts are audited for medication prescriptions for patients with a diagnosis of asthma in accordance with the HEDIS technical specifications and the NIH/NAEPP asthma clinical practice guidelines.

Controlling High Blood Pressure

State-Wide

	NCQA Medicaid 50th Percentile	2009 HEDIS Result
Controlling High Blood Pressure	55.40	40.36

Green: ≥95% of goal Yellow: 85%-94% of goal Red: <85% of goal
Goal is NCQA Medicaid 50th Percentile

This indicator measures the percent of members who have a diagnosis of high blood pressure and who have a controlled blood pressure on the last reading of the year. Medical record review is required to confirm the diagnosis and locate the last blood pressure reading of the year. There were 446 who met criteria for high blood pressure in the State. The result is less than 85% of goal. Upon drilldown analysis, there was a fair amount of co-morbidity with the diabetes population and measure. For this reason, hypertension has been incorporated into the newly developed diabetes workgroup. Strategies for improvement will include blood pressure management. The diabetes education materials are being redeveloped, and includes sections on blood pressure readings, interventions, etc. In addition, a member incentive is being developed that will require routine blood pressure readings as part of the diabetic well care visit. HealthCare USA has also begun collaborating with the Integrated Health Network (IHN) in St. Louis. This grant-funded organization employs —ealth coaches" that complete outreach in the

community to assist in establishing a medical home. One of IHN's health coaches focuses on hypertension and the follow-up with providers, medications, etc., needed to effectively control the blood pressure.

Comprehensive Diabetes Care
State-Wide

Sub-Measure	NCQA Medicaid 50th Percentile	2009 HEDIS Result
Eye Exams	53.80	35.19
Cholesterol Screening	73.20	51.85
Hemoglobin Blood Test	79.60	69.91
Nephropathy Monitoring	76.10	64.58
HbA1c Poorly Controlled[1]	46.00	65.05

Green: ≥95% of goal Yellow: 85%-94% of goal Red: <85% of goal
Goal is NCQA Medicaid 50th Percentile
[1]Inverse measure - lower rate is better

Comprehensive Diabetes Care encompasses many sub-measures, only five of which are required reporting for NCQA Accreditation. Diabetes for this measure is 18 and older and type 1 and type 2, excluding gestational diabetes. A total of 771 members state-wide were included in the denominator. Medical record review occurred. First year results were lower than anticipated. Dilated retinal eye exams and cholesterol screenings were less than 85% of goal. Annual hemoglobin testing and monitoring/treatment for nephropathy were 85 to 94% of goal. Hemoglobin results signifying poor control (>9%) is also less than 85% of goal. Note that this sub-measure is inverse; a higher rate means more members are poorly controlled.

HealthCare USA convened a multi-disciplinary and multi-departmental team, including a medical director and the diabetes disease management nurse. The Diabetes Subgroup has multiple interventions in progress:

- Editing and expanding the member diabetes education materials to match the disease management methodology that has been implemented with Asthma and High Risk OB Disease Management programs.
- Provider education.
- A proposed member incentive to encourage those with diabetes to complete routine diabetes care visits, annual eye exam, HbA1c testing, and other routine screenings as recommended by the American Diabetes Association (ADA)
- Outbound calls to members in the HEDIS datasets to assess for barriers to obtaining care and services consistent with the ADA recommendations, level of diabetes knowledge and understanding, and need for assistance in successfully self-managing their diabetes.
- Data drilldown and barrier analyses to assess factors impacting each measure, such as benefit issues with eye exam coverage, lack of consistent lab data for HbaA1c levels, etc. have and will continue to be completed to identify potential strategies to improve adherence to diabetic care recommendations.

Use of Imaging Studies for Low Back Pain

State-Wide

	NCQA Medicaid 50th Percentile	2009 HEDIS Result
Low Back Pain Imaging	78.20	73.99

Green: ≥95% of goal Yellow: 85%-94% of goal Red: <85% of goal
Goal is NCQA Medicaid 50th Percentile

Measure assesses for testing for low back pain per evidence-based guidelines, which recommends no imaging with 28 days of new diagnosis of low back pain (trauma and cancer excluded). Results are within 95% of goal.*Antidepressant Medication Management*

State-Wide

Sub-Measures	NCQA Medicaid 50th Percentile	2009 HEDIS Result
Effective Acute Phase Treatment	45.10	45.66
Effective Continuation Phase Treatment	28.30	29.99

Green: ≥95% of goal Yellow: 85%-94% of goal Red: <85% of goal
Goal is NCQA Medicaid 50th Percentile

Indicator measures percentage of members newly diagnosed with major depression who stay on their antidepressant medication at 12 weeks (acute phase) and 6 months (continuation phase). Acute phase and continuation phase results are above the Medicaid 50th percentile.

Follow Up Care for Children Prescribed ADHD Medications

State-Wide

Sub-Measures	NCQA Medicaid 50th Percentile	2009 HEDIS Result
Initiation Phase	32.60	45.66
Continuation & Maintenance Phase	38.60	29.29

Green: ≥95% of goal Yellow: 85%-94% of goal Red: <85% of goal
Goal is NCQA Medicaid 50th Percentile

This indicator measures the percent of children who received an initial prescription for ADHD medications that have at least one follow-up visit with a practitioner (initiation phase) within 1 month and then have at least two follow-up visits with a practitioner within 9 months after the initiation phase (continuation and maintenance). Results are within 95% of goal for initiation phase but less than 85% of goal for continuation and maintenance phase. HealthCare USA and MHNet are collaborating to complete provider and member/parent education about the importance of follow up. A pre-authorization requirement was initiated for the first prescription only to improve the number of children receiving ADHD medications that meet the screening criteria. The pre-authorization requirement started matches the pre-authorization requirement implemented by fee-for-service Medicaid pharmacy criteria.

Mental Health Follow Up Within 7 and 30 Days

Central Region

	NCQA Medicaid 50th Percentile	HEDIS Results	
Sub-Measures	**2008**	**2009**	**2008**
Follow Up Within 7 Days	43.20	45.88	42.65
Follow Up Within 30 Days	65.90	70.59	71.32

↑ or ↓ indicates a statistically significant change from the previous year's plan rate.
Green: ≥95% of goal Yellow: 85%-94% of goal Red: <85% of goal
Goal is NCQA Medicaid 50th Percentile

Follow-up within 7 days increased from 2008 and is within 95% of goal. Within 30 days decreased less than 1 percentage point, and remains within 95% of goal.

Eastern Region

	NCQA Medicaid 50th Percentile	HEDIS Results	
Sub-Measures	**2008**	**2009**	**2008**
Follow Up Within 7 Days	43.20	42.79	30.59
Follow Up Within 30 Days	65.90	70.68	57.45

↑ or ↓ indicates a statistically significant change from the previous year's plan rate.
Green: ≥95% of goal Yellow: 85%-94% of goal Red: <85% of goal
Goal is NCQA Medicaid 50th Percentile

Follow-up within 7 days increased from 2008 and is within 95% of goal. Within 30 days also increased and is within 95% of goal. Neither increase is significant.

Western Region

	NCQA Medicaid 50th Percentile	HEDIS Results	
Sub-Measures	**2008**	**2009**	**2008**
Follow Up Within 7 Days	43.20	44.85↑	35.53
Follow Up Within 30 Days	65.90	66.54↑	57.51

↑ or ↓ indicates a statistically significant change from the previous year's plan rate.
Green: ≥95% of goal Yellow: 85%-94% of goal Red: <85% of goal
Goal is NCQA Medicaid 50th Percentile

Follow-up within 7 days increased significantly from 2008 and is within 95% of goal. Within 30 days also increased and is within 95% of goal.

State-Wide

Sub-Measures	NCQA Medicaid 50th Percentile	2009 State-Wide Rate
Within 7 Days	43.20	43.80
Within 30 Days	65.90	69.62

Green: ≥95% of goal Yellow: 85%-94% of goal Red: <85% of goal
Goal is NCQA Medicaid 50th Percentile

Overall

Interventions: MHNet continues a Performance Improvement Project to improve the follow-up rates. Interventions identified as key to addressing identified barriers:

- Utilization of in-home therapists reduced transportation barriers.
- Use of a full-time discharge planner to coordinate discharge planning including contacts with the facility and family.

Mailing discharge-follow up letters to members post-discharge provides a visual reminder for the member and guides them to a single contact at MHNet.

Annual Dental Visit

Central Region

	NCQA Medicaid 50th Percentile	HEDIS Results	
By Age Stratification	2008	2009	2008
2-3 Years	Not available	20.10	19.60
4-6 Years	52.90	43.95↑	39.75
7-10 Years	55.00	48.85	42.07
11-14 Years	48.90	42.92↑	38.59
15-18 Years	41.40	37.76	30.17
19-21 Years	32.70	26.55↑	10.81
All Ages Combined	45.10	40.33	35.08

↑ or ↓ indicates a statistically significant change from the previous year's plan rate.
Green: ≥95% of goal Yellow: 85%-94% of goal Red: <85% of goal
Goal is NCQA Medicaid 50th Percentile

The percentage for dental visits all ages increased from 2008, and is 85% to 94% of goal. There was a significant increase in 3 age stratifications (chi square analysis, $p \leq 0.05$), even though 2 of these are still less than 85% of goal.

Eastern Region

	NCQA Medicaid 50th Percentile	HEDIS Results	
By Age Stratification	**2008**	**2009**	**2008**
2-3 Years	Not available	14.05↑	12.40
4-6 Years	52.90	41.13↑	39.42
7-10 Years	55.00	48.42	46.04
11-14 Years	48.90	40.62	37.41
15-18 Years	41.40	32.80	29.25
19-21 Years	32.70	21.18↑	16.82
All Ages Combined	45.10	37.16	34.61

↑ or ↓ indicates a statistically significant change from the previous year's plan rate.
Green: ≥95% of goal Yellow: 85%-94% of goal Red: <85% of goal
Goal is NCQA Medicaid 50th Percentile

The percentage for dental visits all ages increased from 2008 to 2009, and is 85% to 94% of goal. There was a significant increase in 3 of the age stratifications (chi square analysis, $p \leq 0.05$). However, 4 of the age stratifications are still less than 85% of goal.

Western Region

	NCQA Medicaid 50th Percentile	HEDIS Results	
By Age Stratification	**2008**	**2009**	**2008**
2-3 Years	Not available	13.05↑	11.39
4-6 Years	52.90	37.12↑	34.20
7-10 Years	55.00	42.14	38.00
11-14 Years	48.90	37.32↑	34.07
15-18 Years	41.40	32.51↑	29.85
19-21 Years	32.70	15.03	15.02
All Ages Combined	45.10	33.42	30.29

↑ or ↓ indicates a statistically significant change from the previous year's plan rate.
Green: ≥95% of goal Yellow: 85%-94% of goal Red: <85% of goal
Goal is NCQA Medicaid 50th Percentile

The percent of members completing annual dental visits in all age categories increased from 2008 to 2009, but remains less than 85% of goal. Four age stratifications increased a statistically significant amount (chi square analysis, $p \leq 0.05$).

All Regions

Member well care reminders were revised and to include dental screening reminders. Reminders are mailed prior to the birthday month. HealthCare USA providers are also reminded to include dental screenings during all EPSDT visits. HealthCare USA collaborates with Doral Dental and local health departments to include dental screenings and education at community events.

Prenatal and Postpartum

Central Region

	NCQA Medicaid 50th Percentile	HEDIS Results	
Sub-Measures	**2008**	**2009**	**2008**
Prenatal	84.10	95.81↑	91.40
Postpartum	60.80	76.98	72.79

↑ or ↓ indicates a statistically significant change from the previous year's plan rate.
Green: ≥95% of goal Yellow: 85%-94% of goal Red: <85% of goal
Goal is NCQA Medicaid 50th Percentile

There was an increase in both submeasures, and a statistically significant increase in Timeliness of Prenatal Care (chi square analysis, $p \leq 0.05$). Both are above the 50th percentile goal.

Eastern Region

	NCQA Medicaid 50th Percentile	HEDIS Results	
Sub-Measures	**2008**	**2009**	**2008**
Prenatal	84.10	83.76	83.53
Postpartum	60.80	59.16	54.76

↑ or ↓ indicates a statistically significant change from the previous year's plan rate.
Green: ≥95% of goal Yellow: 85%-94% of goal Red: <85% of goal
Goal is NCQA Medicaid 50th Percentile

Timeliness of Prenatal care remained fairly flat, and Postpartum Visit increased from 2008. Both are within 95% of goal.

Western Region

	NCQA Medicaid 50th Percentile	HEDIS Results	
By Sub-Measures	**2008**	**2009**	**2008**
Prenatal	84.10	93.17	86.11
Postpartum	60.80	71.83	61.34

↑ or ↓ indicates a statistically significant change from the previous year's plan rate.
Green: ≥95% of goal Yellow: 85%-94% of goal Red: <85% of goal
Goal is NCQA Medicaid 50th Percentile

Both submeasures increased from HEDIS 2008, and both are above the 50th percentile.

State-Wide

Sub-Measures	NCQA Medicaid 50th Percentile	2009 HEDIS Result
Timeliness of Prenatal Care	84.10	86.57
Postpartum Care	60.80	61.57

Green: ≥95% of goal Yellow: 85%-94% of goal Red: <85% of goal
Goal is NCQA Medicaid 50th Percentile

Both submeasures above the Medicaid 50th percentile.

All Regions

HealthCare USA expanded the member incentive for prenatal visits to all three regions. The provider bill above program for postpartum visits was also expanded to all 3 regions. This program encourages a provider of a postpartum visit to submit the claim and receive a $25 ~~–b~~ill above." Most post-partum visits are included in the OB global authorization. For this reason, separate prenatal and post-partum visit claims and/or encounters are not sent in by providers. Hybrid methodology was utilized for this measure, as has been done for the past few years.

Well Child Visits: Ages 3-6, First 15 Months of Life, and Adolescent Well Care

Central Region

	NCQA Medicaid 50th Percentile	HEDIS Results	
Measure	**2008**	**2009**	**2008**
Well Care Visits Ages 3-6	68.20	60.66	62.32
Well Child Visits First 15 Months of Life			
0 Visits	1.90	0.65	1.42
1 Visit	1.90	1.03	2.13
2 Visits	3.10	1.81	2.37
3 Visits	5.80	5.05	3.79
4 Visits	10.60	6.34	6.75
5 Visits	17.80	14.23	12.19
6 or More Visits	57.50	70.89	71.36
Adolescent WCV	42.10	38.43	40.19

↑ or ↓ indicates a statistically significant change from the previous year's plan rate.
Green: ≥95% of goal Yellow: 85%-94% of goal Red: <85% of goal
Goal is NCQA Medicaid 50th Percentile

- Well Care Visits Ages 3 to 6 are within 85-94% of goal and have increased slightly from the previous year.
- There was a slight decrease in Well Child Visits in the First 15 Months of Life in the 6 or more visits category. There was a higher percent in 3 visits and 5 visits stratifications. All other stratifications decreased or improved as compared to 2008. However, none of the changes were statistically significant and all remain within 95% of goal.
- Adolescent Well Care decreased from the previous year's result, although not significantly. The reported rate is a hybrid rate. The administrative rate of 36.53% was a statistically significant decline from the previous year (chi square analysis, $p \leq 0.05$). The hybrid rate increased the rate from the administrative data only, but not significantly. The hybrid 2009 rate is does not reflect a significant difference from the administrative 2008 rate. There was an increase of approximately 1000 adolescents in the denominator in 2009 as compared to 2008, which may represent the decrease.

Eastern Region

	NCQA Medicaid 50th Percentile	HEDIS Results	
Measures	2008	2009	2008
WCV Ages 3-6	68.20	68.52	62.68
Well Child Visits First 15 Months of Life			
0 Visits	1.90	2.31↓	5.13
1 Visit	1.90	2.08	3.63
2 Visits	3.10	3.24	5.13
3 Visits	5.80	8.10	8.90
4 Visits	10.60	14.12	13.37
5 Visits	17.80	20.60	20.94
6 or More Visits	57.50	49.54↑	42.90
Adolescent WCV	42.10	45.14	40.35

↑ or ↓ indicates a statistically significant change from the previous year's plan rate.
Green: ≥95% of goal Yellow: 85%-94% of goal Red: <85% of goal
Goal is NCQA Medicaid 50th Percentile

- Well Child Visits Ages 3 to 6 increased and is now above the goal. Medical record review resulted in an increase in visits identified and the percent increased as a result of doing the hybrid data collection method from 63.27% to 68.52%.
- Well Child Visits First 15 Months of Life increased a statistically significant amount for 6 or more visits and decreased a significant amount in 0 visits (chi square analysis, $p \leq 0.05$). A group of PCP offices related to a hospital network were billing using the hospital place of service code. This resulted in all well child/EPSDT claims billed by these providers being screened as not numerator-adherent. The PCP offices and billing department were educated and the NCQA auditor allowed a one-time acceptance of claims from these offices.
- Adolescent Well Care visits increased as compared to last year and are now above the goal. More than likely the billing changes affecting the other well child measures affected the outcome of this measure as well.

Western Region

	NCQA Medicaid 50th Percentile	HEDIS Results	
Measure	**2008**	**2009**	**2008**
WCV Ages 3-6	68.20	61.57	60.42
Well Child Visits First 15 Months of Life			
0 Visits	1.90	3.91	2.08
1 Visit	1.90	3.71	1.85
2 Visits	3.10	7.49	7.41
3 Visits	5.80	9.38	8.80
4 Visits	10.60	13.61	10.88
5 Visits	17.80	20.51	20.66
6 or More Visits	57.50	41.41	46.07
Adolescent WCV	42.10	32.33	32.56

↑ or ↓ indicates a statistically significant change from the previous year's plan rate.
Green: ≥95% of goal Yellow: 85%-94% of goal Red: <85% of goal
Goal is NCQA Medicaid 50th Percentile

- Well Child Visits Ages 3 to 6 increased from HEDIS 2008 and are within 85 to 94% of goal. Hybrid methodology was used again this year, resulting in an increase in from 58.99% to 61.11%.
- Well Child Visits 1st 15 Months of Life decreased from HEDIS 2008 and is less than 85% of goal.
- Adolescent Well Care Visits remained flat as compared to last year and are less than 85% of goal. Hybrid methodology was used and resulted in no change in this rate. The denominator was essentially unchanged as compared to prior years. Outbound calls to members/parents/guardians missing a well child claim were completed as a one-time intervention. In addition to providing a reminder about missed visits, the calls were also a way to provide information about transportation and to offer assistance with choosing a primary care provider and scheduling a visit.

All Regions

Interventions in 2009 include a revised member reminder mailing and a revised process based on the birth month for all well child age groups. Birthday reminders are sent in the quarter prior to the member's birthday. If no EPSDT claim is received in the next quarter, an additional reminder is sent. If it is still not received in the quarter after the initial reminder, a second reminder is sent.

Providers receive education and reminders about the American Academy of Pediatrics' clinical practice guidelines for well care visits and EPSDT requirements. HealthCare USA will also send providers a list of members on their panel that are missing a claim for a well care visit. HealthCare USA continues to participate in the State-wide Adolescent Well Care Performance Improvement Project.

Outpatient Utilization

Central Region

	NCQA Medicaid 50th Percentile	HEDIS Results	
Ambulatory Care	**2008**	**2009**	**2008**
Outpatient Visits/1000	324.00	378.22	362.83
ED Visits/1000	60.20	69.04	74.26
Surgery-Procedures/1000	5.4	9.76	4.99
Obs Room Stays Resulting in DC/1000	1.70	1.24	1.94
↑ or ↓ indicates a statistically significant change from the previous year's plan rate. Goal is NCQA Medicaid 50th Percentile			

Outpatient visits/1000 increased from 2008 to 2009. ED visits decreased from HEDIS 2008 and remain below or better than the goal. Ambulatory surgery/procedures increased from 2008 to 2009 and are above the goal. Observation room stays decreased from 2008 and is below the threshold.

Eastern Region

	NCQA Medicaid 50th Percentile	HEDIS Results	
Ambulatory Care	2008	2009	2008
Outpatient Visits/1000	324.00	240.94	229.70
ED Visits/1000	60.20	75.88	72.68
Surgery-Procedures/1000	5.4	7.01	3.32
Obs Room Stays Resulting in DC/1000	1.70	0.82	1.42
↑ or ↓ indicates a statistically significant change from the previous year's plan rate. Goal is NCQA Medicaid 50th Percentile			

Outpatient visits increased from 2008 to 2009 but are well below the HEDIS 50th percentile. ED visits increased slightly, but are also below the HEDIS 50th percentile. Ambulatory surgery/procedures increased from 2008 and are above the HEDIS 50th percentile. Observation room stays decreased from 2008 and are below the comparison rate.

Western Region

	NCQA Medicaid 50th Percentile	HEDIS Results	
Ambulatory Care	**2008**	**2009**	**2008**
Outpatient Visits/1000	324.00	325.15	310.00
ED Visits/1000	60.20	87.48	88.36
Surgery-Procedures/1000	5.4	12.98	3.20
Obs Room Stays Resulting in DC/1000	1.70	0.94	1.47
↑ or ↓ indicates a statistically significant change from the previous year's plan rate. Goal is NCQA Medicaid 50th Percentile			

Outpatient visits increased as compared to 2008 and remains well below the HEDIS 50th percentile. ED visits decreased slightly and remain below the comparison as well. Ambulatory surgery/procedures increased as compared to 2008 and are well above the HEDIS 50th percentile comparison. Observation room stays decreased in 2009 as compared to 2008 and are below the comparison in 2009.

All Regions

HealthCare USA continues an ED Performance Improvement Project. One of several interventions implemented in 2009 includes establishment of a process to receive ED logs from several of the highest volume EDs in Eastern and Central regions every day or every other day. The case management and disease management nurses receive copies of the logs for review and follow up with any member enrolled in either a case or disease management program. An ED case manager position was also implemented. The case manager makes outbound calls to members not in either case or disease management to assess why they went to the ED, if they understand the ED discharge instructions and if they need assistance to follow the instructions. If the visit was for a non-urgent or avoidable reason, the case manager assesses what barriers the member may have encountered to receiving care in a more appropriate setting. The ED case manager utilizes an access database to document key findings for further analysis.

Mental Health Utilization

Central Region

	NCQA Medicaid 50th Percentile	HEDIS Results	
Sub-Measures	**2008**	**2009**	**2008**
% Mbrs Recvg Inpt Services	0.80	0.57	0.64
% Mbrs Recvg Day/Night Services	0.10	0.13	0.09
% Mbrs Recvg Ambulatory Services	9.00	8.26	9.13
↑ or ↓ indicates a statistically significant change from the previous year's plan rate. Goal is NCQA Medicaid 50th Percentile			

The percent of members receiving in patient services for mental health decreased slightly as compared to 2008. Members receiving day/night or intermediate services increased in 2008 to above the HEDIS 50th percentile. Members receiving ambulatory services also decreased as compared to 2008.

Eastern Region

	NCQA Medicaid 50th Percentile	HEDIS Results	
Sub-Measures	**2008**	**2009**	**2008**
% Mbrs Recvg Inpt Services	0.80	0.59	0.57
% Mbrs Recvg Day/Night Services	0.10	0.05	0.03
% Mbrs Recvg Ambulatory Services	9.00	6.39	6.05
↑ or ↓ indicates a statistically significant change from the previous year's plan rate. Goal is NCQA Medicaid 50th Percentile			

Members receiving in-patient services increased very slightly this year as compared to 2008. Members receiving day/night or intermediate services increased but remains below the Medicaid mean. Members receiving ambulatory services increased slightly and remain below the HEDIS 50th percentile.

Western Region

	NCQA Medicaid 50th Percentile	HEDIS Results	
Sub-Measures	**2008**	**2009**	**2008**
% Mbrs Recvg Inpt Services	0.80	0.75	0.33
% Mbrs Recvg Day/Night Services	0.10	0.11	0.03
% Mbrs Recvg Ambulatory Services	9.00	6.87	1.04
↑ or ↓ indicates a statistically significant change from the previous year's plan rate. Goal is NCQA Medicaid 50th Percentile			

Members receiving in-patient services increased in 2009, as compared to 2008. Members receiving day/night or intermediate services increased the percent who received ambulatory mental health services increased.

Identification of Alcohol & Other Drug Services

Central Region

	NCQA Medicaid 50th Percentile	HEDIS Results	
Sub-Measures	**2008**	**2009**	**2008**
% Mbrs Receiving Inpt Services	0.70	0.30	0.32
% Mbrs Recvg Intermediate Services	0.00	0.00	0.01
% Mbrs Recvg Ambulatory Services	1.30	0.79	0.72
↑ or ↓ indicates a statistically significant change from the previous year's plan rate. Goal is NCQA Medicaid 50th Percentile			

Members receiving in-patient services alcohol/drugs decreased very slightly as compared to 2008. Members receiving intermediate services decreased slightly as well and remain equal to the HEDIS 50th percentile. Members receiving ambulatory services increased slightly in 2009.

Eastern Region

	NCQA Medicaid 50th Percentile	HEDIS Results	
Sub-Measures	**2008**	**2009**	**2008**
% Mbrs Receiving Inpt Services	0.70	0.33	0.26
% Mbrs Recvg Intermediate Services	0.00	0.00	0.00
% Mbrs Recvg Ambulatory Services	1.30	0.73	0.68
↑ or ↓ indicates a statistically significant change from the previous year's plan rate. Goal is NCQA Medicaid 50th Percentile			

Members receiving in-patient services alcohol/drugs decreased slightly and intermediate services remained essentially unchanged. Members receiving ambulatory services increased slightly in 2009 in the Eastern region.

Western Region

	NCQA Medicaid 50th Percentile	HEDIS Results	
Sub-Measures	**2008**	**2009**	**2008**
% Mbrs Receiving Inpt Services	0.70	0.39	0.78
% Mbrs Recvg Intermediate Services	0.00	0.01	0.13
% Mbrs Recvg Ambulatory Services	1.30	1.05	6.43
↑ or ↓ indicates a statistically significant change from the previous year's plan rate. Goal is NCQA Medicaid 50th Percentile			

Members receiving in-patient services alcohol/drugs decreased, as did utilization of intermediate services and members receiving ambulatory services.

CAHPS

Childhood CAHPS 4.0

HealthCare USA utilizes the NCQA CAHPS Child Survey to measure the satisfaction of the membership in each of the three regions across Missouri. DSS Research conducted this survey for HealthCare USA and has done so for the past several years, making comparisons between the years reliable. DSS Research also makes available a comparison between the current year results

and the previous year's Medicaid average. An analysis and final report is completed by DSS Research upon completion of the survey.

The CAHPS survey version 4.0, an updated version was utilized for calendar year 2009. Objectives added in the 4.0 version include the assessment of member perceptions related to:

- Shared decision making
- Coordination of care
- Health promotion and education

For these new objectives, previous years' data and Medicaid comparisons do not exist. In those instances where comparisons are made, they are in relation to the 2009 DSS average. The DSS Book of Business includes 22 Medicaid plans utilizing the child CAHPS survey, including a total of 16,872 respondents. Changes to the wording of a question and/or the response on the survey resulted in an inability to review trends. In these cases, the 2009 DSS survey average is utilized.

Questions related to satisfaction with the appeals and grievances were deleted from the survey.

The survey is mailed to parents of members 17 years and younger who have been continuously enrolled in the plan for at least five of the last six months of the measurement year. HEDIS technical specifications for survey measures were followed for the data collection. A possible total of two mailers, each followed by a reminder postcard, were sent to each member. Fifty-six days after the second reminder postcard was mailed and no response was received, telephone interviewing was initiated. A total of 81 days was allowed to collect all completed surveys.

Overall, HealthCare USA was very pleased with the results. Improvements were achieved in most indicators. As with prior years, an interdepartmental, multi-disciplinary workgroup reviewed all of the results to identify barriers and brain storm possible interventions for improvements.

Sampling

Eastern Region

In 2009, a sample of 533 members was obtained in which the overall sampling error $\pm$4.2% at the 95% confidence level using the most pessimistic assumption regarding variance (p=0.5). The adjusted response rate was 32.84%.

Central Region

In 2009, a sample of 649 members was obtained in which the overall sampling error is $\pm$ 3.9% at the 95% confidence level using the most pessimistic assumption regarding variance (p=0.5). The adjusted response rate was 39.91%.

Western Region

In 2009, a sample of 427 members was obtained in which the overall sampling error is $\pm$ 4.7% at the 95% confidence level using the most pessimistic assumption regarding variance (p=0.5). The adjusted response rate was 26.54%.

Results: Overall Ratings

Central Region

Overall Ratings	Answer	2008 Medicaid Average	2007	2008	2009
Health plan overall	NA	79.7	80.6	83.6	82.7◇
Health care overall	NA	81.9	83.7	83.2	81.4
Personal doctor overall	NA	82.5	81.1	83.3	85.4
Specialist overall	NA	80.4	80.7	75.2	79.3

↑ ↓ Significant change from current year's rate to previous year's rate.
◇Significant difference between current year's rate and Medicaid average

The overall rating for HealthCare USA is significantly above the 2008 Medicaid average. There were a few percentage points variation in health care overall and personal doctor overall, but not significant. Specialist overall improved 4%, and is slightly below the Medicaid average.

Eastern Region

Overall Ratings	Answer	2008 Medicaid Average	2007	2008	2009
Health plan overall	NA	79.7	81.5	83.5	83.1◇
Health care overall	NA	81.9	79.5	81.9	79.1
Personal doctor overall	NA	82.5	78.7	84.2	84.6
Specialist overall	NA	80.4	70.7	84.1	80.4

↑ ↓ Significant change from current year's rate to previous year's rate.
◇Significant difference between current year's rate and Medicaid average.

Results for Eastern region are similar to Central region. HealthCare USA's rate overall is significantly above the 2008 Medicaid average. There was little variation in health care and personal doctor overall ratings. Specialist overall decreased by 4%, but remains in line with the Medicaid average.

Western Region

Overall Ratings	Answer	2008 Medicaid Average	2007	2008	2009
Health plan overall	NA	79.7	78.5	78.9	79.9
Health care overall	NA	81.9	72.0	83.0	79.0
Personal doctor overall	NA	82.5	73.7	77.6	83.5
Specialist overall	NA	80.4	70.7	80.5	82.4

↑ ↓ Significant change from current year's rate to previous year's rate.
◇Significant difference between current year's rate and Medicaid average.

There was no significant change from the previous year or variance from the 2008 Medicaid average.

Overall

Members are satisfied with their health plan overall, which is heavily influenced by customer service. All 3 regions composite score for health care overall is within 1 to 2 percentage points of the Medicaid average, with no significant variances seen. Health care overall is heavily influenced by getting needed care and getting care quickly. Personal doctor and specialist overall results are above or right at the Medicaid average, with the exception of Central specialist

overall. None differs significantly from the Medicaid average. These overall percentages are heavily influenced by how well doctors communicate and share in decision making.

Results: Customer Service

Central Region

Customer Service	Answer	Average	2007	2008	2009
Customer service	Composite	83.4[2]	69.9	80.9	83.3
Health plan gave mbrs forms to fill out	Yes	20.6[1]	25.8	24.6	26.8◇
Health plan forms were easy to fill out	Always/ usually	95.1[2]	NR	NR	97.9
Tried to get info/help from plan's customer service	Yes	23.3[1]	20.8	20.4	14.2◇↓
Received needed info from plan's customer service	Always/ usually	77.4[2]	NR	NR	76.7
Customer service staff treated you with courtesy and respect	Always/ usually	89.3[2]	NR	NR	90.0

Average: [1]2008 Medicaid Average [2]2009 DSS Average
↑ ↓ Significant change from current year's rate to previous year's rate.
◇Significant difference between current year's rate and average.

Overall, members are satisfied with the customer service they received when contacting HealthCare USA's member services line. Significantly fewer members report trying to get information from our member services staff than the Medicaid average and the previous year's results. This could be a result of better information on the member website that is easier to locate and access. Ninety percent of members responded that the customer service staff treated them with courtesy and respect always or usually.

Eastern Region

Customer Service	Answer	Average	2007	2008	2009
Customer service	Composite	83.4[2]	75.6	77.6	75.3
Health plan gave mbrs forms to fill out	Yes	20.6[1]	24.5	23.8	34.2◇↑
Health plan forms were easy to fill out	Always/ usually	95.1[2]	NR	NR	95.7
Tried to get info/help from plan's customer service	Yes	23.3[1]	22.9	24.6	20.9
Received needed info from plan's customer service	Always/ usually	77.4[2]	NR	NR	68.9◇
Customer service staff treated you with courtesy and respect	Always/ usually	89.3[2]	NR	NR	81.7

Average: [1]2008 Medicaid Average [2]2009 DSS Average
↑ ↓ Significant change from current year's rate to previous year's rate.
◇Significant difference between current year's rate and average.

Overall, members in the Eastern region were less satisfied with HealthCare USA's customer service, but not significantly. Members in Eastern region responded that they were given forms to fill out a significantly higher amount than the Medicaid average and as compared to HealthCare USA's prior year result. Members have responded they received needed information from customer service always or usually a significantly lower percent than the Medicaid average. They also responded they were treated with courtesy and respect less frequently than the Medicaid average and as compared to other regions. However, the difference is not statistically significant.

Western Region

Customer Service	Answer	Average	2007	2008	2009
Customer service	Composite	83.4[2]	67.2	73.9	86.0
Health plan gave mbrs forms to fill out	Yes	20.6[1]	24.1	23.4	30.2◇↑
Health plan forms were easy to fill out	Always/ usually	95.1[2]	NR	NR	95.8
Tried to get info/help from plan's customer service	Yes	23.3[1]	22.8	25.0	28.2
Received needed info from plan's customer service	Always/ usually	77.4[2]	NR	NR	78.5◇
Customer service staff treated you with courtesy and respect	Always/ usually	89.3[2]	NR	NR	93.5

Average: [1]2008 Medicaid Average [2]2009 DSS Average
↑ ↓ Significant change from current year's rate to previous year's rate.
◇Significant difference between current year's rate and average.

Western region members were satisfied with their customer service experiences. They also responded that the plan gave them forms to fill out at a higher percent than the Medicaid average, but also responded they received the needed information always or usually at a significantly higher percentage than the Medicaid average. The percent of members who responded that the customer service staff treated them with courtesy and respect was higher than the Medicaid average as well.

Overall

HealthCare USA utilizes the same customer service staff for all 3 regions, so the less positive results in the Eastern region is somewhat puzzling. Customer service staff calls are routinely audited and graded for tone of voice, rushing through the call, etc. Coaching occurs when needed. Customer service also asks members at the end of each call if the member has any other needs or will prompt on issues the member may not have thought of. A barrier to complete investigation of the results is a lack of member level and call detail. Questions regarding customer service satisfaction will be considered for other member satisfaction surveys sent by the plan to try to identify perceptions and member understanding that may affect outcomes of this survey.

Results: Getting Needed Care

Central Region

Getting Needed Care	Answer	Average	2007	2008	2009
Getting needed care	Composite	78.9[2]	81.6	80.8	82.8
Getting appt with a specialist was easy	Always/ usually	74.8[2]	NR	NR	77.6◇
Tried to get care, tests or treatment	Yes	49.1[1]	51.3	54.5	43.6◇↓
Getting needed care, tests or treatment was easy	Always/ usually	83.0[2]	NR	NR	88.0

Average: [1]2008 Medicaid Average [2]2009 DSS Average
↑ ↓ Significant change from current year's rate to previous year's rate.
◇Significant difference between current year's rate and average.

Composite score for getting needed care is above the 2009 DSS average, but not significantly. Two other questions had results above the Medicaid average for DSS research, one significantly

higher. The new question regarding ease of getting an appointment with a specialist was significantly better than the Medicaid average.

Eastern Region

Getting Needed Care	Answer	Average	2007	2008	2009
Getting needed care	Composite	78.9[2]	78.7	81.6	81.0
Getting appt with a specialist was easy	Always/ usually	74.8[2]	NR	NR	77.4◇
Tried to get care, tests or treatment	Yes	49.1[1]	47.5	51.1	43.9◇↓
Getting needed care, tests or treatment was easy	Always/ usually	83.0[2]	NR	NR	84.7

Average: [1]2008 Medicaid Average [2]2009 DSS Average
↑ ↓ Significant change from current year's rate to previous year's rate.
◇Significant difference between current year's rate and average.

Eastern region's results were very similar to the Central region. The ease of getting an appointment with a specialist was significantly better than the Medicaid average.

Western Region

Getting Needed Care	Answer	Average	2007	2008	2009
Getting needed care	Composite	78.9[2]	73.4	80.4	76.6
Getting appt with a specialist was easy	Always/ usually	74.8[2]	NR	NR	74.0
Tried to get care, tests or treatment	Yes	49.1[1]	46.5	53.7	39.8◇↓
Getting needed care, tests or treatment was easy	Always/ usually	83.0[2]	NR	NR	79.1

Average: [1]2008 Medicaid Average [2]2009 DSS Average
↑ ↓ Significant change from current year's rate to previous year's rate.
◇Significant difference between current year's rate and average.

The getting needed care composite is below the average, albeit not significantly. Ease of getting an appointment with a specialist is slightly below the benchmark, but not significantly. Ease of getting needed care, test or treatment is below the average, but not significantly.

Overall

Western region has the greatest room for improvement regarding ease of getting appointments. HealthCare USA continues to complete a geoaccess survey annually and continuously looks to improve and expand the provider network.

Getting Care Quickly

Central Region

Getting Care Quickly	Answer	Average	2007	2008	2009
Getting care quickly	Composite	87.3[2]	82.6	83.8	93.4
Child had illness, injury or condition that needed care right away	Yes	38.4[1]	42.8	43.4	44.5◇
Got urgent care as soon as needed	Always/ usually	86.4[1]	89.6	91.9	95.1◇
Made appt for health care at doctor's office/clinic	Yes	59.5[1]	61.0	60.7	74.1◇↑
Got regular/routine appt as soon as needed	Always/ usually	83.7[1]	92.1	91.5	91.7◇

Average: [1]2008 Medicaid Average [2]2009 DSS Average

↑ ↓ Significant change from current year's rate to previous year's rate.
◇Significant difference between current year's rate and average.

All results are above the averages. Members were always or usually able to get urgent care and regular/routine care as soon as they needed a significant amount above the average. There is also a significant increase in the percent of members who made an appointment for health care.

Eastern Region

Getting Care Quickly	Answer	Average	2007	2008	2009
Getting care quickly	Composite	87.3[2]	78.6	77.0	89.9
Child had illness, injury or condition that needed care right away	Yes	38.4[1]	37.2	43.5	39.3
Got urgent care as soon as needed	Always/ usually	86.4[1]	86.4	89.7	94.1◇
Made appt for health care at doctor's office/clinic	Yes	59.5[1]	56.7	63.7	76.3◇↑
Got regular/routine appt as soon as needed	Always/ usually	83.7[1]	84.1	80.1	85.8

Average: [1]2008 Medicaid Average [2]2009 DSS Average
↑ ↓ Significant change from current year's rate to previous year's rate.
◇Significant difference between current year's rate and average.

All results are above the averages. Members got urgent care as soon as needed a significant amount above the average, and got regular/routine appointment as soon as needed a significant amount above the result for the previous year. In addition, There was a significant increase from the previous year and a significant difference between the average and the result for made appointment for health care at doctor's office/clinic.

Western Region

Getting Care Quickly	Answer	Average	2007	2008	2009
Getting care quickly	Composite	87.3[2]	75.1	77.8	91.0
Child had illness, injury or condition that needed care right away	Yes	38.4[1]	41.0	41.3	42.3
Got urgent care as soon as needed	Always/ usually	86.4[1]	84.8	87.4	93.2◇
Made appt for health care at doctor's office/clinic	Yes	59.5[1]	56.2	62.6	71.7↑
Got regular/routine appt as soon as needed	Always/ usually	83.7[1]	78.0	82.1	88.9◇↑

Average: [1]2008 Medicaid Average [2]2009 DSS Average
↑ ↓ Significant change from current year's rate to previous year's rate.
◇Significant difference between current year's rate and average.

Western region's results also are positive. All indicators are above the averages. Members got urgent care and regular/routine appointments as soon as needed a significant amount above the average. In addition, there is a significant increase in the percentage of members who made an appointment for health care at a doctor's office/clinic.

Overall

Results in all three regions are very encouraging. Members are making appointments at their doctor's office/clinic, and providers are able to get them in when needed. Any outcomes suggesting increased utilization of primary care/a medical home results in increased continuity of care and decreased ED utilization.

Results: Personal Provider

Central Region

Personal Provider	Answer	Average	2007	2008	2009
Have a personal provider	Yes	83.1[1]	89.6	89.7	95.9◇↑
Average # of visits to personal prov in last 6 mos		2.24[2]	NR	NR	2.22
Tried to make appts to see a specialist in last 6 months	Yes	21.8[1]	22.9	21.7	23.1
Number of specialists seen in last 6 months	One or more	88.0[2]	NR	NR	91.8

Average: [1]2008 Medicaid Average [2]2009 DSS Average
↑ ↓ Significant change from current year's rate to previous year's rate.
◇Significant difference between current year's rate and average.

There was a significant increase from the previous year and a significant difference from the average in the percentage of members who say they have a personal doctor. The average number of visits to a personal doctor is slightly below the average. A slightly lower percentage of members tried to make appointments to see a specialist, but the percent members seeing more than one specialist is slightly above the average.

Eastern Region

Personal Provider	Answer	Average	2007	2008	2009
Have a personal provider	Yes	83.1[1]	87.6	88.5	89.7◇
Average # of visits to personal prov in last 6 mos		2.24[2]	NR	NR	1.88
Tried to make appts to see a specialist in last 6 months	Yes	21.8[1]	23.9	24.2	22.5
Number of specialists seen in last 6 months	One or more	88.0[2]	NR	NR	89.5

Average: [1]2008 Medicaid Average [2]2009 DSS Average
↑ ↓ Significant change from current year's rate to previous year's rate.
◇Significant difference between current year's rate and average.

There is a significant positive difference from the average of the percentage of members who say they have a personal doctor. However, the average number of visits to their personal doctor is below the averages. A slightly lower percentage of members tried to make appointments to see a specialist, but the percent members seeing more than one specialists is slightly above the average.

Western Region

Personal Provider	Answer	Average	2007	2008	2009
Have a personal provider	Yes	83.1[1]	79.4	83.8	88.0◇
Average # of visits to personal prov in last 6 mos		2.24[2]	NR	NR	2.08
Tried to make appts to see a specialist in last 6 months	Yes	21.8[1]	23.7	20.7	24.2
Number of specialists seen in last 6 months	One or more	88.0[2]	NR	NR	85.9

Average: [1]2008 Medicaid Average [2]2009 DSS Average
↑ ↓ Significant change from current year's rate to previous year's rate.
◇Significant difference between current year's rate and average.

There is a significant positive difference from the average of the percentage of members who say they have a personal doctor. However, the average number of visits to their personal doctor is below the average. A slightly lower percentage of members tried to make appointments to see a specialist, and the percent members seeing more than one specialists is slightly below the average.

Overall

Percent of members who say they have a personal provider is encouraging. Establishment of a medical home improves continuity of care and member safety, and frequently results in a decrease in ED utilization. HealthCare USA continues to educate members about the importance of a medical home. A comprehensive member reminder system also encourages members to see their PCP in accordance with the AAP, the CDC and other nationally recognized clinical practice guidelines and recommendations for children and adults.

Results: How Well Doctors Communicate

Central Region

How Well Doctors Communicate	Answer	Average	2007	2008	2009
How well doctors communicate	Composite	89.7[1]	91.8	92.7	94.1
Doctor listened carefully	Usually	91.4[1]	92.3	94.2	93.9◇
Doctor explained things in a way you could understand	Always/ usually	90.1[1]	902.1	93.8	95.8◇
Doctor showed respect for what you had to say	Always/ usually	92.4[1]	93.9	94.2	96.2◇
Doctor spent enough time with child	Always/ usually	85.0[1]	88.8	88.6	90.5◇
Doctor talked with you about how child feeling/ growing/ behaving	Yes	71.5[1]	69.7	68.6	82.8◇↑
Child is able to talk with doctors about health care	Yes	62.0[1]	64.0	67.9	65.1
Doctor explained things in a way child could understand	Always/ usually	85.9[1]	90.9	87.5	91.5◇

Average: [1]2008 Medicaid Average [2]2009 DSS Average
↑ ↓ Significant change from current year's rate to previous year's rate.
◇Significant difference between current year's rate and benchmark.

All results are above the 2008 Medicaid average. Significant differences from the average include doctors listened carefully, doctors explained things in a way you could understand, doctors showed respect for what you had to say, doctor spent enough time with child, doctor

explained things in a way child could understand, and doctor talked with you about how child feeling/growing/behaving. The last result also had a significant increase from the prior year.

Eastern Region

How Well Doctors Communicate	Answer	Average	2007	2008	2009
How well doctors communicate	Composite	89.7[1]	89.1	90.6	92.2
Doctor listened carefully	Usually	91.4[1]	90.3	91.7	91.4
Doctor explained things in a way you could understand	Always/ usually	90.1[1]	87.5	89.5	93.1
Doctor showed respect for what you had to say	Always/ usually	92.4[1]	91.3	93.4	94.1◇
Doctor spent enough time with child	Always/ usually	85.0[1]	86.8	87.8	87.9
Doctor talked with you about how child feeling/ growing/ behaving	Yes	71.5[1]	71.0	76.1	87.2◇↑
Child is able to talk with doctors about health care	Yes	62.0[1]	68.8	74.7	67.7◇
Doctor explained things in a way child could understand	Always/ usually	85.9[1]	82.4	86.8	88.8

Average: [1]2008 Medicaid Average [2]2009 DSS Average
↑ ↓ Significant change from current year's rate to previous year's rate.
◇Significant difference between current year's rate and average.

All results are above the 2008 Medicaid average. Significant differences from the average include doctors showed respect for what you had to say, doctor spent enough time with child, doctor explained things in a way child could understand, child is able to talk with doctors about health care, and doctor talked with you about how child feeling/growing/behaving. The last result also had a significant increase from the prior year.

Western Region

How Well Doctors Communicate	Answer	Average	2007	2008	2009
How well doctors communicate	Composite	89.7[1]	86.9	92.7	90.7
Doctor listened carefully	Usually	91.4[1]	85.9	94.3	92.5
Doctor explained things in a way you could understand	Always/ usually	90.1[1]	89.9	94.0	92.5
Doctor showed respect for what you had to say	Always/ usually	92.4[1]	89.6	94.0	92.0
Doctor spent enough time with child	Always/ usually	85.0[1]	82.2	88.3	85.9
Doctor talked with you about how child feeling/ growing/ behaving	Yes	71.5[1]	60.4	64.4	87.4◇↑
Child is able to talk with doctors about health care	Yes	62.0[1]	50.3	57.5	57.9
Doctor explained things in a way child could understand	Always/ usually	85.9[1]	79.1	86.0	87.8

Average: [1]2008 Medicaid Average [2]2009 DSS Average
↑ ↓ Significant change from current year's rate to previous year's rate.
◇Significant difference between current year's rate and average.

Almost all results are above the 2008 Medicaid average. The result for doctor talked with you about how child feeling/growing/behaving is significantly above the average and improved significantly from the prior year's result.

Overall

Members are very satisfied with communication with their child's doctor. They believe their doctor shows respect for what they said, spent enough time with their child, explained things in a way they could understand and in a way their child could understand. Perhaps having a personal primary care provider and a medical home, which in all 3 regions is above the Medicaid average, enhances communication and understanding. HealthCare USA's efforts to promote routine well child visits and reinforcing the importance and value of a medical home to members and providers will continue to result in improvement in satisfaction with communication.

Results: Shared Decision Making

Central Region

Shared Decision Making	Answer	Average	2007	2008	2009
Doctor told you there were choices for your child's treatment or health care	Yes	42.1[2]	NR	NR	44.0
Doctor discussed pros and cons of each treatment choice	Definitely Yes	68.6[2]	NR	NR	71.6
Doctor asked you which treatment choice was best for your child	Definitely Yes	63.4[2]	NR	NR	63.4

Average: [1]2008 Medicaid Average [2]2009 DSS Average
↑ ↓ Significant change from current year's rate to previous year's rate.
◇Significant difference between current year's rate and average.

All three results for this measure are above the 2009 DSS average.

Eastern Region

Shared Decision Making	Answer	Average	2007	2008	2009
Doctor told you there were choices for your child's treatment or health care	Yes	42.1[2]	NR	NR	39.1
Doctor discussed pros and cons of each treatment choice	Definitely Yes	68.6[2]	NR	NR	71.2
Doctor asked you which treatment choice was best for your child	Definitely Yes	63.4[2]	NR	NR	64.3◇

Average: [1]2008 Medicaid Average [2]2009 DSS Average
↑ ↓ Significant change from current year's rate to previous year's rate.
◇Significant difference between current year's rate and average.

The result doctor asked you which treatment choice was best for your child is significantly above the 2009 DSS average. Doctor discussed pros and cons of each treatment choice slightly below the average, and doctor told you there were choices for your child's treatment or health care was below the average, but not significantly.

Western Region

Shared Decision Making	Answer	Average	2007	2008	2009
Doctor told you there were choices for your child's treatment or health care	Yes	42.1[2]	NR	NR	41.6
Doctor discussed pros and cons of each treatment choice	Definitely Yes	68.6[2]	NR	NR	66.4
Doctor asked you which treatment choice was best for your child	Definitely Yes	63.4[2]	NR	NR	59.0◇

Average: [1]2008 Medicaid Average [2]2009 DSS Average
↑ ↓ Significant change from current year's rate to previous year's rate.
◇Significant difference between current year's rate and average.

Results for this region are below the 2009 DSS average, with doctor asked you which treatment choice was best for your child significantly below average.

Overall

This is a new set of questions, with trending and Medicaid averages unavailable. The regional trend for this measure is in line with doctor communication and having a personal provider: Central region has the highest percentage of having a personal provider, communication with doctors, and shared decision making. Eastern region has the next highest, with most results above the average. Western region has the lowest percentage of those saying they have a personal provider, and also has lower results for communication and shared decision making.

Results: Coordination of Care

Central Region

Coordination of Care	Answer	Average	2007	2008	2009
Received care from doctor or health provider besides personal doctor in last 6 mos	Yes	43.2[2]	NR	NR	46.4
Personal doctor seemed informed about care from other providers	Always/ usually	76.7[2]	NR	NR	79.1
You and doctor discussed ways to prevent illness	Always/ usually	59.7[2]	NR	NR	64.8

Average: [1]2008 Medicaid Average [2]2009 DSS Average
↑ ↓ Significant change from current year's rate to previous year's rate.
◇Significant difference between current year's rate and average.

All results are above the 2009 DSS average.

Eastern Region

Coordination of Care	Answer	Average	2007	2008	2009
Received care from doctor or health provider besides personal doctor in last 6 mos	Yes	43.2[2]	NR	NR	40.3
Personal doctor seemed informed about care from other providers	Always/ usually	76.7[2]	NR	NR	78.6
You and doctor discussed ways to prevent illness	Always/ usually	59.7[2]	NR	NR	63.1

Average: [1]2008 Medicaid Average [2]2009 DSS Average
↑ ↓ Significant change from current year's rate to previous year's rate.
◇Significant difference between current year's rate and average.

Eastern region had a lower than average percentage of members who received care from doctor other than their personal doctor in last 6 months. Two remaining measures above the average.

Western Region

Coordination of Care	Answer	Average	2007	2008	2009
Received care from doctor or health provider besides personal doctor in last 6 mos	Yes	43.2[2]	NR	NR	45.8
Personal doctor seemed informed about care from other providers	Always/ usually	76.7[2]	NR	NR	84.4
You and doctor discussed ways to prevent illness	Always/ usually	59.7[2]	NR	NR	62.5

Average: [1]2008 Medicaid Average [2]2009 DSS Average
↑ ↓ Significant change from current year's rate to previous year's rate.
◇Significant difference between current year's rate and average.

All results above the 2009 DSS average.

Overall

This is a new measure with trending and Medicaid averages unavailable. Members view of the coordination of care between their personal doctor and other providers is above the average, albeit not significantly. Collaboration regarding discussion of ways to prevent illness is above the average for all three regions as well.

Adult CAHPS 4.0

In preparation for NCQA Accreditation, HealthCare USA completed the Adult CAHPS survey in 2009. It was completed as one state-wide survey versus regionally as the Child CAHPS is completed in order to meet the NCQA requirements. DSS Research conducted this survey for HealthCare USA and as it does for the Child CAHPS survey. DSS Research makes available a comparison between the current year results and the previous year's Medicaid average and the 2009 DSS Average. The DSS Average is derived from the DSS Adult Medicaid Book of Business, which includes 28 adult Medicaid plans with a total of 12,877 respondents. An analysis and final report is completed by DSS Research upon completion of the survey.

Since this is the first year Healthcare USA has completed the survey, there are no previous year results for trending. While the survey is very similar to the Child CAHPS survey, there are additional measures, such as Health Promotion and Education and Smoking Cessation.

Members eligible for the survey are those 18 years and older (as of December 31 of the measurement year) who are currently enrolled and have been continuously enrolled in the plan for at least five of the last six months of the measurement year. A random sample of adults was pulled from the entire eligible HealthCare USA population, de-duplicated for only one adult per household in the sample. Mailed surveys were 1350, with 333 completed surveys. Adjusted response rate is 25.19% with an overall sampling error of 5.4%.

Results: Composite Scores

Overall Ratings	Answer	2009 DSS Average	2008 Medicaid Average	2009
Health plan overall	NA	73.7	70.6	72.8
Health care overall	NA	67.8	67.1	69.4
Personal doctor overall	NA	76.2	75.7	68.5◇
Specialist overall	NA	76.1	75.5	70.5
◇Significant difference between current year's rate and Medicaid average. ○ Significant difference between current year's rate and DSS average.				

Health plan overall is above the Medicaid average and below the DSS average. Health plan overall is heavily influenced by customer service. Greatest opportunity to improve revolves around members being able to get needed information from customer service. Health care overall is above both averages. Composite is heavily influenced by getting needed care and getting care quickly. Personal doctor overall is significantly below the Medicaid average. Specialist overall is below both averages, but not significantly. Both personal doctor and specialist are heavily influenced by how well doctors communicate and shared decision making.

Results: Customer Service

Measures	Answer	2009 DSS Average	2008 Medicaid Average	2009
Customer service	Composite	81.1	78.9	85.4
Looked for info in written materials or on the internet	Yes	18.3	16.6	15.7
Found needed info in written materials or on the internet	Always/ usually	66.1	63.3	61.2
Health plan gave mbrs forms to fill out	Yes	31.9	25.6	38.8◇
Health plan forms were easy to fill out	Always/ usually	93.7	94.4	93.6
Tried to get info/help from plan's customer service	Yes	27.9	28.1	35.5◇
Received needed info from plan's customer service	Always/ usually	74.1	71.3	77.9○
Customer service staff treated you with courtesy and respect	Always/ usually	88.1	86.5	92.9◇
◇Significant difference between current year's rate and Medicaid average. ○ Significant difference between current year's rate and DSS average.				

Overall, scores for customer service are above the averages. There was a significantly higher percentage of members who said they received forms to fill out, tried to get info or help from customer service. There was also a significantly higher percentage of members who said they received their needed information and the customer service staff treated you with courtesy and respect.

Results: Getting Needed Care

Measures	Answer	2009 DSS Average	2008 Medicaid Average	2009
Getting needed care	Composite	76.1	75.2	66.7
Getting appt with a specialist was easy	Always/ usually	73.2	73.0	64.1◇○
Tried to get care, tests or treatment	Yes	56.1	53.9	49.7
Getting needed care, tests or treatment was easy	Always/ usually	78.9	77.3	69.2◇

◇Significant difference between current year's rate and Medicaid average.
○ Significant difference between current year's rate and DSS average.

The composite score for getting needed care is lower than both averages. There is a significant difference between the result and the average for ease of getting an appointment with a specialist and ease of getting needed care, tests or treatment.

Getting Care Quickly

Measures	Answer	2009 DSS Average	2008 Medicaid Average	2009
Getting care quickly	Composite	79.7	80.2	79.7
Had illness, injury or condition that needed care right away	Yes	47.1	47.9	50.6
Got urgent care as soon as needed	Always/ usually	80.6	81.1	83.5
Made appt for health care at doctor's office/clinic	Yes	74.9	75.1	70.2
Got regular/routine appt as soon as needed	Always/ usually	78.7	79.4	75.9○

◇Significant difference between current year's rate and Medicaid average.
○ Significant difference between current year's rate and DSS average.

Composite for getting care quickly fairly equal to averages. Percentage of those who made an appointment for health care at doctor's office lower than averages, and the percentage of those who got a regular/routine appointment as soon as needed significantly below average.

Personal Provider

Measures	Answer	2009 DSS Average	2008 Medicaid Average	2009
Have a personal provider	Yes	82.4	83.3	69.8◇
Average # of visits to personal prov in last 6 mos		2.85	2.95	2.33◇
Tried to make appts to see a specialist in last 6 months	Yes	39.4	40.8	36.6
Number of specialists seen in last 6 months	One or more	89.7	90.2	82.9◇

◇Significant difference between current year's rate and Medicaid average.
○ Significant difference between current year's rate and DSS average.

Results are significantly below the Medicaid average for having a personal provider, average number of visits, and number of specialists seen in last 6 months. Result for tried to make appointment with specialist below averages as well.

How Well Doctors Communicate

Measures	Answer	2009 DSS Average	2008 Medicaid Average	2009
How well doctors communicate	Composite	87.4	86.7	84.2
Doctor listened carefully	Usually	88.3	87.5	87.6
Doctor explained things in a way you could understand	Always/ usually	87.2	86.5	83.5
Doctor showed respect for what you had to say	Always/ usually	89.8	89.2	88.8
Doctor spent enough time with you	Always/ usually	84.3	83.5	76.8◇○
◇Significant difference between current year's rate and Medicaid average. ○ Significant difference between current year's rate and DSS average.				

Results at or below the average for all. Only significant difference is doctor spent enough time with you.

Shared Decision Making

Measures	Answer	2009 DSS Average	2008 Medicaid Average	2009
Shared decision making	Composite	57.1	58.1	59.6
Doctor told you there were choices for your treatment or health care	Yes	51.4	49.7	46.7
Doctor discussed pros and cons of each treatment choice	Definitely Yes	60.1	59.4	63.5
Doctor asked you which treatment choice was best for you	Definitely Yes	54.2	56.8	55.7○
◇Significant difference between current year's rate and Medicaid average. ○ Significant difference between current year's rate and DSS average.				

Composite of measure above average, along with doctor discussed pros and cons of each treatment choice. Doctor asked you which treatment choice was best for you significantly above the DSS average. Doctor told you there were choices for your treatment or health care below average.

Coordination of Care and Health Promotion and Education

Measures	Answer	2009 DSS Average	2008 Medicaid Average	2009
Received care from doctor or health provider besides personal doctor in last 12 mos	Yes	57.6	57.4	49.7◇
Personal doctor seemed informed about care from other providers	Always/ usually	76.2	75.7	66.3
You and doctor discussed ways to prevent illness	Always/ usually	56.6	56.1	46.8◇
◇Significant difference between current year's rate and Medicaid average. ○ Significant difference between current year's rate and DSS average.				

Significantly lower percentage of members who received care from their doctor or health care provider besides personal doctor in last 12 months and doctor and member discussed ways to prevent illness. Personal doctor being informed about care from other providers also below average.

Smoking Cessation

Measures	Answer	2009 DSS Average	2008 Medicaid Average	2009
Advised to quit smoking by a doctor or other health provider	One or more visits	68.9	69.4	56.8
Currently smoke cigarettes every day or some days	Yes	35.5	36.4	42.4◇
Medication recommended/discussed to assist with smoking cessation	One or more visits	42.3	39.7	21.0◇
Other strategies recommended/ discussed to assist with smoking cessation	One or more visits	41.5	40.2	26.0◇
◇Significant difference between current year's rate and Medicaid average. ○ Significant difference between current year's rate and DSS average.				

There is significant negative variation from the Medicaid average for members who currently smoke cigarettes every day or some days and recommendation of medication to assist with smoking cessation and/or other strategies recommended to assist with smoking cessation.

Overall CAHPS Analysis and Interventions

The overall Adult CAHPS composite scores are lower than average, and lower than the Child CAHPS results. Satisfaction with customer service is positive. Adult members use the customer service line more often than respondents to the Child CAHPS, and are more satisfied with the results and courtesy of the staff. Results for the Adult CAHPS are significantly lower than average for having a personal provider, seeing specialists and trying to make routine appointments. Child CAHPS has better results overall for personal providers. There is also lower results in the Adult CAHPS survey in getting care quickly, communication with providers, and coordination of care as compared to the Child CAHPS results.

Overall, both survey results suggest pediatric members have a medical home, are going to their provider more often and are satisfied with their ease of access and availability to care, coordination of care, and communication with their provider. However, the Child CAHPS respondents are less satisfied with HealthCare USA's customer service.

HealthCare USA has in place for the past year a member reminder system for EPSDT visits, encouraging routine care and reminder members who are missing a claim for an EPSDT visit. HealthCare USA also continues to focus on provider education for EPSDT visits. Chart audits identify gaps in utilization of the HCY forms and EPSDT visits not adherent to the AAP schedule. Provider Relations conducts provider EPSDT education to all new EPSDT providers (pediatricians, family practice) and for any provider identified as needing more education. Customer service is the same for both survey respondents. The reasons for variation in results is

unclear. Adding additional questions to other satisfaction surveys in an effort to identify any reasons for the variations in responses may help resolve this.

Adult CAHPS respondents are more satisfied with customer service and more frequently receive the information they are seeking. However, they are less likely to have a medical home and see a provider routinely. They are also less satisfied with ease and availability of providers for routine appointments, coordination of care, and how well doctors communicate.

In 2009, HealthCare USA modified the women's flyer to promote more routine well care visits and the importance of having a medical home. In addition, a men's health flyer has been developed with the same focus on promotion of routine tests and well care visits. HealthCare USA also focuses on promotion of the medical home through education such as the Understanding How to Get the Right Care at the Right Place brochure.

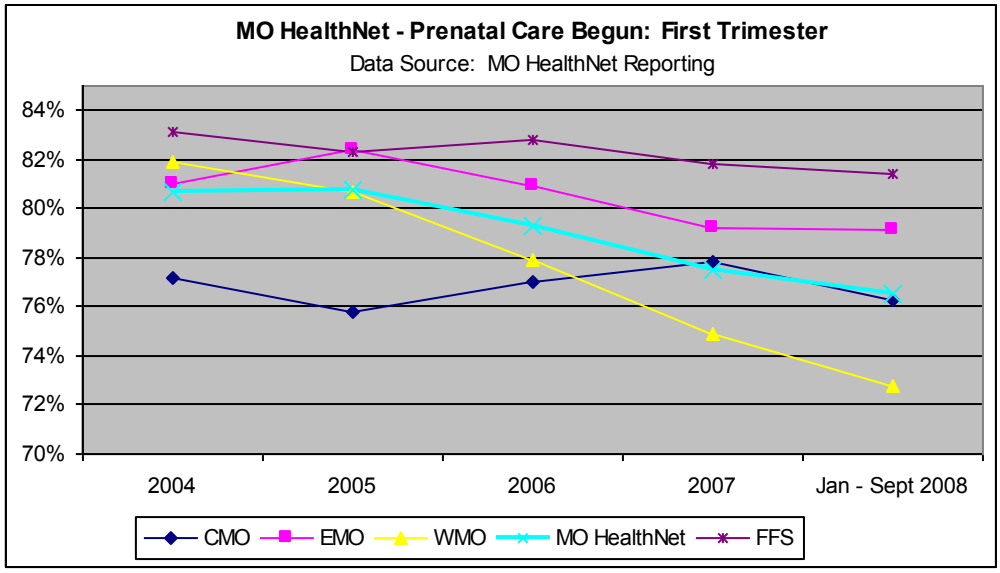
The Adult CAHPS Survey includes questions regarding smoking cessation. Since medications are not a covered benefit with the October 1, 2009 contract and recently published literature does not support use of medications as being as effective as coaching and other smoking cessation activities, education is being created to focus on use of the Quitline. Smoking cessation information is included in the asthma and high risk OB member education booklets. Provider education related to smoking cessation assistance in the process of being developed.

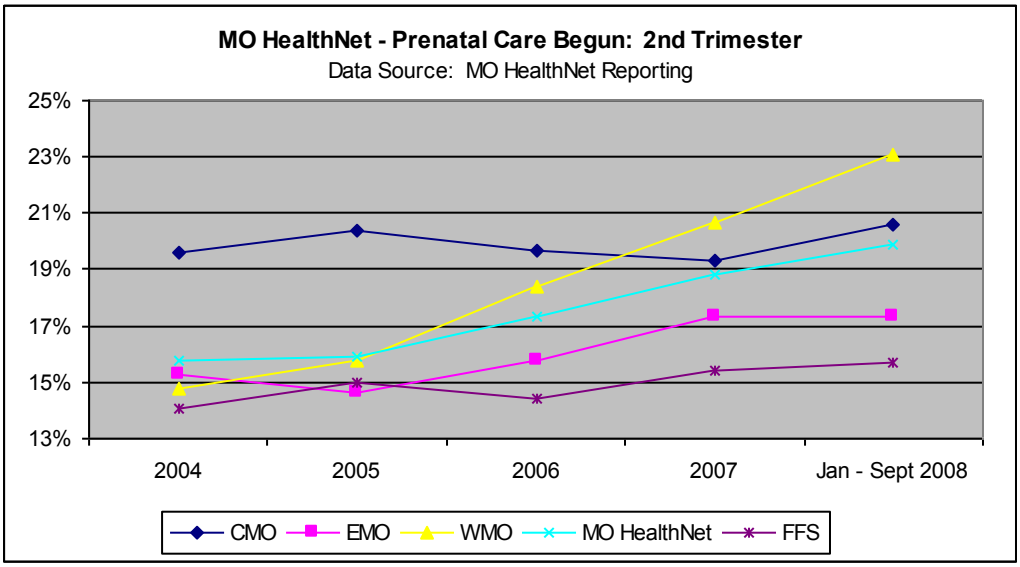
Trends in Missouri Medicaid Quality Indicators

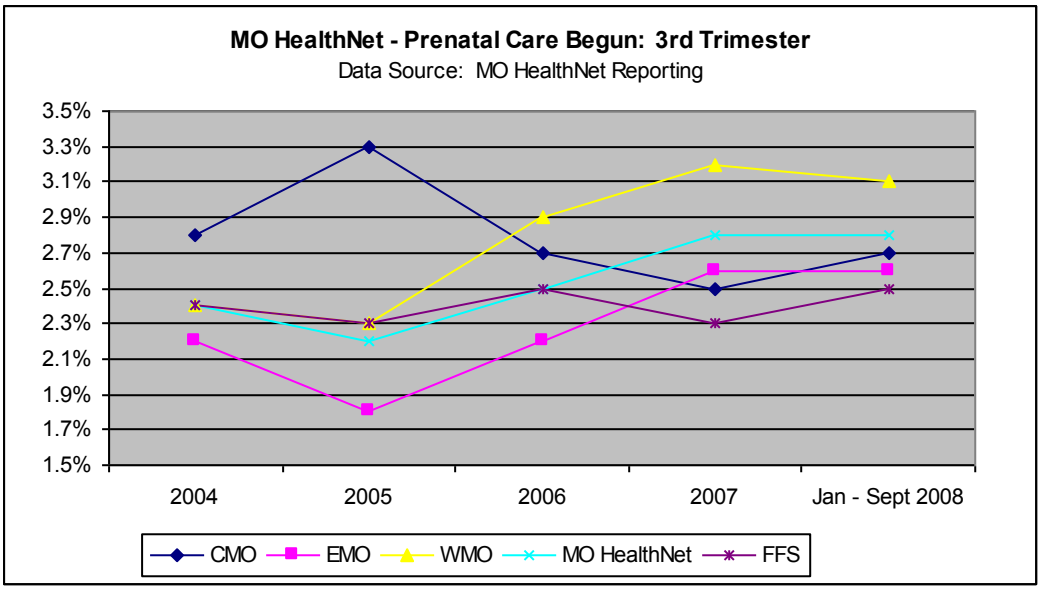
This secondary-source report is received by HealthCare USA from the State. HealthCare USA reviews this data and compares it to the Indicators by Missouri MO HealthNet Managed Care Health Plans within Regions, Live Births report, as well as internal data, such as HEDIS rates where applicable.

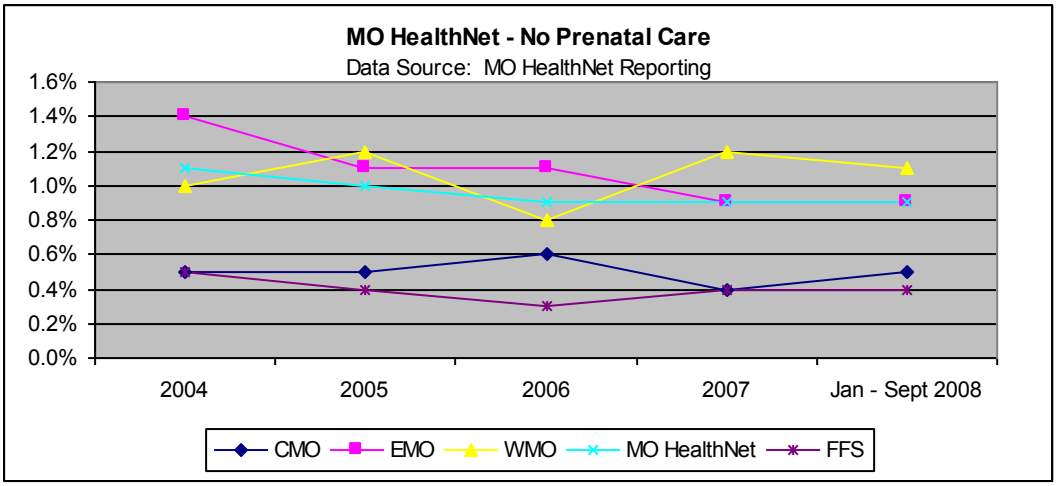
Indicators by MO HealthNet Managed Care Health Plans Within Regions, Live Births (secondary-source reporting) are tracked by MO HealthNet and are reported at the MO HealthNet QA&I Committee. HealthCare USA analyzes this data to determine how we compare to other MO HealthNet Plans in the State, where we have improved or not, and how we can plan to improve. All data for the graphs are from the MO HealthNet Managed Care –Trends in

Missouri Medicaid: Quality Indicators" Report.









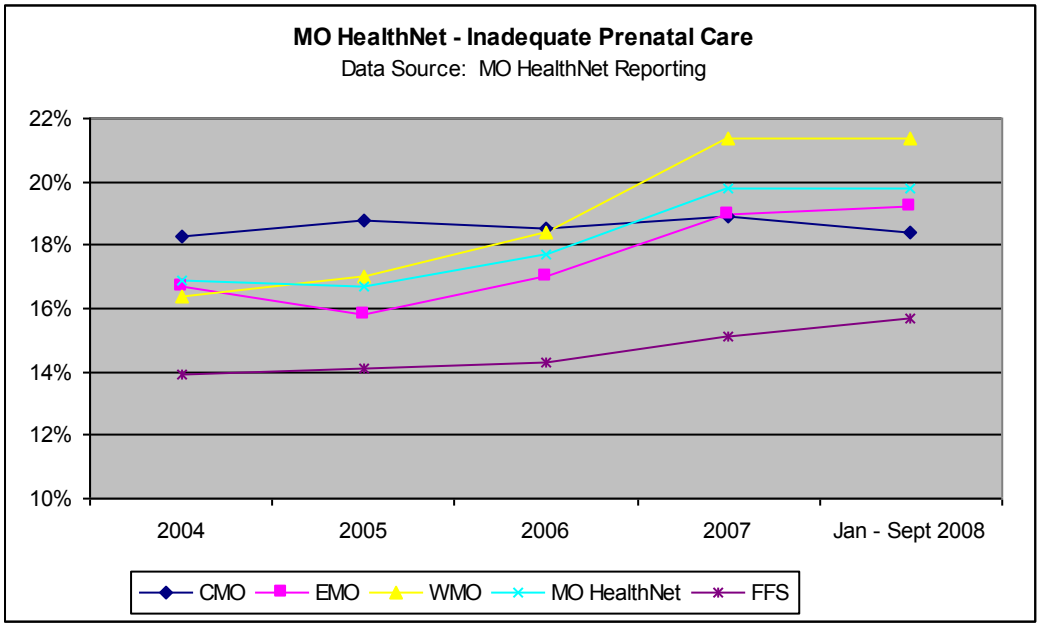
The most significant changes occurred in the Western region. There was a significant decrease in the percent of women receiving prenatal care in the first trimester in the region, correlating with a significant increase in the percentage of women starting prenatal care in the second trimester. There was little variance in start of prenatal care in the third trimester and no change in the percent of prenatal care in the Western region.

In the Central region, if the expansion counties are excluded, there was a significant decrease in the percent of women receiving prenatal care in the first trimester with a correlating increase in the second trimester. There were no significant changes in the other two measures.

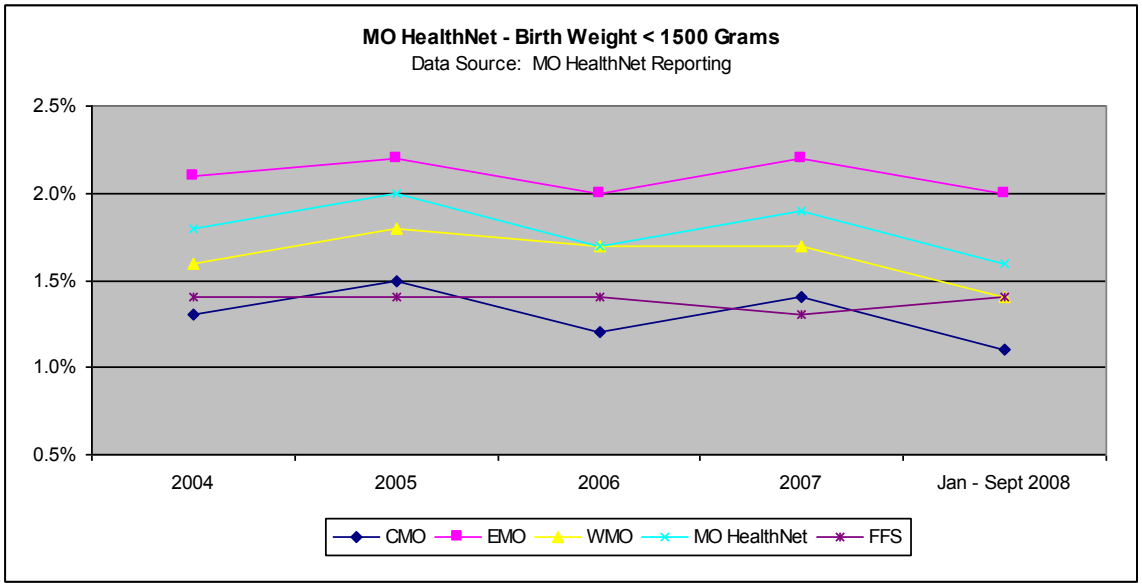
Eastern region remained essentially unchanged from the previous time period.

Members in fee for service had a higher percent of members beginning prenatal care in the first trimester versus the MO HealthNet regions and a lower percentage of members with no prenatal care. The later start of prenatal care among MO HealthNet members is most likely a reflection

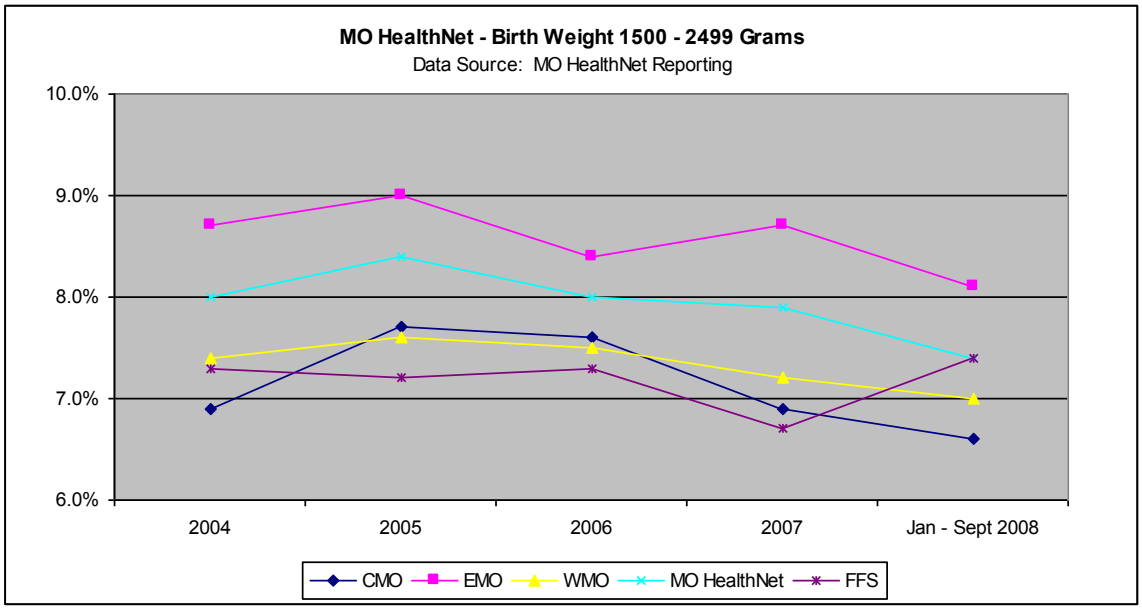
of the time it takes from application for Medicaid benefits to being active on a MO HealthNet managed care health plan. Over a brief period of time, HealthCare USA tracked the date of the Missouri OB Risk Assessment form completion separately from the actual date of the first prenatal visit. While the data has not been tracked for a long enough period, preliminary data analysis indicates that at least 20% of members actually have their first prenatal visit prior to initiating the Medicaid application process.



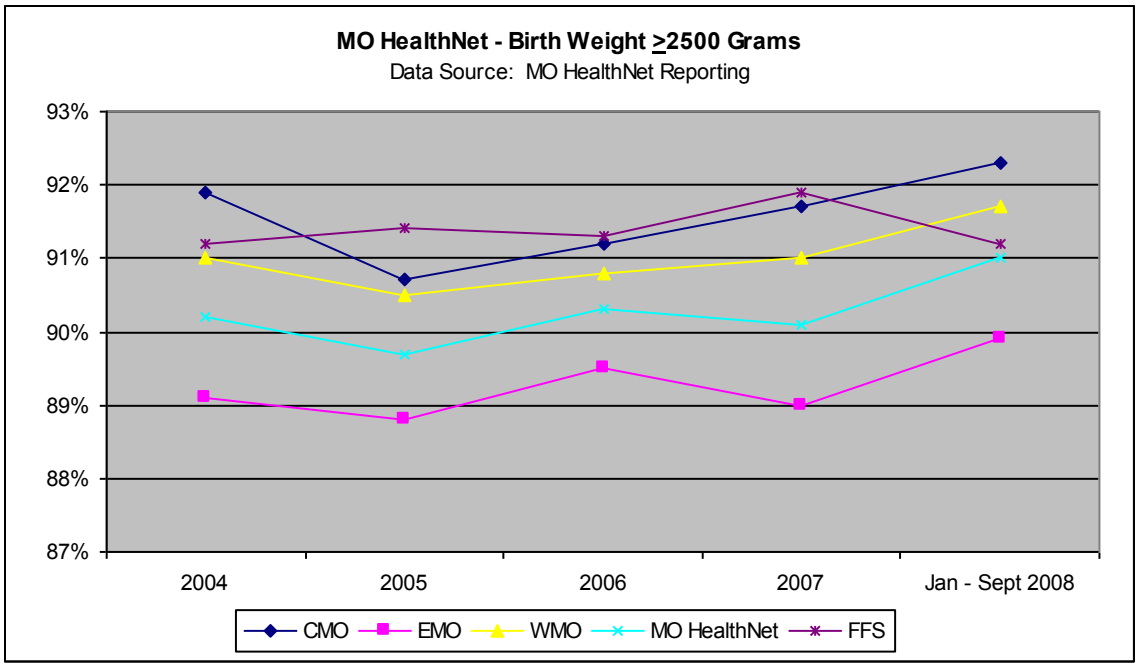
The Central region data remained essentially unchanged. Eastern and Western MO HealthNet regions have increased since 2006, although none a statistically significant amount. Fee for service has also increased, but remains below the MO HealthNet regions.



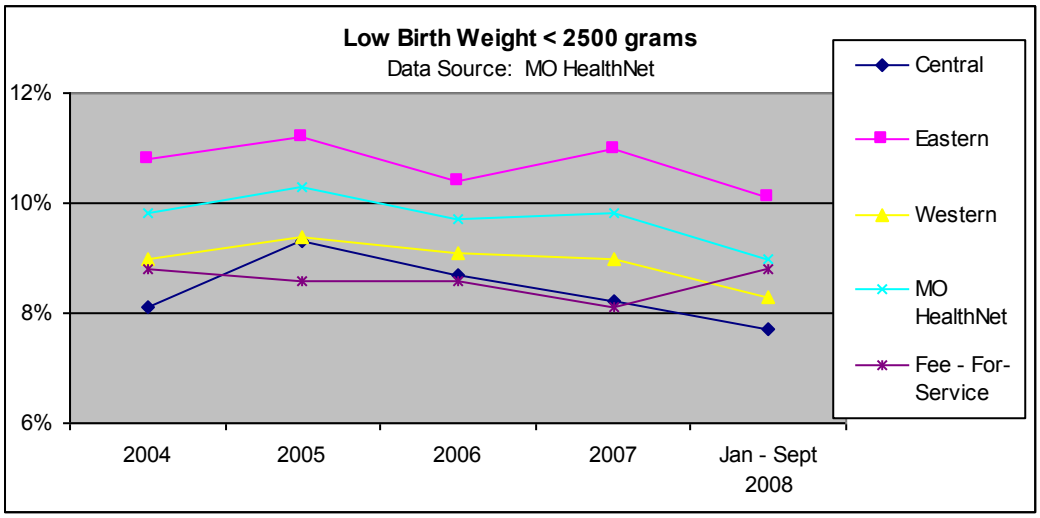
There have been no significant changes in the percentage of babies born weighing less than 1500 grams. The number has trended down since 2004 for all managed care regions. Fee for service percent of babies born weighing 1500 grams or less has remained essentially unchanged. Central region has the lowest percentage in this measure, consistent with higher percentage of women beginning prenatal care in the first trimester.



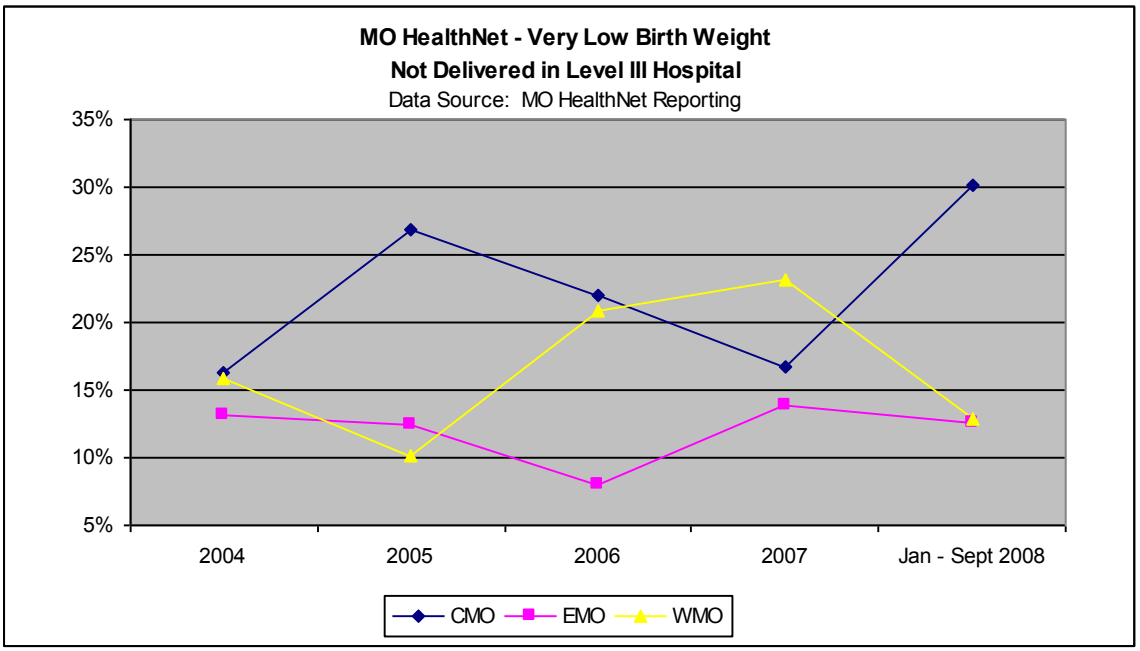
All three MO HealthNet regions have trended down for this birth weight stratification, although none significantly. Fee for service remained flat, with a dip in 2007 and 2008 increasing.



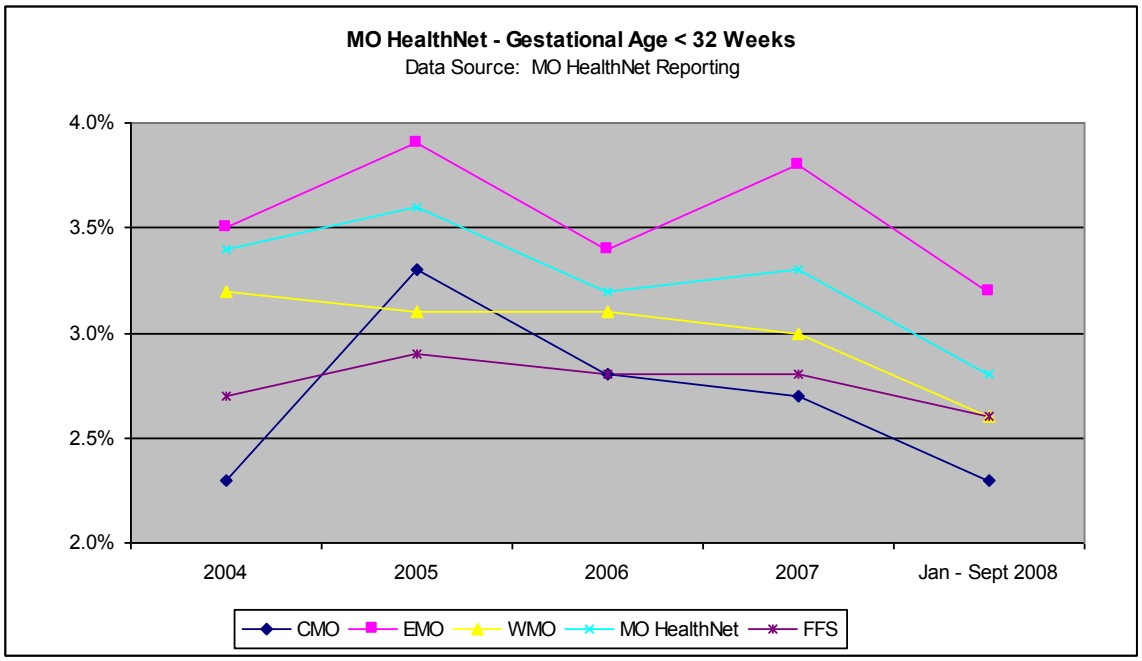
All three MO HealthNet regions have increased the number of babies born with a birth weight greater than or equal to 2500 grams. This correlates with decreases in the percent of babies born less than 1500 grams and 1500-2499 grams. The number of babies born weighing 2500 grams or more that receive fee for service Medicaid benefits and decreased over the 2008 reporting period.



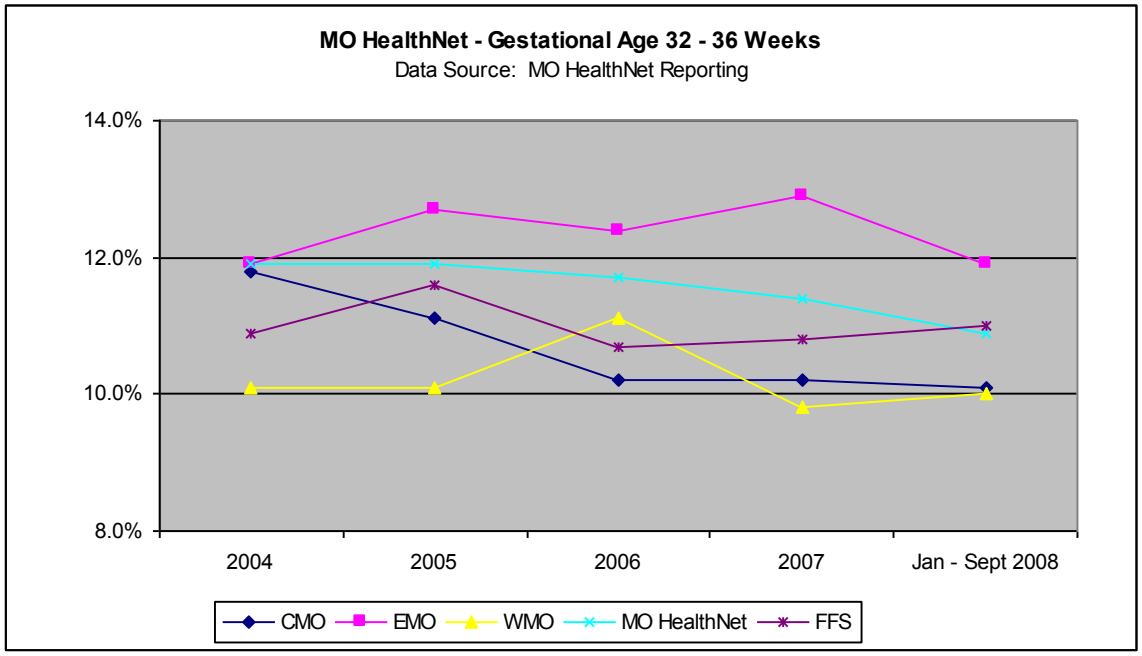
The pattern is similar to the birth weight stratifications in the previous chart. Low birth weights are decreasing for those in managed care in each region and fee for service percentages increased after a an initial decline in 2007. None of the changes are significant.



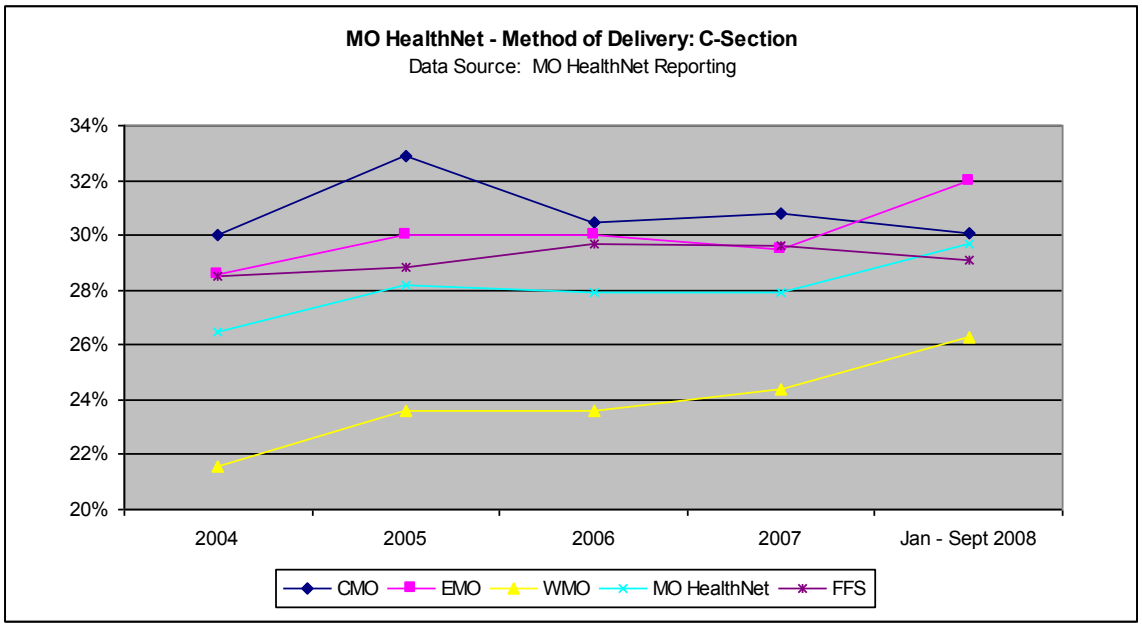
There is wide variation in the percentages of very low birth weight babies (<1500 grams) born in non-level III hospitals due to low numerators and denominators. None of the changes from 2007 to 2008 are significant.



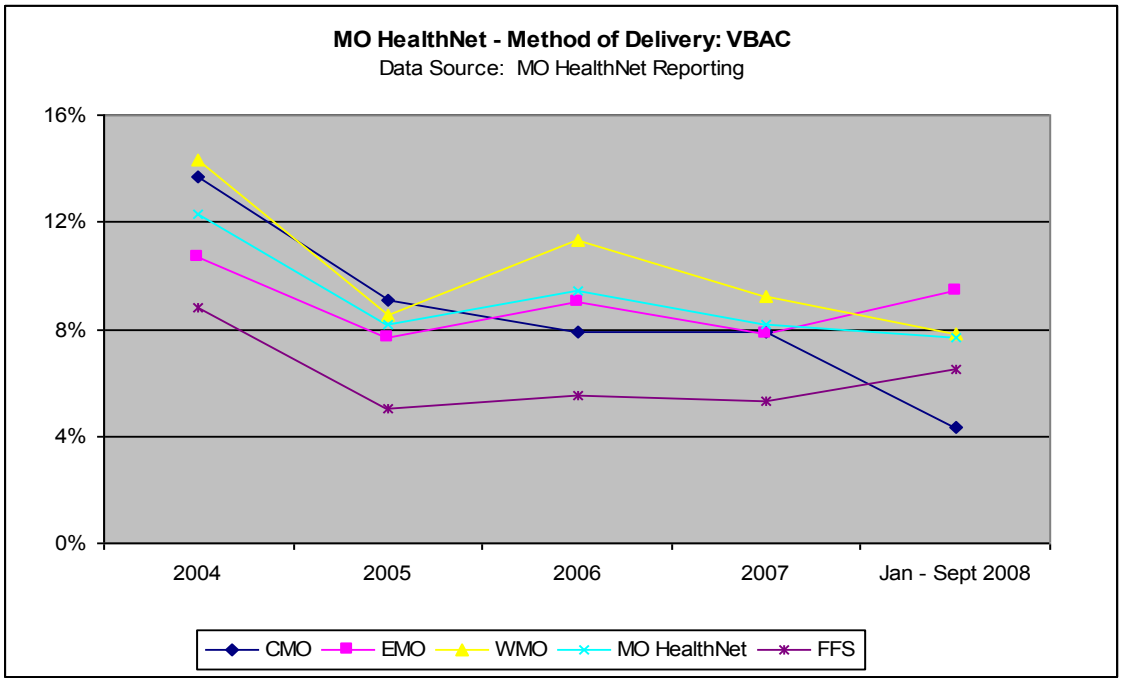
There is a significant decrease in the Eastern region of babies born with a gestational age less than 32 weeks, from 2007 to 2008 (0.05 level of significance, chi square analysis). All regions and fee for service decreased from 2007. This correlates with an increase in babies born with a higher birth weight



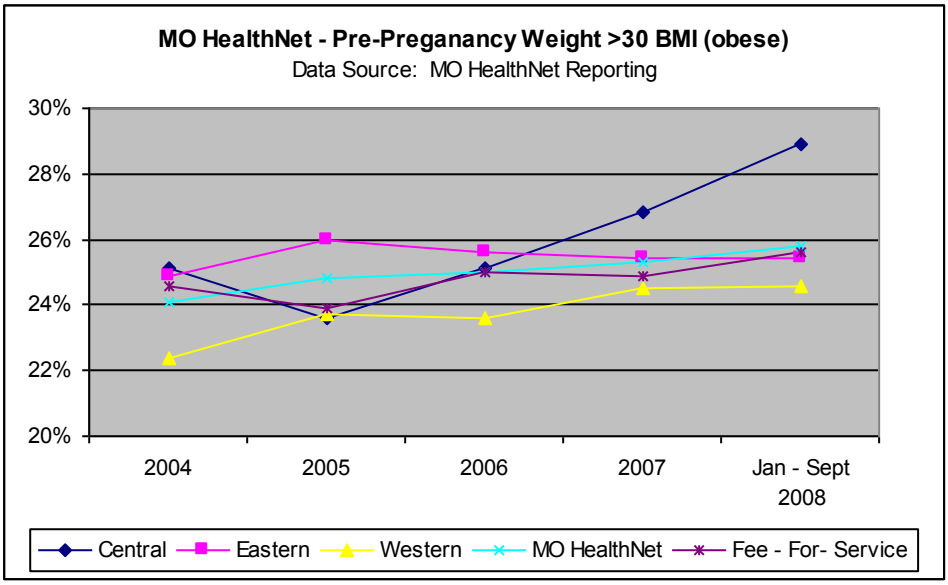
There is a significant decrease in the Eastern region in the percentage of babies born between 32 and 36 weeks gestation, when the expansion counties are excluded (0.05 significance level using chi square analysis). Central region remained fairly flat, with Western region increasing slightly. Fee for service increased as well.



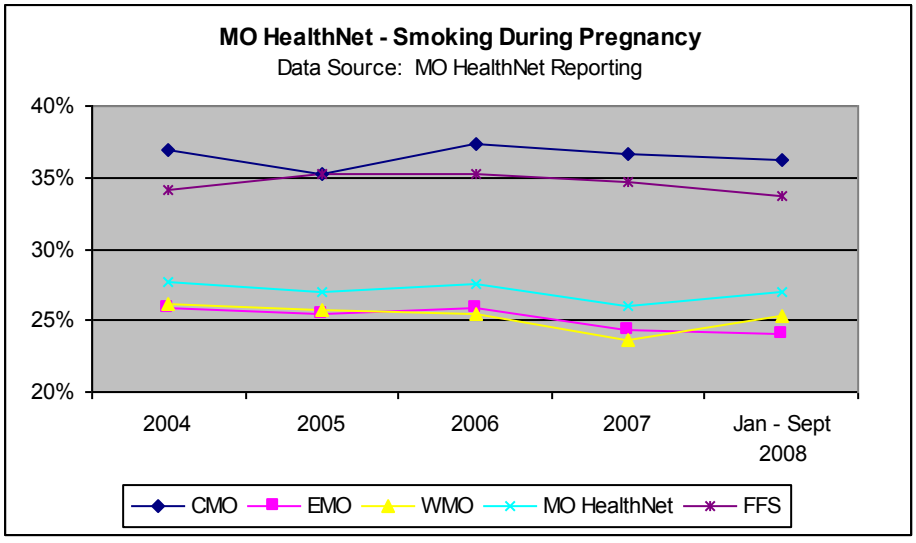
The percentage of deliveries by Cesarean section increased significantly from 2007 to 2008 in the Western region (0.05 confidence level using chi square analysis) when the expansion counties are excluded. Eastern region also increased significantly (0.05 confidence level using chi square analysis). Central region and fee for service declined slightly. Central region has historically had a higher percentage of deliveries by Cesarean, but Eastern region is now higher



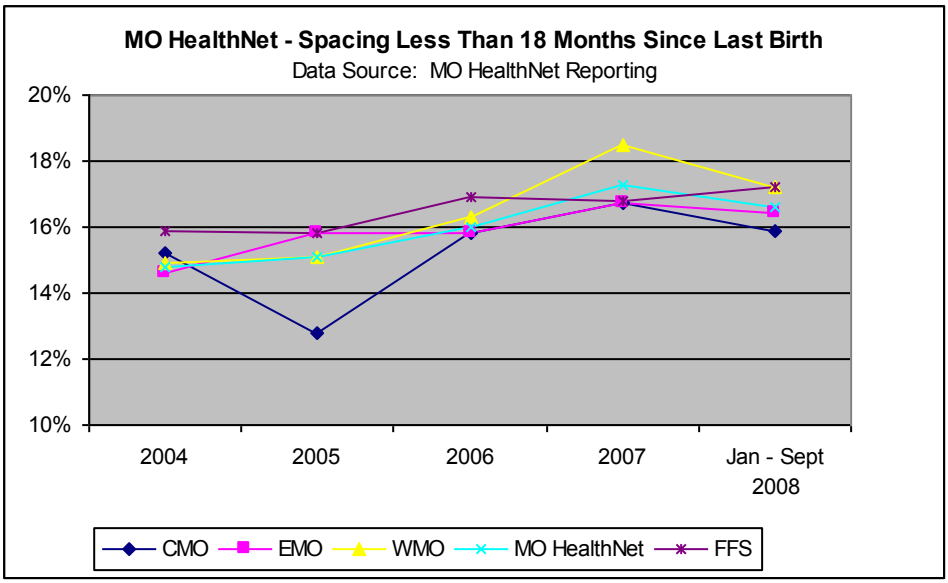
The Central region had a significant decline from 2007 to 2008, with the expansion counties excluded (0.05 significance level, chi square testing), this in spite of a decrease in the Cesarean section rate in the region. Eastern region and fee for service increased from 2007.



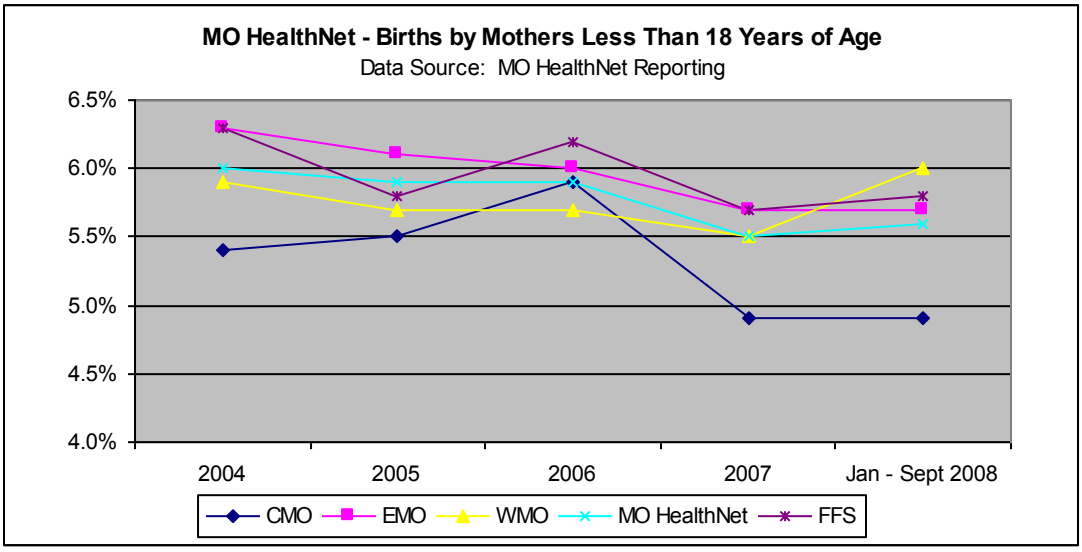
Central region has an increased percent of women diagnosed as obese (BMI >30) before pregnancy and is the highest rate compared regionally and to fee for service. It is unclear if this is an increase in the number of women who became or are obese or an increase in the assessment and diagnosis of obesity.



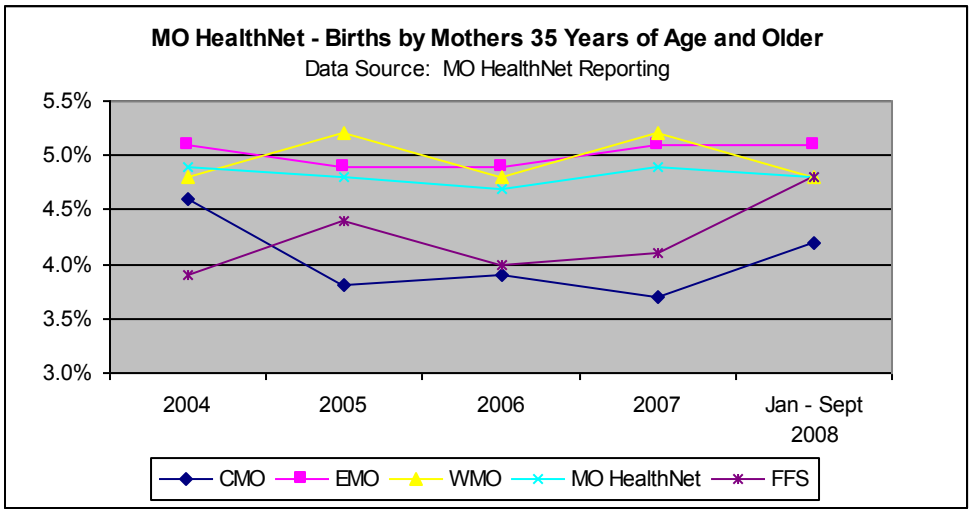
There continues to be no significant change in smoking during pregnancy. Central region and fee for service have the highest rate of smoking during pregnancy than the Eastern and Western regions.



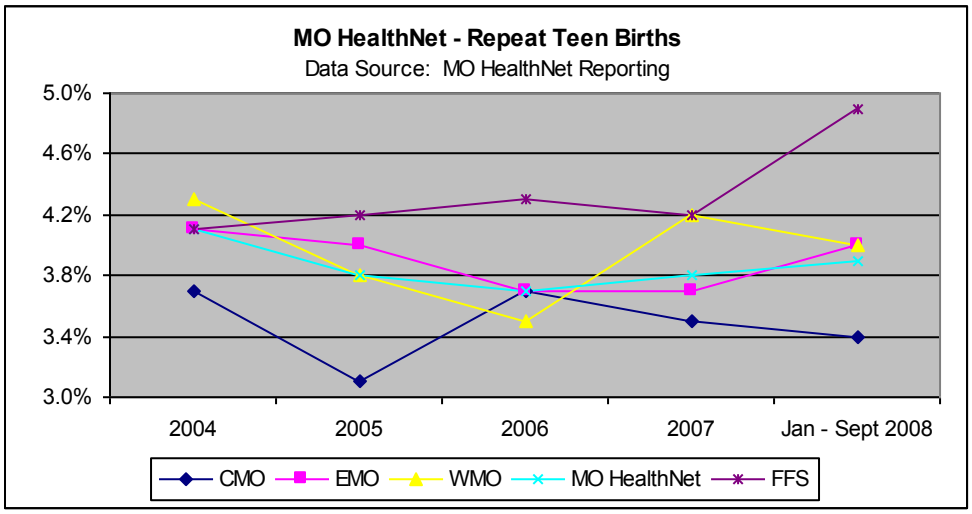
There is no significant change, with all regions and fee for service having essentially the same percent with birth spacing of less than 18 months. Birth spacing improved slightly from 2008 to 2008 as reflected in the chart above.



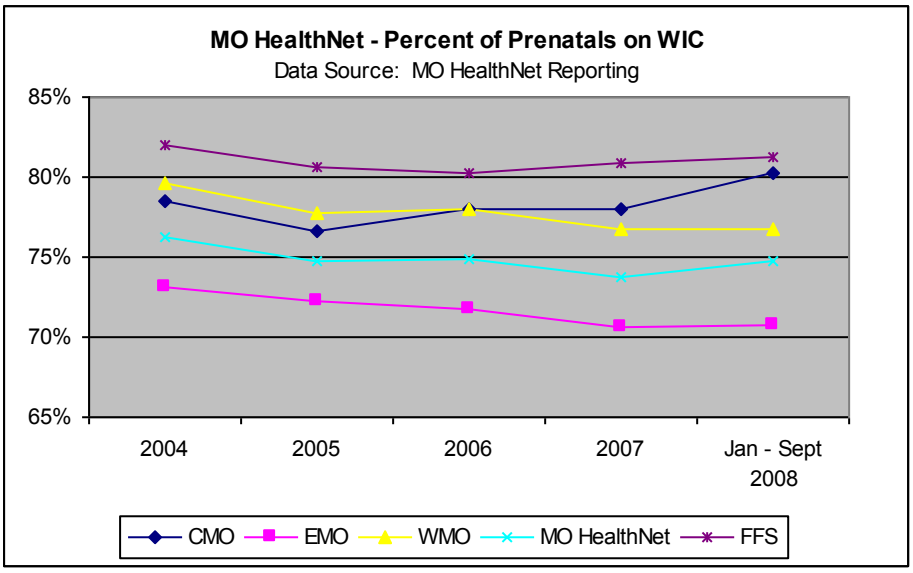
Central region declined from 2007 and now has the lowest rate of births by mothers less than 18 years of age. Western increased and Eastern and fee for service remained essentially unchanged. None of the changes are statistically significant.



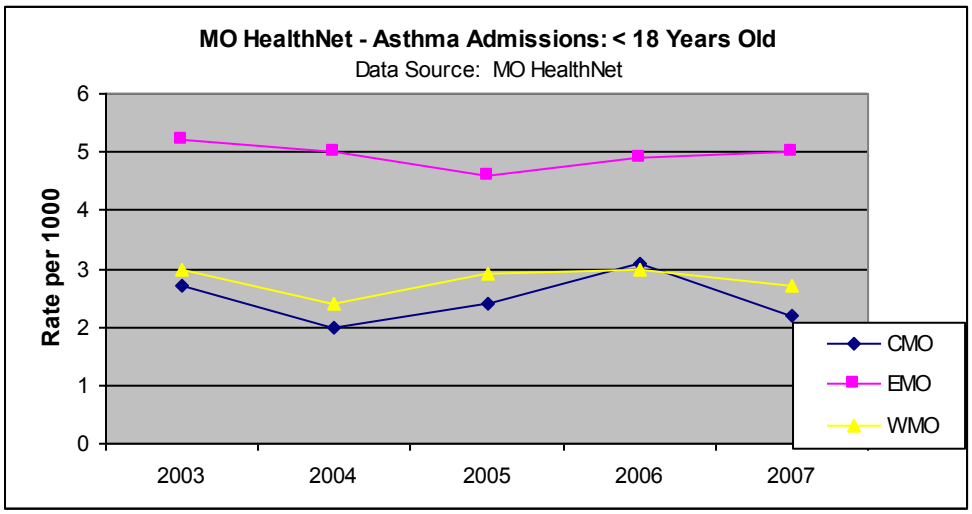
There is no significant change. Central region has the lowest rate of births by mothers 35 years of age and older, then fee for service.

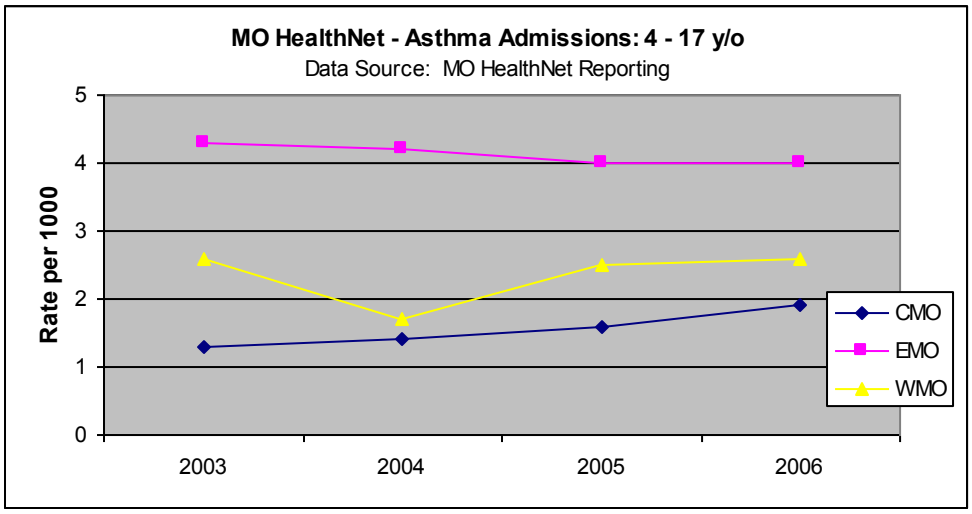


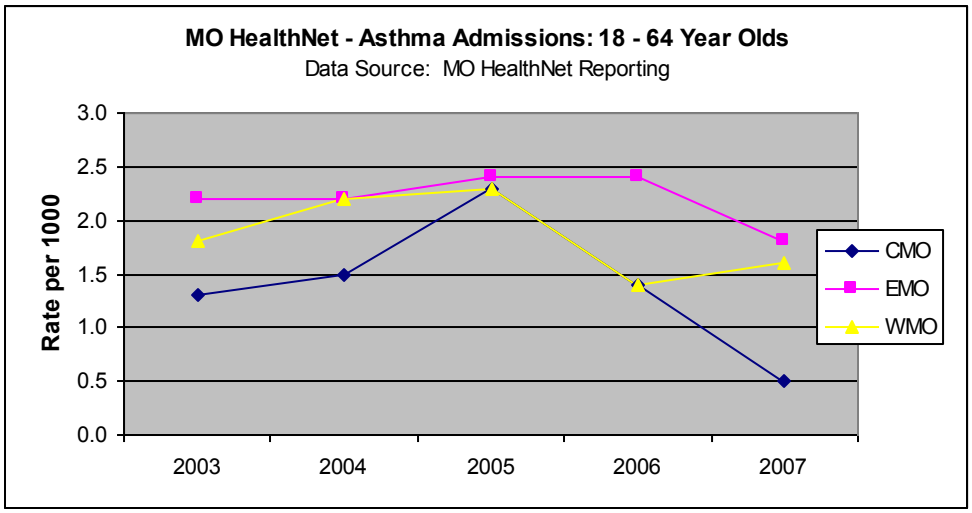
There is no significant change. Central region has the lowest percentage of repeat teen births, in line with its lower percentage of teen births. Fee for service has the highest percentage and is increasing.



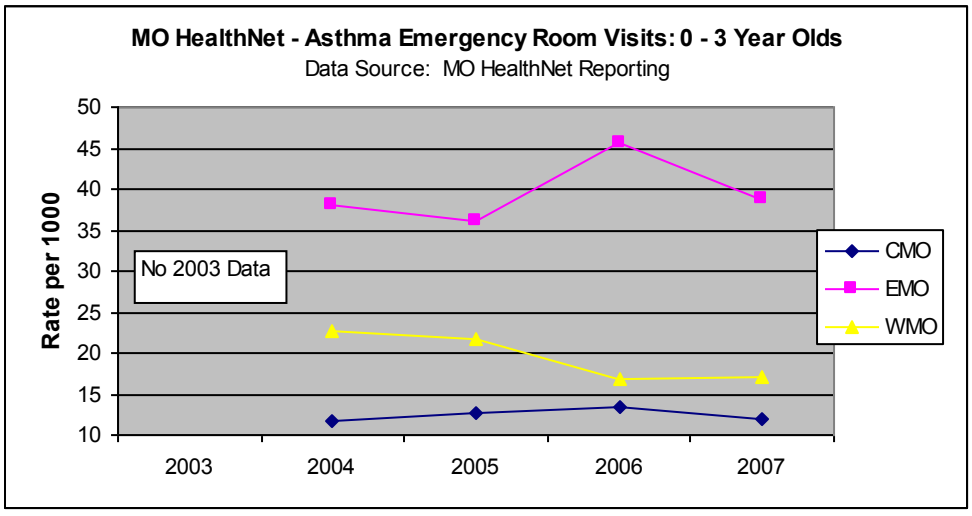
There is no significant change. Fee for service has the highest percentage of prenatals on WIC, with Eastern region having the lowest. This could represent a need for increased education on the benefits of WIC and how to access.

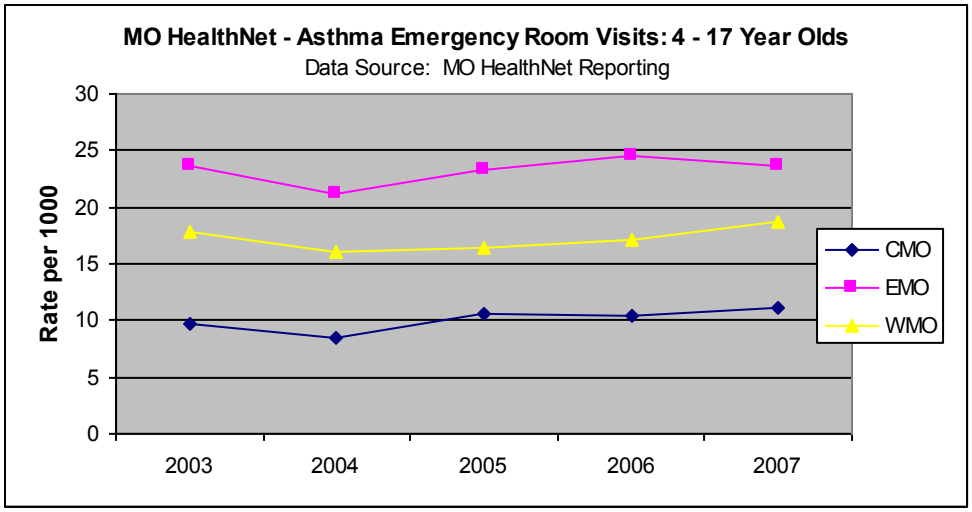


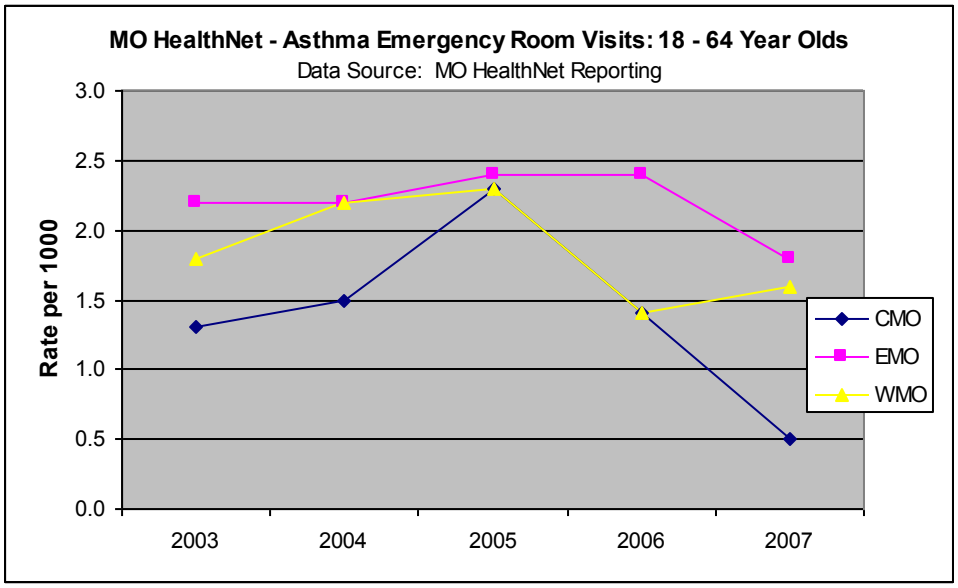




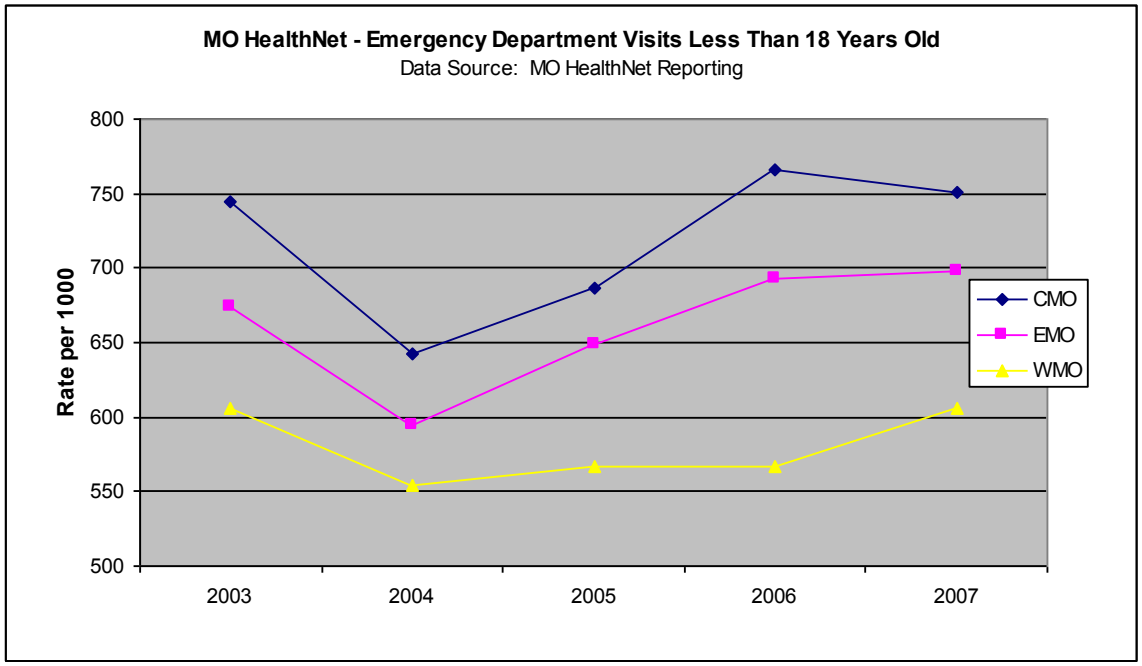
Asthma admissions are highest in each age stratification in the Eastern region, consistent with a higher rate of members with asthma disease in the region. Rates have remained fairly flat with some decline in the youngest and oldest age stratifications in Eastern region.

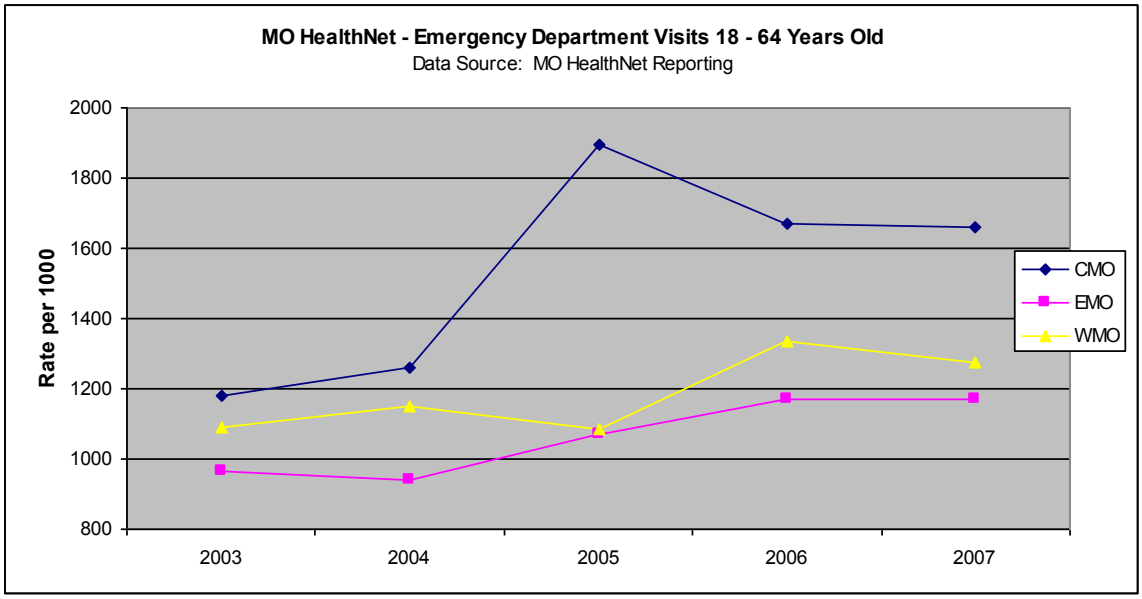




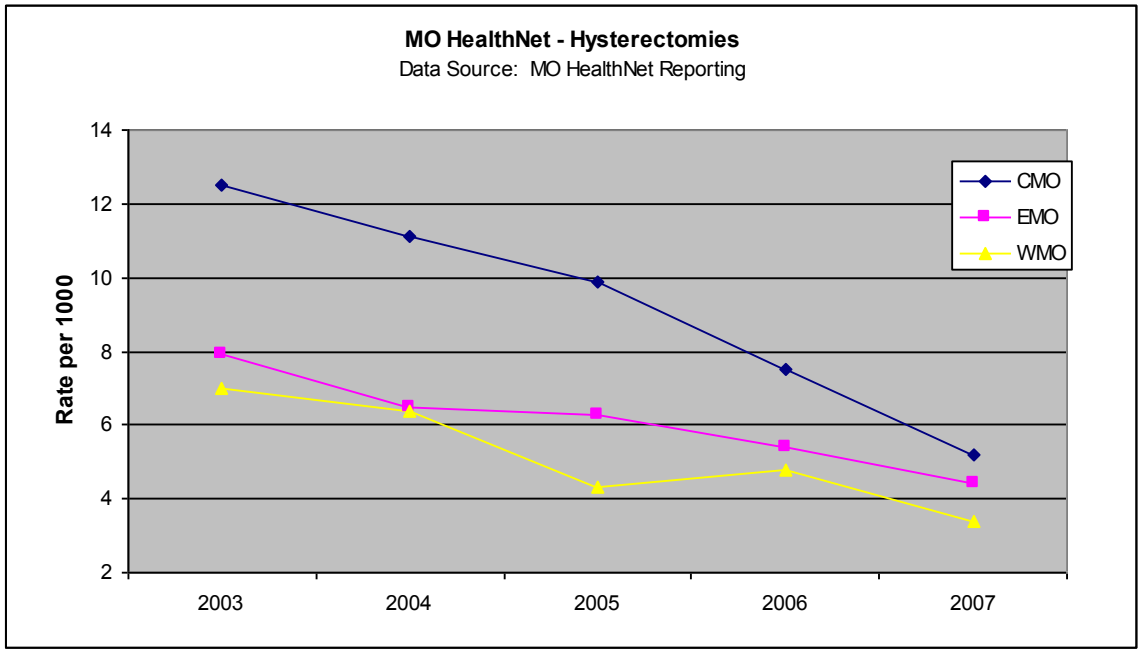


The rate of emergency room visits with a diagnosis of asthma is higher in each stratification in the Eastern region, consistent with the population. There is decline in each age stratification in Eastern region.

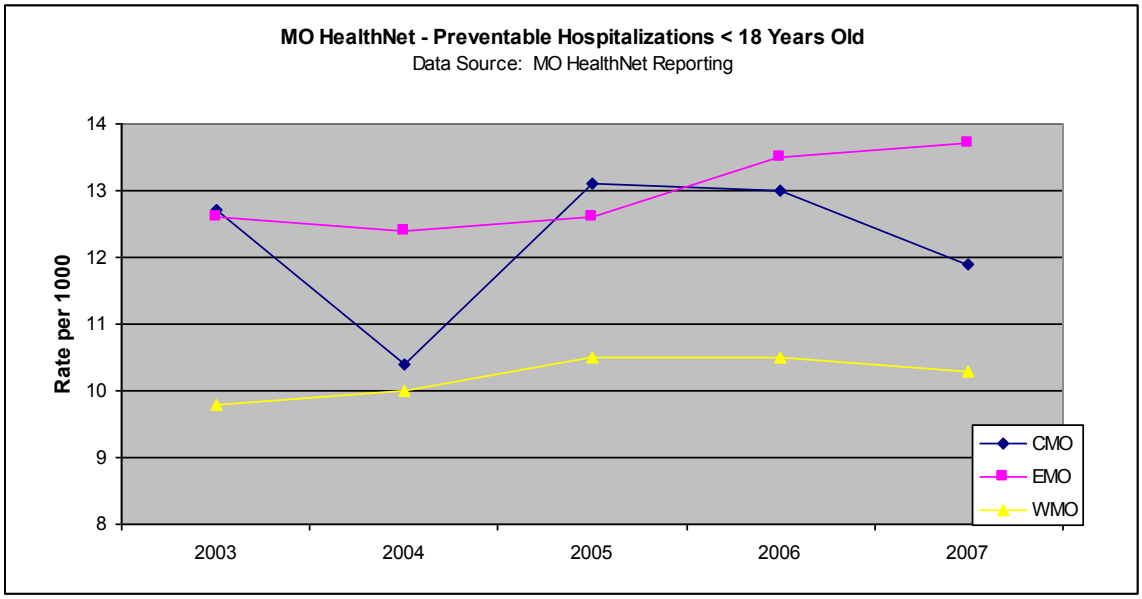




The Central region continues to have a higher rate of ER visits. From 2006 to 2007 rate of ER visits has no significant change.

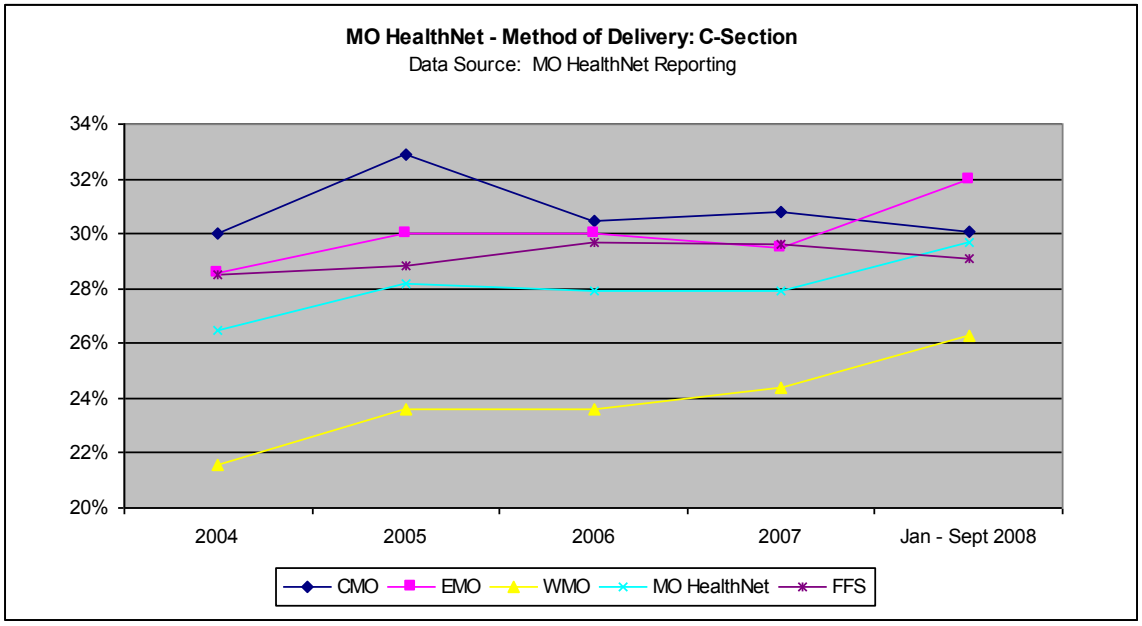


The rate of hysterectomies continues to decline. Central region has the highest rate, but the gap between Central and the other two regions is closing.

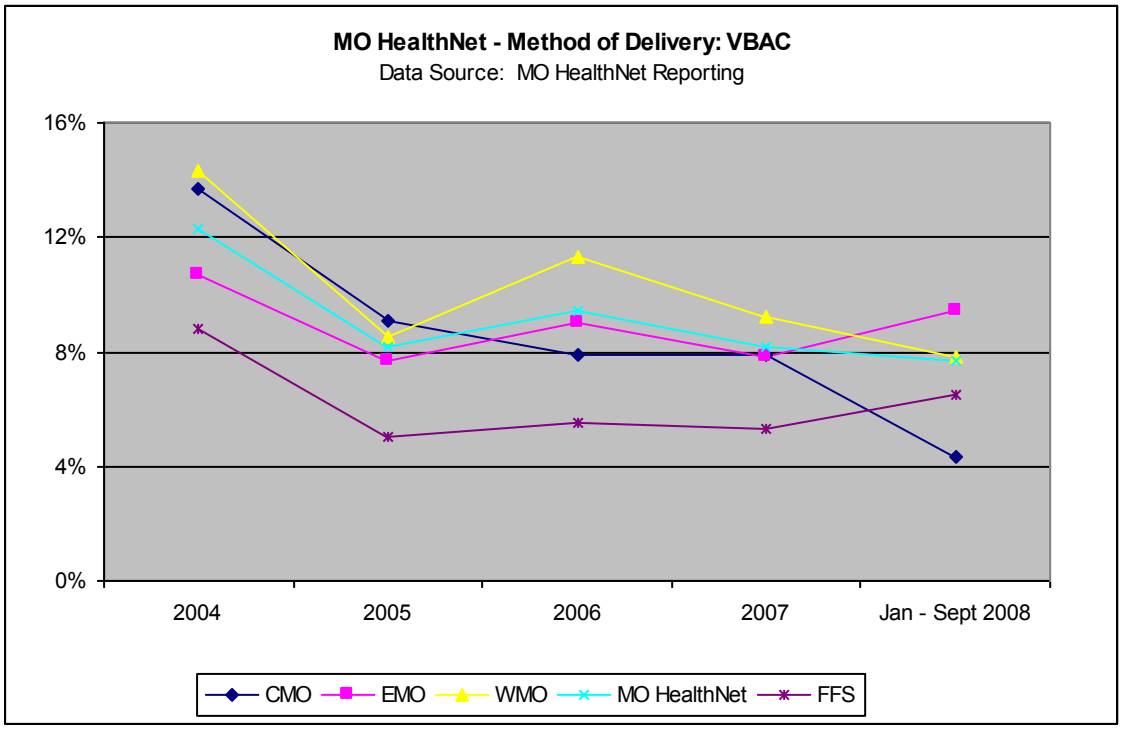


Eastern region has the highest rate of preventable hospitalizations and continues to increase. Western region has the lowest, and remains flat.

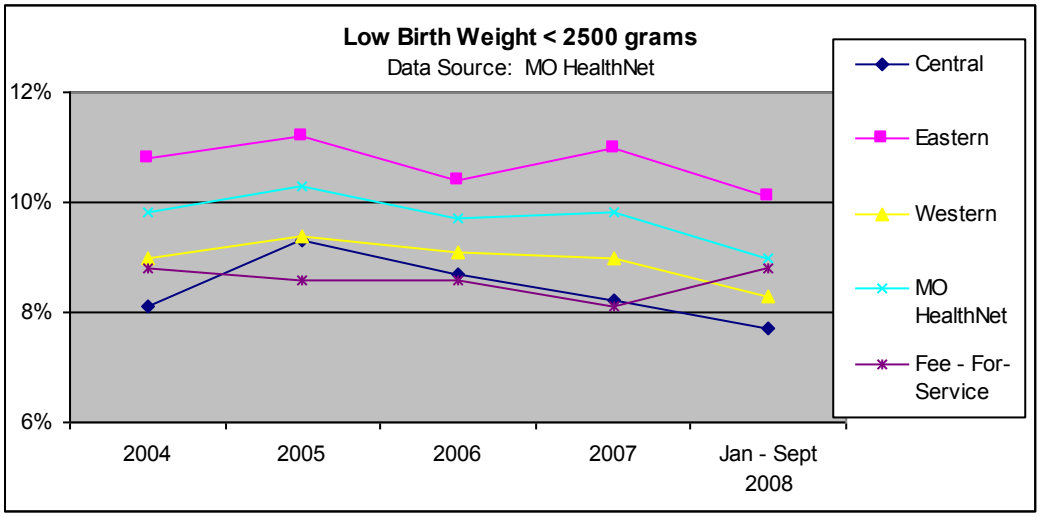
Indicators by MO HealthNet Managed Care Health Plans Within Regions, Live Births



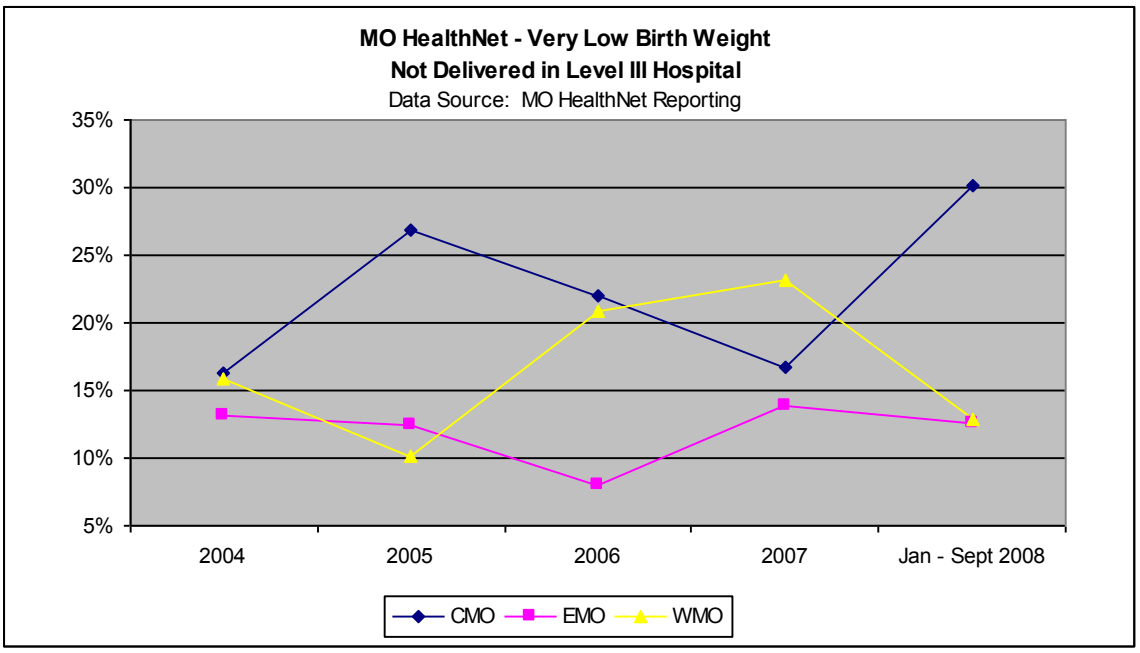
The percentage of deliveries by Cesarean section increased significantly from 2007 to 2008 in the Western region (0.05 confidence level using chi square analysis) when the expansion counties are excluded. Eastern region also increased significantly (0.05 confidence level using chi square analysis). Central region and fee for service declined slightly. Central region has historically had a higher percentage of deliveries by Cesarean, but Eastern region is now higher.



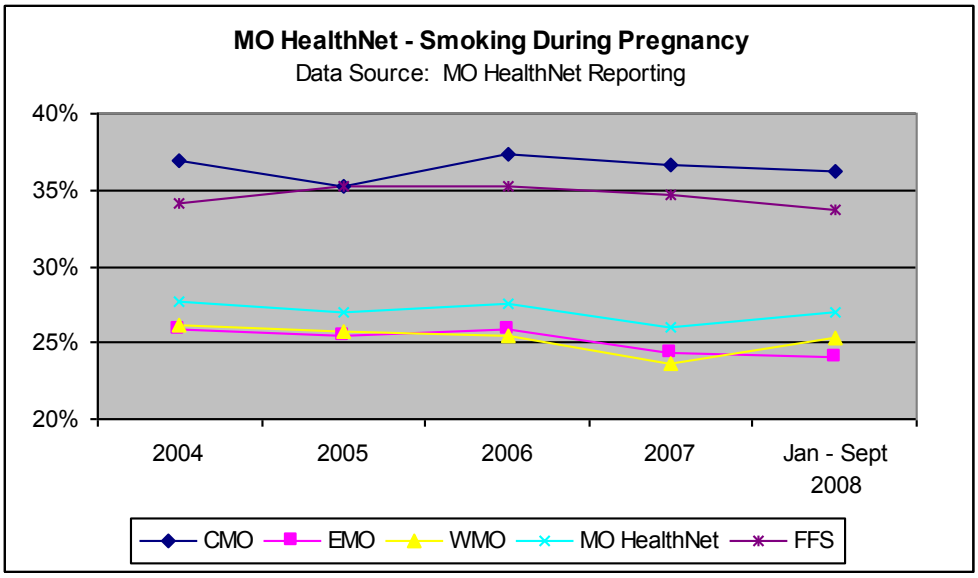
The Central region had a significant decline from 2007 to 2008, with the expansion counties excluded (0.05 significance level, chi square testing), this in spite of a decrease in the Cesarean section rate in the region. Eastern region and fee for service increased from 2007.



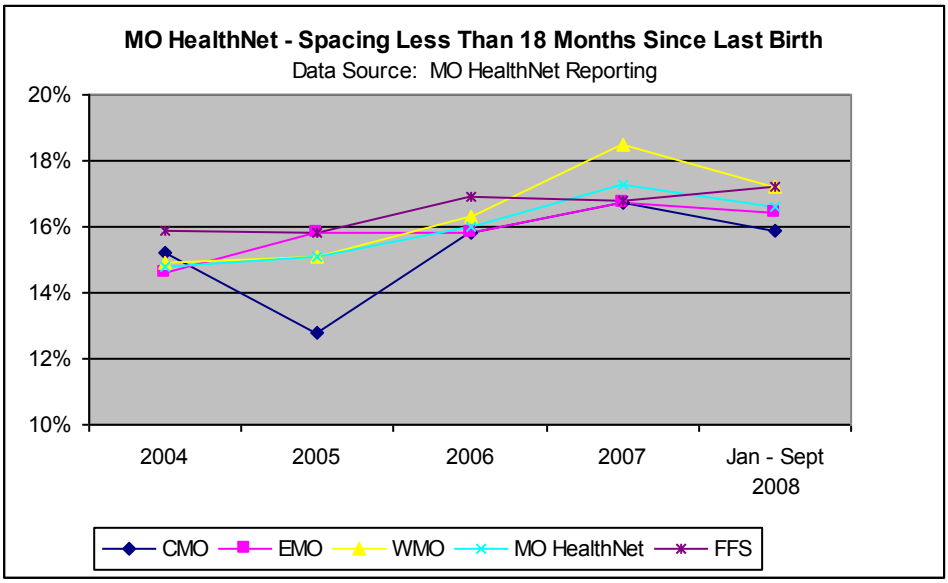
Pattern is similar to the birth weight stratifications above. Regional percentages are decreasing for low birth weights, and fee for service increased after a dip in 2007. No changes are significant.



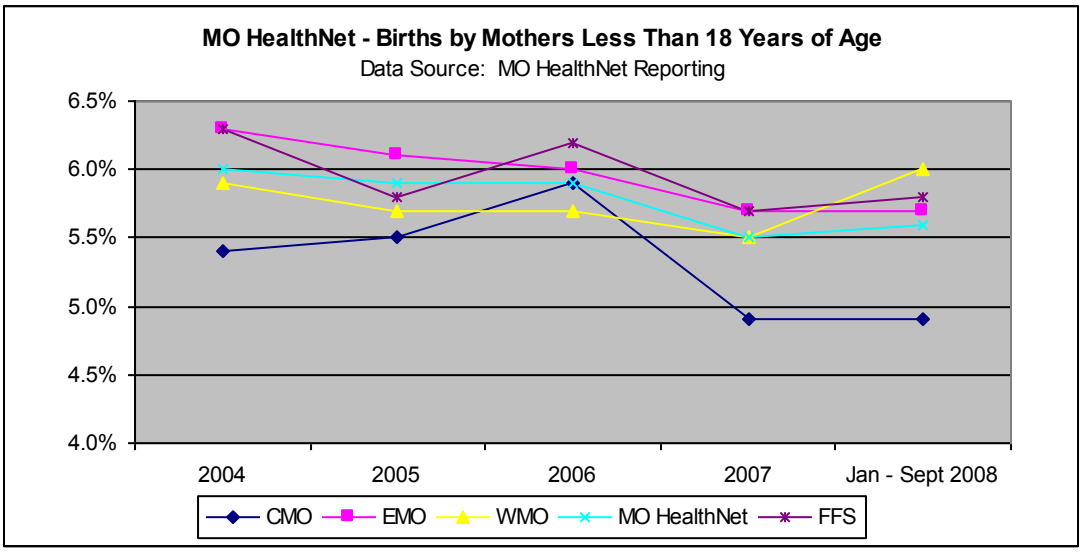
There is wide variation in the percentages of very low birth weight babies (<1500 grams) born in non-level III hospitals due to low numerators and denominators. None of the changes from 2007 to 2008 are significant.



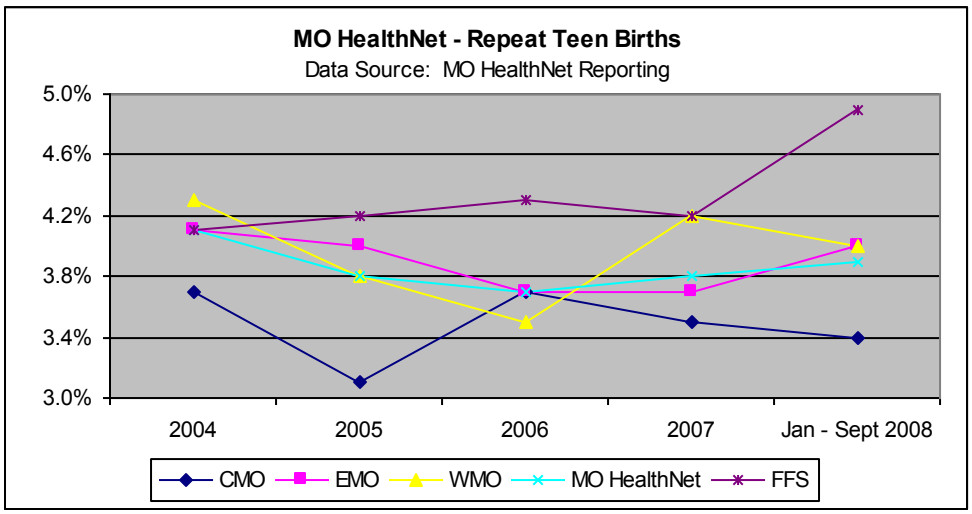
There continues to be no significant change. Central region and fee for service have the highest rate of smoking during pregnancy.



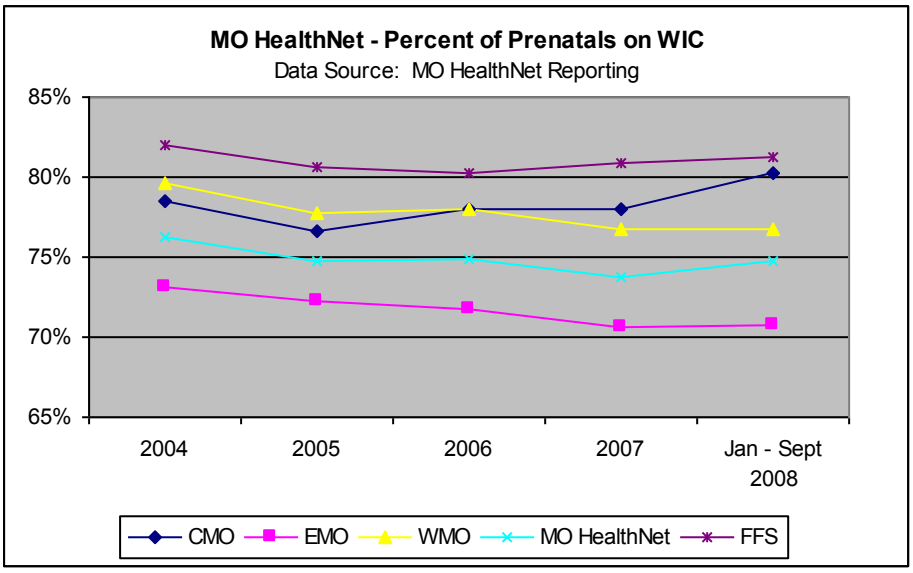
There is no significant change, with all regions and fee for service having essentially the same rate. The percentages regionally have decreased some since 2007.



Central region declined from 2007 and now has the lowest rate of births by mothers less than 18 years of age. Western increased, and Eastern and fee for service remained fairly unchanged. No changes were significant.



There is no significant change. Central region has the lowest percentage of repeat teen births, in line with its lower percentage of teen births. Fee for service has the highest percentage and is increasing.



There is no significant change. Fee for service has the highest percentage of prenatals on WIC, with Eastern region having the lowest. This could represent a need for increased education on the benefits of WIC and how to access.

Missouri Care

HEDIS Measures

Missouri Care tracks several performance measures in accordance with MO HealthNet contract requirements. They include the National Committee on Quality Assurance's (NCQA) Healthcare Effectiveness Data Information Set (HEDIS) measures. Presented in this report is Missouri Care's performance on HEDIS measures over the past four years, from HEDIS 2006 to HEDIS 2009. HEDIS data is a report of the prior measurement year's performance, thus HEDIS 2009 is a report of the calendar year 2008. Performance is compared against both state and national NCQA Medicaid health plan percentiles over time. Missouri Care also tracks and trends HEDIS data through trending charts, which present a chronology of interventions implemented, and the corresponding improvements in performance (see Appendix A). The health plan reviews these graphs for quality and process improvement planning.

HEDIS performance is measured in the following areas: Effectiveness of Care, Access/Availability of Care, Use of Services, and Satisfaction with the Experience of Care.

Effectiveness of Care

Missouri Care reports the following HEDIS Effectiveness of Care measures:

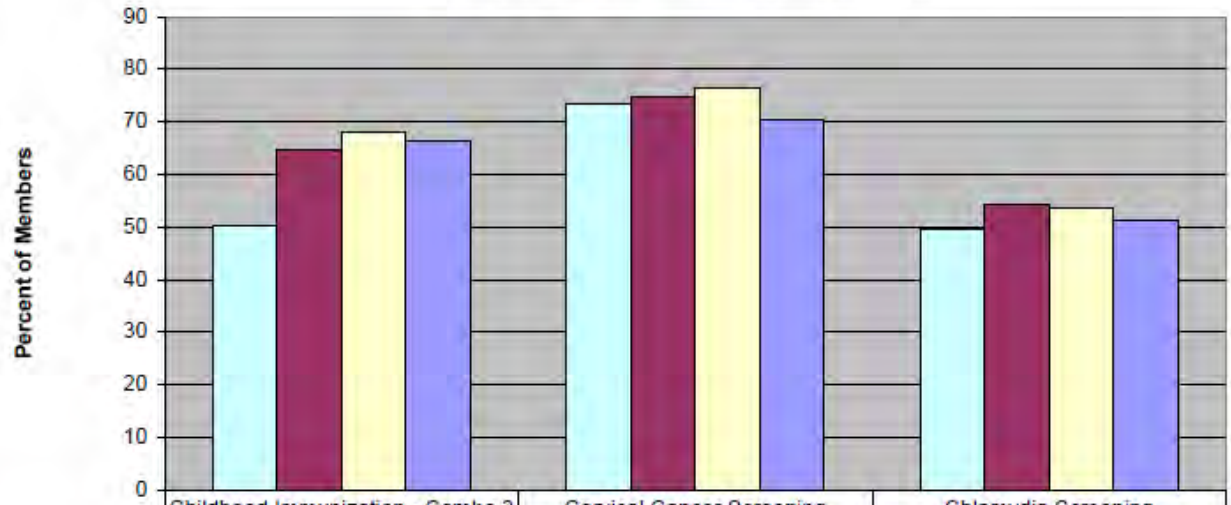
- Childhood Immunization Status (CIS Combo 3)
- Cervical Cancer Screening (CCS)
- Chlamydia Screening in Women (CHL)
- Follow-up After Hospitalization for Mental Health Illness (FUH-7 and 30-day)
- Use of Appropriate Medications for People with Asthma (ASM)

Figures 2 and 3 summarize Missouri Care's performance for HEDIS 2006 though 2009 (measurement years 2005 through 2008). Over the past four years, the health plan significantly improved in, or maintained top state performance in five out of six Effectiveness of Care measures. There were significant rate improvements in Childhood Immunizations Combo 3, Follow-up After Mental Health Hospitalization (7- and 30-day), and Use of Appropriate Medications for People with Asthma.

Performance on the CIS Combo 3 measure has steadily improved since HEDIS 2006, from 50.36% to 66.23% in HEDIS 2009. Missouri Care is best-in-state on this measure, with a rate over 12 percentage points higher than the MO HealthNet statewide average of 53.58%. Missouri Care also significantly improved its' Follow-Up After Hospitalization for Mental Health – 7 Day rate, from 30% in HEDIS 2008 to 39.34% in HEDIS 2009. This placed the health plan slightly above the state average of 38.24%. The HEDIS 2009 FUH 30-day rate of 62.13% is also comparable to the state average of 62.06%.

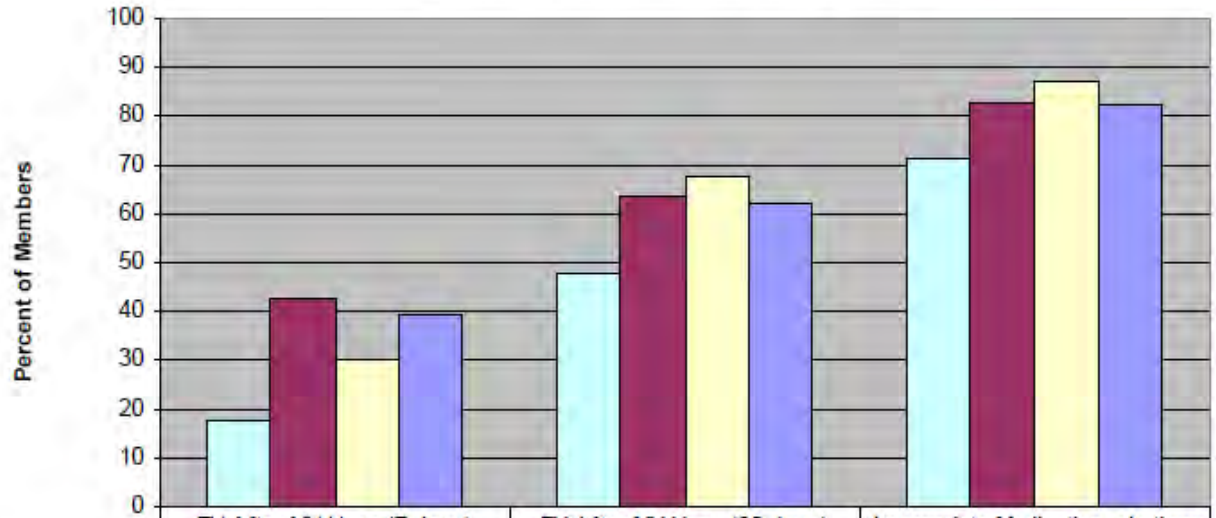
Missouri Care also continues to be the top state performer for Cervical Cancer Screening (CCS). Although Missouri Care's rate dipped over the past measurement year to 70.25% (95% CI: 65.05% to 75.45%), it still scores at the national NCQA Medicaid 75th percentile (72.99%). The health plan's HEDIS 2009 CCS rate is significantly higher than the statewide average of 56.47%.

Figure 2. HEDIS Effectiveness of Care Measures



	Childhood Immunization - Combo 3	Cervical Cancer Screening	Chlamydia Screening
HEDIS 2006	50.36	73.32	49.44
HEDIS 2007	64.81	74.59	54.24
HEDIS 2008	67.92	76.35	53.76
HEDIS 2009	66.23	70.25	51.16

Figure 3. HEDIS Effectiveness of Care Measures



	FU After MH Hosp (7 days)	FU After MH Hosp (30 days)	Appropriate Medication - Asthma
HEDIS 2006	17.65	47.79	71.09
HEDIS 2007	42.48	63.16	82.75
HEDIS 2008	30	67.78	86.96
HEDIS 2009	39.34	62.13	82.46

Measures that proved most challenging to Missouri Care were Chlamydia screening (CHL) and Use of Appropriate Medications for People with Asthma (ASM). CHL screening rates have been flat since HEDIS 2006. HEDIS requires reporting for two age groups: members 16-20 years old and 21-24 years old. Missouri Care members in the 21-24 age group tend to be more compliant with screening than younger members (58.17% vs 48.45%, respectively). In September 2007 Missouri Care initiated a PIP to improve CHL screening rates, specifically in younger adolescents, which continues today (see Section XI: PIPs).

Missouri Care has observed the opposite age group pattern for the HEDIS ASM rate. Asthma medication compliance has been higher in the younger age groups. Between HEDIS 2008 and HEDIS 2009 the rate: (1) decreased in ages 5-9 years, from 88.6% to 86.7%; (2) decreased in the 10-17 year age group, from 90.48% to 82.56%; and (3) increased in members 18 and older, from 72% to 75%. Although overall compliance diminished slightly in HEDIS 2009, performance on this measure has increased by 11 percentage points since HEDIS 2006. In 2009 Missouri Care's Medical Management team developed new member education tools for asthma, as described in the Asthma PIP section.

Access/Availability of Care

Missouri Care reports the following HEDIS Access/Availability of Care measures:

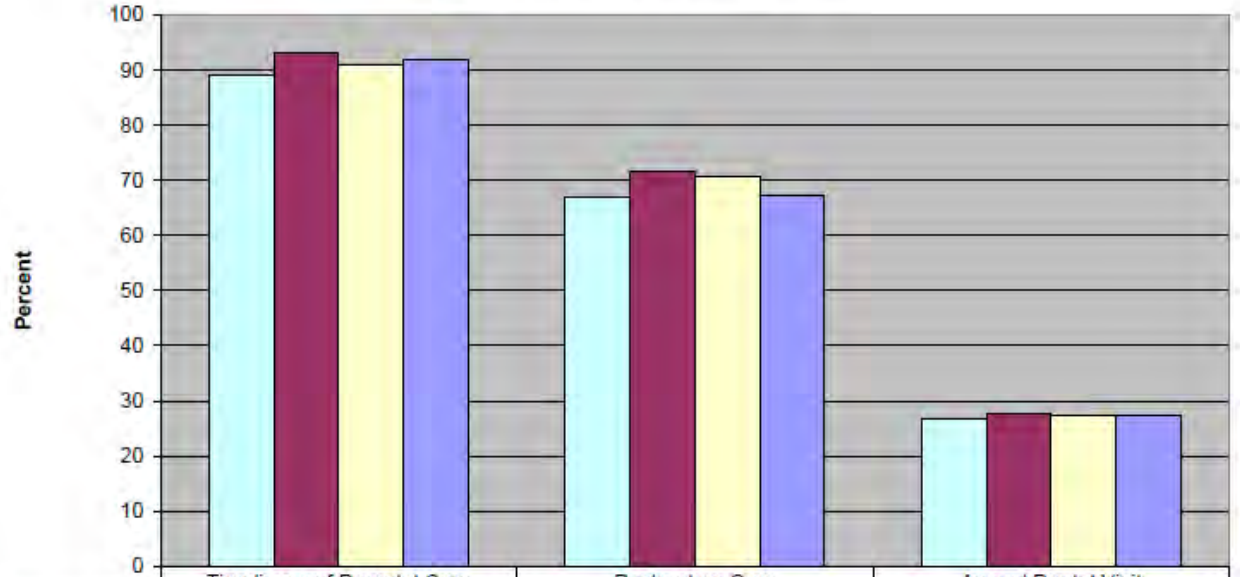
- Timeliness of Prenatal Care (TOPC)
- Postpartum Care (PPC)
- Annual Dental Visits (ADV).

Figure 4 depicts Missouri Care's performance between HEDIS 2006 and 2009 (measurement years 2005 through 2008).

Missouri Care's HEDIS 2009 rate for TOPC was 92.08% (95% CI: 89.17% to 94.98%), which is statistically equivalent to the national NCQA Medicaid 90th percentile of 92.21%. The HEDIS 2009 PPV rate of 67.21% (95% CI: 62.27% to 72.16%) placed the health plan at the national 75th percentile (68.23%). Performance on these measures is in large part attributable to Missouri Care's strong prenatal and postpartum case management programs. Nurses educate members through one-to-one health coaching and provide easily understandable health education materials that promote and support member's prenatal and postpartum self-care (see Section VIII: Quality Management).

Access to dental care continues to be a challenge in mid-Missouri and Missouri Care. The HEDIS 2009 ADV rate was 27.41%, showing little improvement over the past four years. In September of 2008 Missouri Care partnered with a new vendor, Doral Dental. The partnership has resulted in the design and implementation of several new interventions for 2009-2010, including member education and appointment reminders, PCP support tools, and a new dental incentive program. The statewide Dental Task Force was initiated in June 2009 and Missouri Care will measure the success of its' new interventions in the statewide dental PIP.

Figure 4. HEDIS Access/Availability of Care



	Timeliness of Prenatal Care	Postpartum Care	Annual Dental Visit
HEDIS 2006	89.05	66.91	26.76
HEDIS 2007	93.24	71.56	27.76
HEDIS 2008	91.1	70.83	27.5
HEDIS 2009	92.08	67.21	27.41

Use of Services

The HEDIS indicators for Use of Services include:

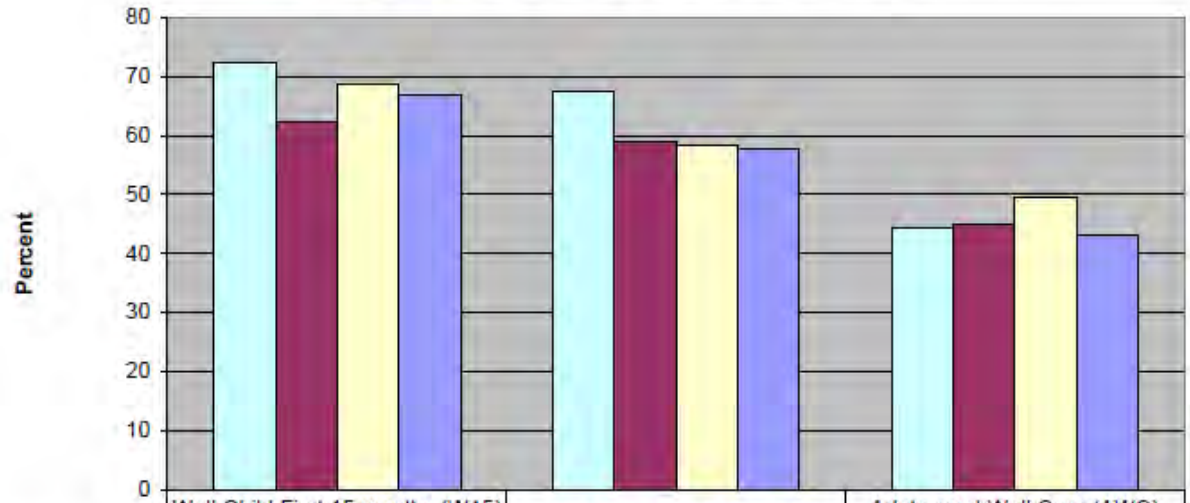
- Well-Child Visits in the First 15 Months of Life (W15)
- Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life (W34)
- Adolescent Well Care Visits (AWC)
- Ambulatory Care (AMB)

- Mental Health Utilization (MPT)
- Identification of Alcohol and Other Drug Services (IAD)

Well-Care Visits

Figure 5 presents Missouri Care's performance on the Well Child Visit measures between HEDIS 2006 to 2009 (measurement years 2005 through 2008). The percentage of Well-Child Visits in the First 15 Months of Life (W15) ranked second among all state managed care plans in HEDIS 2009, at 66.93% (95% CI: 61.38 to 71.09%), and placed the health plan at the national NCQA Medicaid 75th percentile (67.39%). This measure has been the target of both OB case management and population health improvement initiatives over the past several years, with noticeable results. Baby booklets are sent to all post partum mothers, along with a checklist that encourages well-child follow-up visits. EPSDT postcards are sent to members according to the periodicity schedule (birth to 21 years) to remind members of needed check-ups and to provide age-appropriate health education.

Figure 5. HEDIS Use of Services Measures: Well-Care Visits



	Well Child First 15 months (W15) 6+ Visits	Well Child 3, 4, 5, 6 (W34)	Adolescent Well Care (AWC) 12-21 years
HEDIS 2006	72.46	67.37	44.53
HEDIS 2007	62.27	58.97	44.91
HEDIS 2008	68.63	58.22	49.54
HEDIS 2009	66.93	57.87	43.06

Because of stalled performance improvement on Well Child Visits at Three, Four, Five, and Six years of age (W34) Missouri Care has implemented multiple interventions targeting both families and providers. One initiative, a partnership with WIC programs to improve well child checkups, proved highly successful and is described in Section XI: Performance Improvement Projects. Missouri Care has established new partnerships and interventions as part of the new state contract with the expectation of improved performance in 2010.

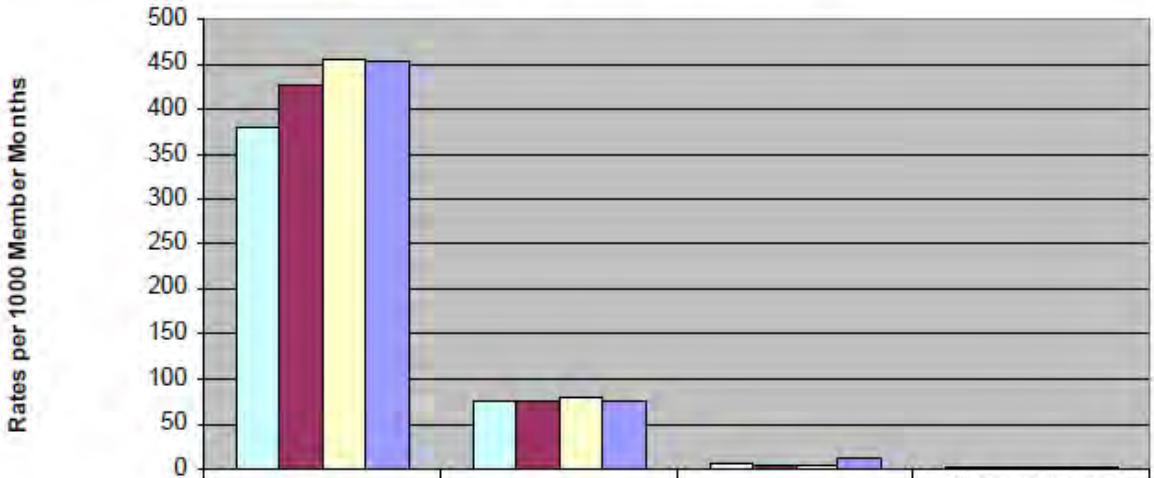
Missouri Care has been the highest MO HealthNet managed care plan performer on Adolescent Well Care (AWC) visits since 2002. Although the rate decreased in HEDIS 2009 Missouri Care

maintained the top performance of 43.06%, as compared to the statewide average of 35.82%. Still, the health plan is not satisfied that so few adolescents receive appropriate well care and strives to improve performance through its' Adolescent Well Care PIP. A summary of the interventions targeting all well-child measures is provided in the summary charts in Appendix A.

Ambulatory Care

The Ambulatory Care indicators for HEDIS 2006 through 2009 (measurement years 2005 through 2008) are displayed in Figure 6. Outpatient visits per 1000 member months increased by 17%, or 75 visits per 1000 between HEDIS 2006 and HEDIS 2008, but decreased slightly in HEDIS 2009. Emergency department visits per 1000 member months have remained relatively unchanged since the 2005 calendar year. This ratio indicates that ED visits are declining as a percentage of all ambulatory care visits. Although Missouri Care did not observe a significant decrease in ED utilization, an upward trend in use has been avoided for four years.

Figure 6. HEDIS Use of Services: Ambulatory Care



	Outpatient Visits	Emergency Department Visits	Ambulatory Surgery/Procedures	Observation Room Stays Resulting in Discharge
HEDIS 2006	379.73	76.26	7.36	3.52
HEDIS 2007	425.43	75.99	5.94	1.8
HEDIS 2008	454.31	78.31	5.45	2.03
HEDIS 2009	451.76	75.99	11.26	2.14

The ED rate of 75.99 visits per 1000 member months places the health plan above the national 75th percentile for the Medicaid population. For this measure, higher is not better. Although Missouri Care's ED visit rate has been stable over the past four years, it compares poorly against national rates, confirming the need for ongoing focus and improvement. In general, Missouri Care strives to perform at the national 50th percentile on AMB and MPT utilization measures to avoid under or overutilization.

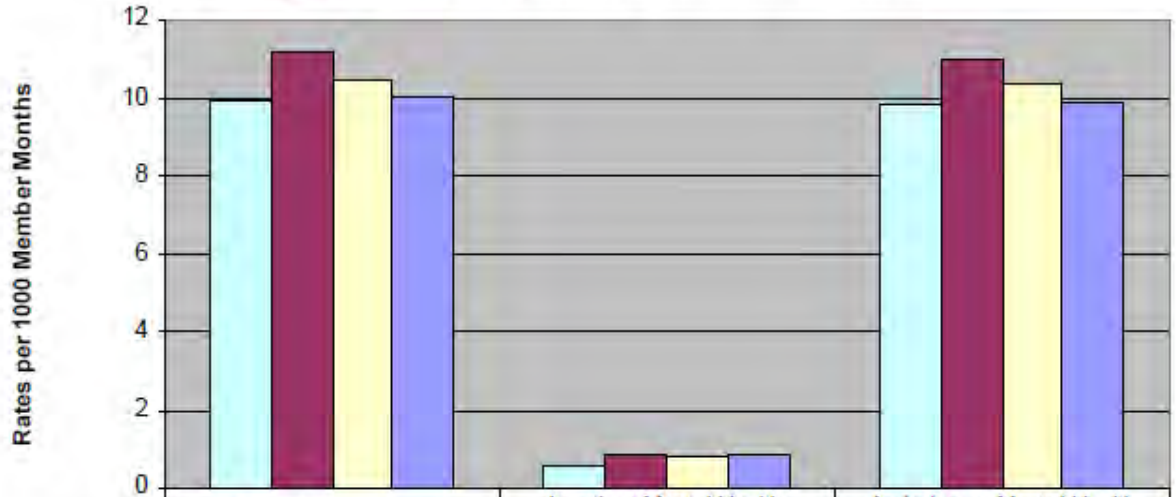
Ambulatory surgery/procedures doubled between HEDIS 2008 and HEDIS 2009, from 5.45 per

1000 member months in HEDIS 2008 to 11.26 in HEDIS 2009. The national 75th percentile is 11.76 visits per 1000 member months. Observation room stays resulting in discharge declined by 39% between HEDIS 2006 and HEDIS 2009, placing the health plan between the national NCQA 50th and 75th percentiles (1.53 and 2.37 visits/1000 mm, respectively).

Mental Health Utilization

The 2006 through 2009 HEDIS rates for Mental Health Utilization are charted in Figure 7. In HEDIS 2009 the use of any mental health services returned approximately to the level seen in HEDIS 2006—about 10 visits per 1000 member months. Variance on this measure has been minimal over the past four years. Missouri Care's rate falls between the NCQA 2009 national Medicaid 50th and 75th percentiles (7.72 and 11.46 visits per 1000 member months, respectively). The use of inpatient mental health services increased over the past year, from 0.78 in HEDIS 2008 to 0.87 in HEDIS 2009, placing Missouri Care at the national 50th percentile of 0.87 visits per 1000 member months. In HEDIS 2009 ambulatory mental health services decreased slightly to 9.87. Missouri Care falls between the national 50th and 75th percentiles on this measure.

Figure 7. HEDIS Use of Services: Mental Health Utilization



	Any Mental Health Services	Inpatient Mental Health Services	Ambulatory Mental Health Services
HEDIS 2006	9.93	0.58	9.79
HEDIS 2007	11.15	0.82	10.98
HEDIS 2008	10.45	0.78	10.34
HEDIS 2009	10.01	0.87	9.87

Identification of Alcohol or Other Drug Use Services
Lastly, the Identification of Alcohol and Other Drug Services became a NCQA measure in HEDIS 2007. It reflects the percentage of members with an alcohol and other drug (AOD) claim who received chemical dependency services during the measurement year. Missouri Care's HEDIS 2009 "any AOD services" rate of 1.38% places the health plan below the NCQA 2009 Medicaid average of 2.17%. Outpatient services comprised the majority of AOD claims (1.04%).

Satisfaction with the Experience of Care
Per the MO HealthNet contract, Missouri Care measures member satisfaction using the NCQA's Consumer Assessment of Healthcare Providers and Systems (CAHPS) Medicaid Child Survey. Survey versions and vendors have changed over the past four years, as follows:

- CAHPS 3.0H Health Plan Survey – Medicaid, Child Version
  - CAHPS 2007 (CY 2006) –The Myers Group
  - CAHPS 2008 (CY 2007) – The Center for the Study of Services (CSS)
- CAHPS 4.0H Health Plan Survey – Medicaid, Child Version
  - CAHPS 2009 (CY 2008) – CSS
  - "Overall Performance Ratings" questions/response options remained the same
  - "Domains of Care" questions/response options changed

Getting Needed Care, Getting Care Quickly, and Customer Service measures are not trendable due to these changes

CSS administered both mailed and telephone follow-up surveys to parents of children (birth to 18 years old), between February and May, 2009. Respondents reported on their child's experience with Missouri Care during the previous six months. In CAHPS 2009, a total of 1,650 eligible members of Missouri Care health plan were randomly selected for the survey. The final survey response rate was 30.5%. Results over the past three years are summarized in Table 1.

Table 1. CAHPS Medicaid Child Survey Rates			
Composite/Rating Areas	**CAHPS 2007 3.0H**	**CAHPS 2008 3.0H**	**CAHPS 2009 4.0H**
OVERALL PERFORMANCE			
Rating of Personal Doctor or Nurse	78.5%	79.9%	85.9%
Rating of Specialist	76.4%	76.1%	75.2%
Rating of All Health Care	79.6%	77.6%	79.1%
Rating of Health Plan	77.6%	75.5%	78.1%
DOMAINS OF CARE COMPOSITES*			
How Well Doctors Communicate	91.90%	91.70%	93.20%*
Getting Needed Care	81.40%	80.10%	80.20%*
Getting Care Quickly	81.30%	81.40%	91.00%*
Courteous and Helpful Office Staff	92.00%	92.50%	Category removed
Customer Service	79.30%	69.50%	71.80%*

* Not trendable due to question and response option changes for CAHPS 4.0H

Overall Performance

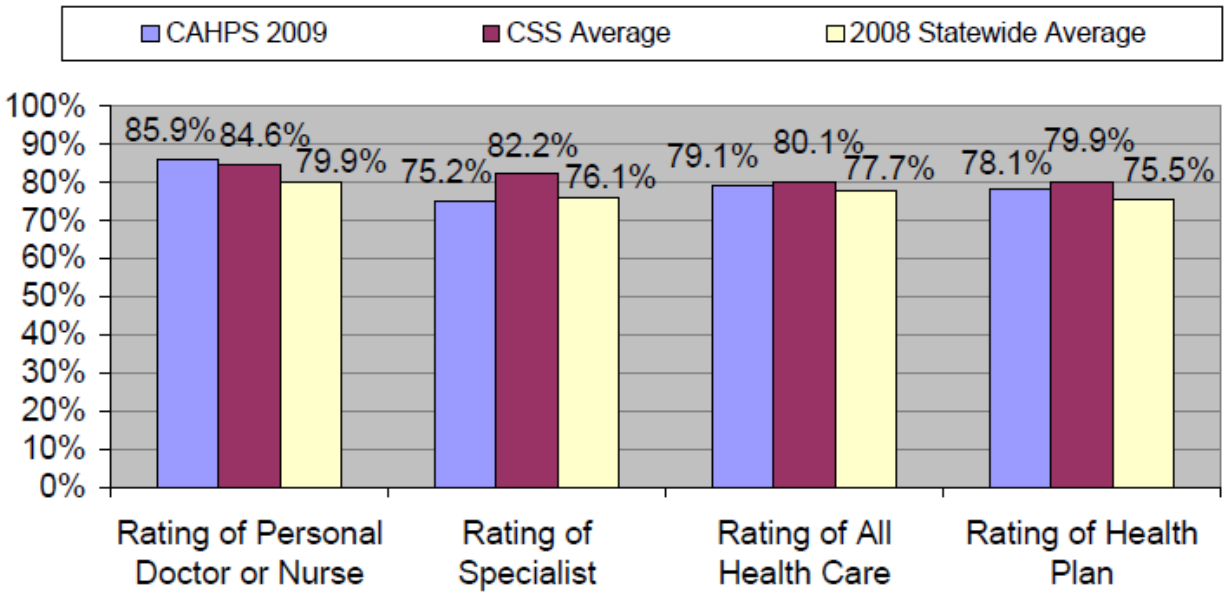
The Overall Performance charts display members' ratings in four areas. Using a scale of *0* to *10*, where *0* is the ~~"w~~worst possible" rating and *10* is the ~~"b~~est possible" rating, respondents were asked to rate their child's personal doctor or nurse, the specialist their child saw most often, all health care their child received, and their child's health plan. Table 1 presents the percentage of respondents answering in the ranges of *8-10*. In CAHPS 2009, this percentage increased for all categories except Rating of Specialist, which remained about the same. Missouri Care parents' ratings of their personal physician or nurse have increased by 9.2 percentage points since CAHPS 2006.

Missouri Care's CAHPS 2009 member satisfaction compares favorably with the MO HealthNet and CSS book of business[3] average ratings (Figure 8). Rating of Personal Doctor or Nurse exceeded both averages, and Rating of All Health Care and Rating of Health Plan are comparable with CSS' national Medicaid book of business. Missouri Care exceeded the CAHPS

[3] Pooled results from all of the Medicaid health plans in CSS' book of business. Results were calculated by CSS following NCQA specifications. These are not official NCQA results.

2008 MO HealthNet statewide average on all overall performance ratings except Rating of Specialist, for which there was no significant variation.

Figure 8. CAHPS 4.0 Overall Performance - State and National Comparisons



Domains of Care
Members' responses to groups of related questions are used to measure plan performance in various Domains of Care. A Global Proportion ranges in value from *0* to *100* and represents the average percentage of respondents selecting *Always* or *Usually* to questions in the domain. Missouri Care's performance is summarized in Table 1 and displayed graphically in Figures 9 and 10.

<u>How Well Doctor's Communicate</u>
Figure 9 presents the composite score of members responding *Always* or *Usually* to four questions regarding How Well Doctor's Communicate. Respondents were asked, "In the last 6 months…"

- How often did your child's personal doctor explain things in a way that was easy to understand?
- How often did your child's personal doctor listen carefully to you?
- How often did your child's personal doctor show respect for what you had to say?
- How often did your child's personal doctor spend enough time with your child?

Missouri Care scored equal to or higher than CSS's national book of business on all sub measures, and members were significantly more likely than other CSS plans to report that their PCP spent enough time with their child (91.3% vs. 84.5%, at 95% CI).

Figure 9. CAHPS 4.0 Domains of Care - How Well Doctor's Communicate

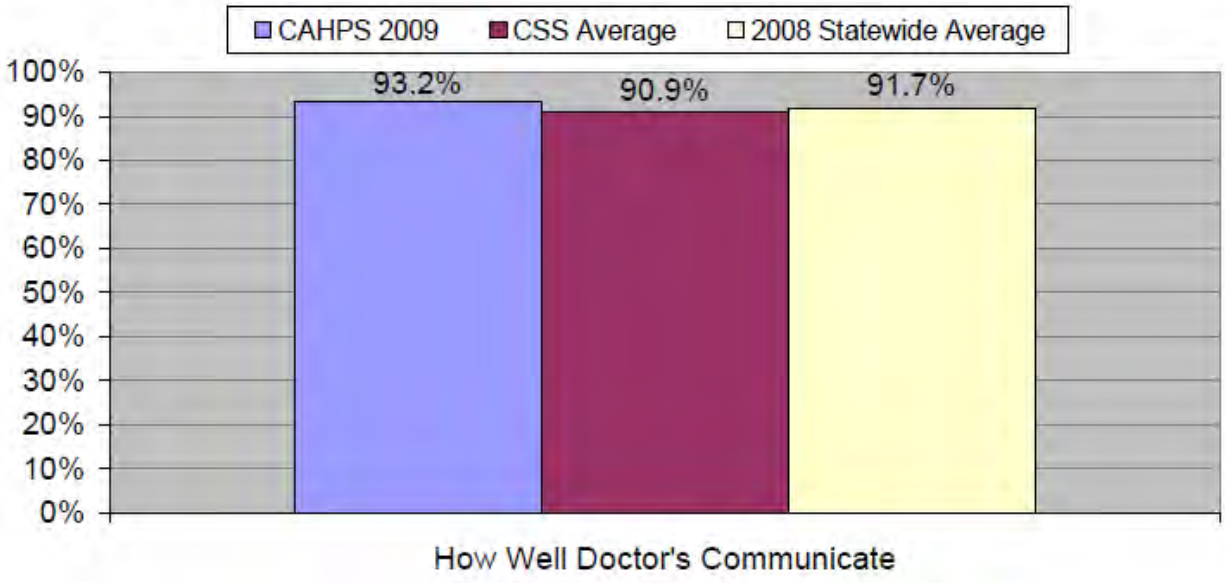


Figure 10. CAHPS 4.0 Domains of Care - New Composite Measures

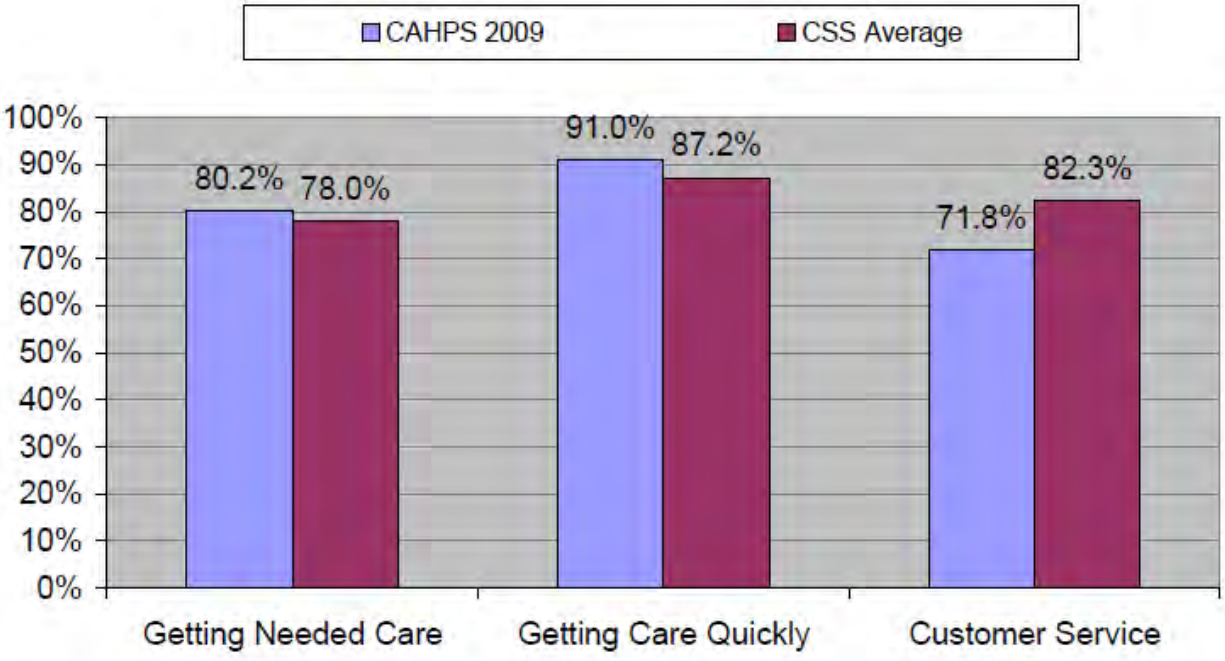


Figure 10 charts Missouri Care's performance on the other Domains of Care composite measures for which question and response option changes render them incomparable to previous year's surveys.

Getting Needed Care

This composite item was assessed through two questions: ~~"~~In the last 6 months…"

- How often was it easy to get appointments for your child with specialists?
- How often was it easy to get the care, tests, or treatment you thought your child needed?

Missouri Care members responded more favorably than the CSS book of business on both sub questions.

Getting Care Quickly

Two questions comprised this category: "In the last 6 months…"

- When your child needed care right away, how often did your child get care a soon as you thought he or she needed?
- Not counting the times your child needed care right away, how often did you get an appointment for health care at a doctor's office or clinic as soon as you thought your child needed?

Again, for both sub-questions, Missouri Care was rated more favorably by its' members than members in other CSS surveyed plans. Member ratings for question two, non-urgent care, were significantly higher than the CSS national average (90.4% vs. 84.5%, respectively, at 95% CI).

Customer Service

Two new questions reflecting Customer Service were asked for CAHPS 2009: "In the last 6 months…"

- How often did Customer Service at your child's health plan give you the information or help that you needed?
- How often did Customer Service staff at your child's health plan treat you with courtesy and respect?

On the first question, "providing needed information", Missouri Care's customer service was rated significantly below the CSS national average (58.1% vs. 75.8%, respectively; 95% CI). On the second question, "providing courtesy and respect", the health plan's scores were comparable to CSS's book of business (85.5% vs. 88.8%). Given these results, in the first quarter of 2010, Missouri Care is implementing an Interactive Voice Response (IVR) member satisfaction survey for a random sample of members who contact the health plan's Member Services staff. This will assist the plan in verifying member satisfaction at the point of contact with health plan staff, as opposed to satisfaction with Missouri Care's provider networks' office staff.

Trends in Missouri Medicaid Quality Indicators

Annually, MO HealthNet provides the following data on maternal child health indicators to evaluate the health status of the state's managed care population. Data presented in Table 2 are taken from the report: *Trends in Missouri MO HealthNet Quality Indicators: Central Region MO HealthNet Baseline vs. Last 57Months of MO HealthNet Managed Care*.

MO HealthNet conducted statistical testing of managed care performance between CY 2007 and January-September 2008. The results are displayed in the final "After Managed Care" column. During this time period, vaginal births after Caesarian Section (VBAC) significantly decreased from 7.9% of total births to 4.3%. This is consistent with a national trend of fewer VBAC procedures due to risk of uterine rupture, as well as litigation issues. Although the state did not report a significant improvement in the percentage of members enrolled in WIC between 2007

and 2008, Missouri Care's analysis, using a Z-test of proportions, indicated that this was a significant increase. No other trends over the past year were observed.

Missouri Care conducted additional statistical significance testing comparing maternal and child health indicators in CY 1995 (which MO HealthNet presented as pre-managed care) with those in CY 2007 (after managed care), as shown in the "Before Managed Care, Significant Change 1995-2007" column.

MO HealthNet measures showing significantly better performance *prior* to managed care are:

- Pre-pregnancy weight > 30 BMI. Pre-pregnancy obesity increased between 1995 and 2007 by 10.5 percentage points (from 18.4% to 26.8%). This likely reflects increasing obesity in the general population over the past 12 years rather than weight increases in pregnant women after the inception of managed care.
- Spacing < 18 months since last birth. Inadequate birth spacing increased by 2.3 percentage points (from 13.6% to 15.9%).

MO HealthNet measures showing significantly better performance *after* managed care are:

- Trimester prenatal care began. Early, first-trimester prenatal care increased by 7%, or 5 percentage points between 1995 and 2007.
- Births to mothers < 18 years of age. Births by teenage mothers dropped by almost 50% (from 9.2% to 4.9%).
- Repeat teen births. Dropped by 46% (from 5.1% to 3.5%).
- Percent of prenatals on WIC. The percentage of women seeking WIC assistance increased by 7%, or 5 percentage points between 1995 and 2007 (from 72.6% to 78.0%).
- Asthma inpatient admissions ages 4-17. Children and adolescents in this age group experienced significantly fewer inpatient admissions for their disease. Inpatient admission rates dropped by 43% between 1995 and 2007 (from 0.7% to 0.4%).
- Preventable hospitalizations under age 18. Decreased significantly from 6.7 to 6.3%.

Other measures for which MO HealthNet managed care performed more favorably, but not at the level of statistical significance, include:

- Inadequate prenatal care. Downward trend.
- Adequate birth weight. Upward trend.
- Low birth weight. Downward trend.
- Smoking during pregnancy. Downward trend.
- Asthma emergency room visits, ages 4-17. Downward trend.
- Emergency room visits under age 18. Downward trend.

Table 2. Trends in Missouri MO HealthNet Quality Indicators: Central Region Before and After Managed Care (Secondary Source Reporting)

	Before Managed Care (1995)			*After Managed Care (2007-2008)*				
	CY 1995 Births	Percent of total births	Sig. chg. 1995-2007	CY 2007 Births	Percent of total Births	Jan-Sept 2008 Births	Percent of total births	Sig. chg.* 2007-2008
1. Trimester Prenatal Care Began								
a. First	12,495	72.8%	*increase* (p<0.001)*	2,567	77.8%	2,826	76.3%	*No*
b. Second	3,698	21.6%	--	636	19.3%	762	20.6%	*No*
c. Third	614	3.6%	*decrease* (p<0.001)*	83	2.5%	100	2.7%	*No*
d. None	351	2.0%	*decrease* (p<0.001)*	14	0.4%	17	0.5%	*No*
e. Total	17,158			3,300		3,705		
2. Inadequate Prenatal Care	498	20.4%	--	588	18.9%	659	18.4%	*No*
3(1). Birth Weight (grams)								
a. < 1500	42	1.6%	--	48	1.4%	43	1.1%	*No*
b. 1500-2499	175	6.9%	--	244	6.9%	257	6.6%	*No*
c. 2500+	2,334	91.5%	--	3,258	91.7%	3,594	92.3%	*No*
d. Total	2,551			3,552		3,895		
3(2). Low Birth Weight (< 2500 grams)	217	8.5%	--	292	8.2%	300	7.7%	*No*
4. Gestational Age (weeks)								
a. <32 week	77	3.0%	--	95	2.7%	90	2.3%	*No*
b. 32-36 weeks	275	10.8%	--	364	10.%	395	10.1%	*No*
5. Method of Delivery								
a. C-Section	466	18.3%	*increase+*	1,093	30.8%	1,174	30.1%	*No*
b. VBAC	79	35%	*decrease+*	45	7.9%	27	4.3%	*Yes*
6. Pre-pregnancy Weight > 30 BMI (Obese)	440	18.4%	*increase+*	772	26.8%	990	28.9%	*No*
7. Smoking During Pregnancy	937	36.7%	--	1,300	36.6%	1,410	36.2%	*No*

Table 2. Trends in Missouri MO HealthNet Quality Indicators: Central Region Before and After Managed Care (Secondary Source Reporting) *Continued*

	Before Managed Care (1995)			*After Managed Care (2007-2008)*				
	CY 1995 Births	Percent of total births	Sig. chg. 1995-2007	CY 2007 Births	Percent of total Births	Jan-Sept 2008 Births	Percent of total births	Sig. chg.* 2007-2008
8. Spacing < 18 months since last birth	176	13.6%	*increase* [+]	335	16.7%	364	15.9%	*No*
9(1). Births to mothers < 18 years of age	234	9.2%	*decrease* [+]	174	4.9%	189	4.9%	*No*
9(2). Births to mothers > 35 years of age	104	4.1%	--	132	3.7%	165	4.2%	*No*
10. Repeat Teen Births	131	5.1%	*decrease* [+]	124	3.5%	134	3.4%	*No*
11. Percent of Prenatals on WIC	1,851	72.6%	*increase* [+]	2772	78.0%	3,122	80.2%	*"No"* [+]
12. VLBW not delivered in level III hospitals	7	16.7%	--	8	16.7%	13	30.2%	*No*
13. Asthma inpatient admissions under age 18 †	81	2.9%	--	63	0.7%	NR	NR	NR
14. Asthma inpatient admissions ages 4-17 †	55	0.7%	*decrease* [#]	33	0.4%	NR	NR	NR
15. Asthma emergency room visits ages 0-3 †	NA	NA	NA	72	4.1%	NR	NR	NR
16. Asthma emergency room visits ages 4-17 †	242	3.1%	--	185	2.5%	NR	NR	NR
17. Asthma inpatient admissions ages 18-64 †	NA	NA	NA	245	0.7%	NR	NR	NR
18. Emergency room visits under age 18 †	24,322	263.3	--	24,310	266.1	NR	NR	NR

Table 2. Trends in Missouri MO HealthNet Quality Indicators: Central Region Before and After Managed Care (Secondary Source Reporting) ***Continued***

	Before Managed Care (1995)			*After Managed Care (2007-2008)*				
	CY 1995 Births	Percent of total births	Sig. chg. 1995-2007	CY 2007 Births	Percent of total Births	Jan-Sept 2008 Births	Percent of total births	Sig. chg.* 2007-2008
19. Emergency room visits ages 18-64 †	NA	NA	NA	115,227	325.6	NR	NR	NR
20. Hysterectomies †	NA	NA	NA	1,127	6.5	NR	NR	NR
21. Preventable hospitalization under age 18 †	618	6.7	*decrease* #	575	6.3	NR	NR	NR

* MO HealthNet analyses: Statistically significant change at 0.05 level of significance using Chi-Square test. Unless otherwise indicated, measures are reported as Rate per 1000 Live Births and Percent of Live Births.

+ Missouri Care analyses: Statistically significant change at 0.05 level of significance using a Z-test of proportions.

Missouri Care analyses: Statistically significant change at 0.05 level of significance using a two-sample t-test.

† Rate per 1000 population.

Source: Missouri Department of Health and Senior Services (1/14/2009).

Indicators by MO HealthNet Managed Care Health Plans Within Regions, Live Births

Table 3 compares Missouri Care to other plans within the Central region. Data are trended and tested for significance across years (i.e., HEDIS 2007 – HEDIS 2009 for Missouri Care and for the Central Region) and between groups (i.e., Missouri Care rates are compared to the Central Region). Significant changes across time or between groups are highlighted in red and summarized below.

The percent of babies with low birth weight (LBW) delivered in a Level II or III hospital significantly decreased in HEDIS 2009 for both Missouri Care and the Central Region. Missouri Care's rate decreased from 80.5% in HEDIS 2008 to 71% in HEDIS 2009. In SFY 09 teenage pregnancies also decreased in the Central region. During the same period, Missouri Care members' participation in WIC significantly increased, placing Missouri Care first in WIC participation, not only in the Central region, but across all regions. The data also revealed higher rates of smoking during pregnancy; this has been made a quality improvement priority for 2010.

Table 3: HEDIS Indicators by Managed Care Health Plans (Secondary Source Reporting)

Indicator		HEDIS 2007	HEDIS 2008	HEDIS 2009	Total Deliveries*
Method of Delivery					
Cesarean Section					
	Missouri Care	**28.3**	**29.1**	**29.2**	**2,500**
	Statistically Different by Year (Missouri Care)		0.575	0.950	
	Central Region Total	**29.9**	**31.2**	**29.9**	**4,727**
	Statistically Different by Year (Central Reg.)		0.249	0.208	
	Statistically Different by Region (Missouri Care vs. Central Region)	0.221	0.106	0.539	
Vaginal Birth after Cesarean Section					
	Missouri Care	**10**	**8.1**	**8.0**	**376**
	Statistically Different by Year (Missouri Care)		0.420	0.972	
	Central Region Total	**8.1**	**6.6**	**5.0**	**719**
	Statistically Different by Year (Central Reg.)		0.367	0.240	
	Statistically Different by Region (Missouri Care vs. Central Region)	0.388	0.444	0.066	
**Total Deliveries = Total live births*					
Adequate Prenatal Care					
	Missouri Care	**82.3**	**81.8**	**83.0**	**2,300**
	Statistically Different by Year (Missouri Care)		0.687	0.317	
	Central Region Total	**83.5**	**82.6**	**83.5**	**4,360**
	Statistically Different by Year (Central Reg.)		0.372	0.310	
	Statistically Different by Region (Missouri Care vs. Central Region)	0.315	0.489	0.597	
**Total Deliveries = Total live births with known prenatal care*					
Data based on births in a MC plan at delivery, irrespective of length of enrollment					
Early Prenatal Care					
	Missouri Care	**73.6**	**73.5**	**79.4**	**252**
	Statistically Different by Year (Missouri Care)		0.986	0.104	
	Central Region Total	**77.9**	**75.2**	**75.2**	**419**
	Statistically Different by Year (Central Reg.)		0.304	0.981	
	Statistically Different by Region (Missouri Care vs. Central Region)	0.130	0.585	0.206	
**Total Deliveries = Total live births to continuously enrolled women up to 289 days prior to delivery*					
One gap of up to 45 days was allowed					

Table 3: HEDIS Indicators by Managed Care Health Plans (Secondary Source Reporting) *Continued*

Indicator	HEDIS 2007	HEDIS 2008	HEDIS 2009	Total Deliver-ies*
Low Birth Weight (< 2500 gms)				
Missouri Care	**8.7**	**9.2**	**9.9**	**223**
Statistically Different by Year (Missouri Care)		0.791	0.810	
Central Region Total	**8.8**	**9.7**	**10.4**	**374**
Statistically Different by Year (Central Reg.)		0.707	0.735	
Statistically Different by Region (Missouri Care vs. Central Region)	0.881	0.825	0.825	
**Total Deliveries = Total live births to continuously enrolled women for 12 mos prior to delivery One gap of up to 45 days in the 175 days to delivery was allowed*				
LBW delivered in Level II/III hospital				
Missouri Care	**75.8**	**80.5**	**71.0**	**200**
Statistically Different by Year (Missouri Care)		0.304	*0.037**	
Central Region Total	**76.5**	**78.9**	**68.6**	**376**
Statistically Different by Year (Central Reg.)		0.503	*0.003**	
Statistically Different by Region (Missouri Care vs. Central Region)	0.857	0.687	0.552	
**Total Deliveries =Total live births with birth weight less than 2500 gms*				
VLBW delivered in Level II/III hospital				
Missouri Care	**84.2**	**90.9**	**76.5**	**34**
Statistically Different by Year (Missouri Care)		0.518	0.129	
Central Region Total	**81.6**	**91.7**	**84.7**	**59**
Statistically Different by Year (Central Reg.)		0.176	0.260	
Statistically Different by Region (Missouri Care vs. Central Region)	0.801	0.917	0.339	
**Total Deliveries =Total live births with birth weight less than 1500 gms*				
Smoking during Pregnancy				
Missouri Care	**40.2**	**38.4**	**39.3**	**2,500**
Statistically Different by Year (Missouri Care)		0.252	0.538	
Central Region Total	**38.4**	**36.5**	**36.7**	**4,727**
Statistically Different by Year (Central Reg.)		0.114	0.860	
Statistically Different by Region (Missouri Care vs. Central Region)	0.198	0.165	*0.030**	
**Total Deliveries = Total live births*				
Spacing < 18 months				
Missouri Care	**15.1**	**16.0**	**16.5**	**1,394**
Statistically Different by Year (Missouri Care)		0.555	0.739	
Central Region Total	**14.9**	**16.3**	**16.1**	**2,696**
Statistically Different by Year (Central Reg.)		0.239	0.850	
Statistically Different by Region (Missouri Care vs. Central Region)	0.900	0.827	0.742	
**Total Deliveries =Total second or higher order live births with know spacing*				

Table 3: HEDIS Indicators by Managed Care Health Plans (Secondary Source Reporting) *Continued*

Indicator		HEDIS 2007	HEDIS 2008	HEDIS 2009	Total Deliver-ies*
Births to mothers < 18 y/o					
	Missouri Care	**6.5**	**5.7**	**5.4**	**2,500**
	Statistically Different by Year (Missouri Care)		0.313	0.660	
	Central Region Total	**6.4**	**5.2**	**4.9**	**4,727**
	Statistically Different by Year (Central Reg.)		*0.041**	0.549	
	Statistically Different by Region (Missouri Care vs. Central Region)	0.903	0.444	0.371	
**Total Deliveries = Total live births*					
Repeat births to teen mothers					
	Missouri Care	**3.2**	**3.7**	**3.3**	**2,500**
	Statistically Different by Year (Missouri Care)		0.375	0.491	
	Central Region Total	**3.6**	**3.4**	**3.2**	**4,727**
	Statistically Different by Year (Central Reg.)		0.665	0.596	
	Statistically Different by Region (Missouri Care vs. Central Region)	0.414	0.581	0.775	
**Total Deliveries = Total live births*					
Prenatal WIC participants					
	Missouri Care	**78.4**	**78.1**	**80.9**	**2,467**
	Statistically Different by Year (Missouri Care)		0.820	*0.021**	
	Central Region	**77.7**	**76.9**	**79.8**	**4,628**
	Statistically Different by Year (Central Reg.)		0.442	*0.002**	
	Statistically Different by Region (Missouri Care vs. Central Region)	0.566	0.381	0.260	
**Total Deliveries = Total live births with known WIC participant*					

Statistically Different by Year = statistical difference in rates, when comparing current year to previous year for each region individually, using a Z-test of proportions (represented by a *p*-value).
Statistically Different by Region = statistical difference in rates, when comparing each region by individual year, using a Z-test of proportions (represented by a *p*-value).
* Difference in rates considered statistically significant where *p*-value less than established alpha level = 0.05.

Missouri Care's Perinatal and Postpartum Care Management programs are described in Section VIII: Quality Management.

Molina Healthcare of Missouri

HEDIS Measures (Performance Measures)
Molina Healthcare of Missouri (MHMO) monitors performance on a monthly basis. The performance measures are presented to the Quality Improvement Committee (QIC) and the Quality Improvement (QI) sub-committees for analysis, review, identification of trends, recognition of goal achievement, and establishment of corrective actions.

The performance measures are divided into the following (3) three categories:

- Customer Service indicators are focused on membership activity, phone metrics, and timeliness of claims payment

- Quality Improvement indicators focus on provider complaints, grievances and appeals, member grievances and appeals and credentialing
- Medical Management indicators are focused on authorization and referral calls, days/1000, obstetrics and utilization management

The performance measures for the reporting period are reflected in the Accessibility of Services section below.

Trends in Missouri Medicaid Quality Indicators

The following *Healthcare Effectiveness Data and Information Set (HEDIS)* 2009 data was reported to the Department of Health and Senior Services (DHSS) for MHMO in all Missouri Regions (Eastern, Western and Central).

	Reported Rate Eastern Region	Reported Rate Western Region	Reported Rate Central Region
Childhood Immunization: DTP	63.4	49.33	70.00
Childhood Immunization: MMR	84.43	84.00	86.67
Childhood Immunization: IPV/OPV	85.53	74.67	83.33
Childhood Immunization: Hib	92.72	82.67	96.67
Childhood Immunization: Hepatitis B	88.30	80.00	86.67
Childhood Immunization: VZV	82.12	78.67	86.67
Childhood Immunization: Pneumococcal Conjugate	64.24	46.67	70.00
Childhood Immunization: Combo 3	53.42	40.00	60.00
Childhood Immunization: Combo 2	60.71	45.33	70.00
Adolescent Well-Care Visits	3.85	30.82	32.44
Use of Appropriate Meds for People w/ Asthma: 5-9 years old	86.18	*	*
Use of Appropriate Meds for People w/ Asthma: 10-17 years old	88.65	*	*
Use of Appropriate Meds for People w/ Asthma: 18-56 years old	78.86	*	*
Use of Appropriate Meds for People w/ Asthma: combined	86.34	*	*
Chlamydia Screening: 16-20 years old	55.49	40.94	49.40
Chlamydia Screening: 21-25 years old	62.21	44.23	33.33
Chlamydia Screening: combined	57.71	41.90	43.75

Cervical Cancer Screening	61.04	32.19	33.13
Annual Dental Visits: 2-3 years old	10.58	13.03	14.36
Annual Dental Visits: 4-6 years old	36.42	35.97	30.00
Annual Dental Visits: 7-10 years old	46.24	39.27	38.99
Annual Dental Visits: 11-14 years old	40.12	28.73	29.45
Annual Dental Visit Total	33.97	29.32	29.52

*N/A = Denominator fewer than 30

HEDIS Indicators by MO HealthNet plans within Regions, Live Births

The following HEDIS 2009 data was reported to the MO HealthNet Division (MHD) for MHMO in all Missouri Regions (Eastern, Western and Central).

	Reported Rate Eastern Region	**Reported Rate Western Region**	**Reported Rate Central Region**
Well Child Visits in the first 15 Months of Life: 0 visits	10.62	18.95	6.67
Well Child Visits in the first 15 Months of Life: 1 visit	2.88	12.63	*
Well Child Visits in the first 15 Months of Life: 2 visits	5.75	4.21	3.33
Well Child Visits in the first 15 Months of Life: 3 visits	4.42	6.32	*
Well Child Visits in the first 15 Months of Life: 4 visits	9.73	16.84	23.33
Well Child Visits in the first 15 Months of Life: 5 visits	18.14	14.74	16.67
Well Child Visits in the first 15 Months of Life: 6 or more visits	48.45	26.32	50.00
Well Child Visits in the Third, Fourth, Fifth and Sixth Year of Life	51.88	42.22	49.12
W/in 7 Days of Discharge Mental Illness Hospital	38.89	36.11	17.65
W/in 30 Days of Discharge Mental Illness Hospital	63.52	58.33	47.06
Timeliness of Prenatal Care	80.13	79.20	81.05
Postpartum Care	59.38	59.29	67.32

*N/A = Denominator fewer than 30

Consumer Assessment of Healthcare Providers and Systems (CAHPS)
The following CAHPS data for 2009 was reported to the National Committee for Quality Assurance (NCQA) for MHMO in the Eastern, Western and Central Regions.

	Reported Rate Eastern Region	**Reported Rate Western Region**	**Reported Rate Central Region**
Health Plan Overall	77.58	64.61	72.56
Health Care Overall	79.43	72.85	79.91
Personal Doctor Overall	83.52	85.29	88.61
Specialist Overall	80.53	*	*
Customer Service	81.26	*	82.56
Getting Needed Care	75.51	70.60	74.99
Getting Care Quickly	87.13	89.28	91.28
How Well Doctors Communicate	92.10	95.12	94.09

* N/A= Denominator less than 30

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Accessibility of Services

The following information was taken from the MO HealthNet Managed Care health plans' SFY 2009 Annual Evaluations:

Blue Advantage Plus of Kansas City

Average Speed of Answer
Call Abandonment Rate

Telephone accessibility to members is monitored for call abandon rate and call wait time in queue (average time to answer). Performance is reported monthly to the BA+ Oversight Committee and Quality Council with recommendations for action when standards are not met. During FY2009, an average of 3,676 calls was received each month with an average membership of 27,938.

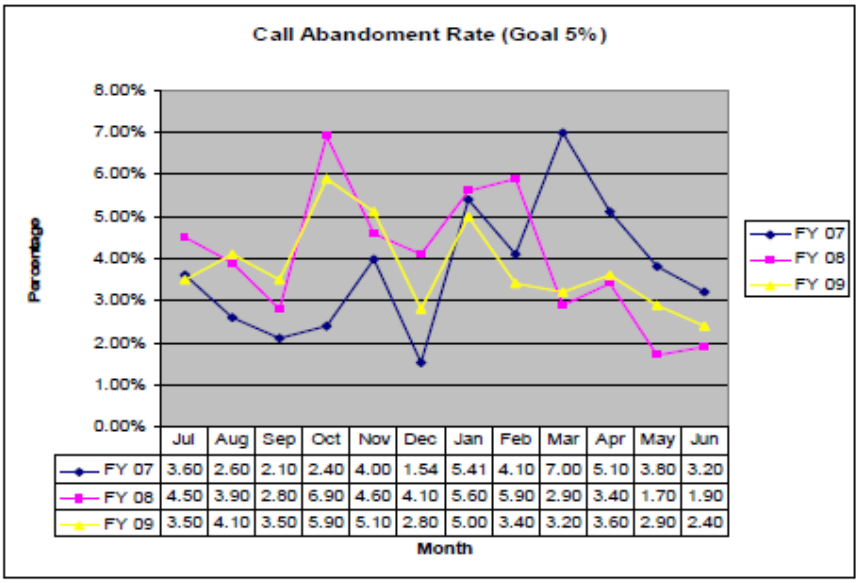
With the average speed to answer goal of no greater than 30 seconds during FY2009, callers waited an average of 31 seconds.

	SFY07	SFY08	SFY09
Call Wait Time (Goal: 30 Seconds)	30	27.5	31
Calls Received	37,875	42,943	44,117
Calls Handled	36,346	39,757	42,057

The call wait time of 31 seconds has increased since FY08 and is not within goal.
Inability to meet goal was attributed to the following.

- Increased membership.
- Lack of staff during the first half of FY09.

The goal for abandonment rate is not greater than 5%. Below is a graph indicating month-to-month call abandonment rates for SFY07, SFY08, and SFY09.



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
FY 07	3.60	2.60	2.10	2.40	4.00	1.54	5.41	4.10	7.00	5.10	3.80	3.20
FY 08	4.50	3.90	2.80	6.90	4.60	4.10	5.60	5.90	2.90	3.40	1.70	1.90
FY 09	3.50	4.10	3.50	5.90	5.10	2.80	5.00	3.40	3.20	3.60	2.90	2.40

During SFY09, the abandonment rate ranged from 2.4% to 5.9%. BA+ did not meet the 5% goal during October and November of SFY09, due to training of staff.

Non-Routine Needs Appointments
Routine Needs Appointments
BA+ maintains standards for appointment access for members to their primary care physician. These standards are formally developed and updated each year under the direction of the Quality Council.

BA+ monitors member appointment access to their physician for routine and urgent care. The standard states that members will receive an appointment for routine sick care within 5 calendar days and will receive an appointment for urgent sick care within 24 hours. The goal is to reach and maintain at least 80% compliance. Annual analysis is performed using CAHPS questions regarding the member's access to routine and urgent care as well as any oral or written complaints related to appointment access that are received by the Plan.

Results
BA+ members expressed satisfaction with the availability of routine sick care appointments 86.2% of the time and with urgent sick care 94.5% of the time. There was a statistically significant improvement in the member's satisfaction score for urgent sick care. No written or oral appointment access complaints were received during 2009.

Measure	Source	2009	2008	2007	QC 2009 Comm-ercial National Average	Significant Change 2008 to 2009
Routine Sick Care						
80% received routine appt as soon as wanted	Q6 CAHPS	**86.2%**	86.6%	84.4%	85.6%	No
Urgent Sick Care						
80% received urgent care as soon as needed	Q4 CAHPS	**94.5%**	87.6%	83.9%	88.6%	Yes, improvement

AFTER HOURS MEMBER ACCESS TO THEIR PHYSICIAN
BA+ maintains standards for member access to their primary care physician after regular business hours. The standard states that the primary care physician must provide 24 hours, seven days a week coverage to allow a member to talk with a physician for further guidance.

After hours calls were made by a Quality Department representative to 314 offices in the commercial HMO, Medicaid and Preferred-Care Blue products. Physicians included in the audit practiced in internal medicine, general practice, family practice or general pediatrics. This represents 2,662 primary physicians across the three products.
Results
87% (273) of physician offices were compliant with the standard. These offices gave their patients a method to contact a physician in the practice after the office was closed.

- 13% (41) of physician offices were not compliant with the standard.
- 17 offices directed the members to dial 911 or go to the nearest ED
- 8 offices called did not answer
- 8 offices had phone or message problems
- 6 offices did not give after-hours instructions how to contact the physician
- 2 offices had other reasons for non-compliance

A Quality Management representative will re-call the 41 non-compliant offices within the next three months. If the office remains non-compliant the office manager will be contacted to discuss a plan to reach compliance. If noncompliance continues to exist, a list of all the non-compliant offices will be sent to the Director of Provider Services at BCBSKC.

Access to Emergent and Urgent Care

Urgent Care Access – Urgent Care is available to members through many sources. BCBSKC has contracts with Take Care Health and Minute Clinics, as well as some provider offices to provide urgent care services for BCBSKC/BA+ members. BA+ continues to provide communication to members on how and where to find an urgent care center. BA+ members can find information on urgent care centers in the Member Handbook and the Well Aware newsletter. In addition an urgent care list is included in various member mailings.

Emergent Care Access – Members are informed of emergent care centers in the Member Handbook. The Member Handbook contains information on how and when to access emergent care. The HMO and PPO Appointment and Access Availability Standards are provided to providers annually through the Physician Office Guide.

	SFY07	SFY08	SFY09
# of ER visits	21,489	22,564	22,976
# of Members	11,258	11,989	12,456

BA+ has continued to experience an increase in ER utilization.

Network Adequacy – Provider/Enrollee Ratios

BA+ has positively affected the healthcare status of Missouri Medicaid members by providing ongoing monitoring of BCBSKC provider networks. BCBSKC monitors geographic availability, open panels, and appointment access.

2009 ANALYSIS OF BLUE-ADVANTAGE PLUS GEOGRAPHIC NETWORK AVAILABILITY

Purpose:

This evaluation is designed to assess geographic availability for Primary Care Physicians (PCP) and high volume specialties of Obstetrics (OB/GYN), Cardiologists, and Orthopedic Surgeons by BCBSKC members enrolled in BA+.

Conclusions:

BA+'s geographic network availability meets or exceeds performance standards for all availability standards measures, as detailed below:

a. The overall ratio of members to BA+ Primary Care physicians continues in 2009 to be well below the 500/1 ratio established by BCBSKC availability standards.

b. The percentage of members within the urban (Kansas City metro) area having access to at least two (2) Primary Care Physicians within an ten (10) mile radius exceeds the 90% urban standard performance goal for BA+ network.

c. The percentage of members within the basic/non-urban (suburban) service area having access to at least two (2) Primary Care Physicians within a twenty (20) mile radius exceeds the 90% basic/non-urban standard performance goal for the BA+ network.

d. The percentage of members within the rural service area having access to at least two (2) Primary Care Physicians within a thirty (30) mile radius exceeds the 90% rural standard performance goal for the BA+ network.

e. The percentage of women members 18 years old but less than 64 years of age within the urban, basic, and rural service areas having access to at least one (1) OB/GYN is well above the 90% standard performance goal for the BA+ network.

f. The percentage of members within the urban, basic, and rural service areas having access to at least one cardiologist and one orthopedic surgeon is 100% for all networks, well above the 90% standard performance goal for this high-volume specialty for all the BA+ network.

2009 ANALYSIS OF OPEN PRACTICES AVAILABILITY STANDARDS PERFORMANCE FOR BA+
BA+ evaluates the availability of PCPs with open practices. For 2009, 67% of PCP's are accepting new patients. BA+ is slightly below the 70% standard.

Evaluation results and recommendations are presented to the Quality Improvement Committee and Quality Council for review and further action as appropriate. An evaluation will be conducted in August, 2010 unless member complaints on access increase, prompting an earlier reevaluation.

24 Hour Access/After Hours Availability
BA+ provides a Nurse Advice Line to members 24 hours per day/7 days per week answered by a Registered Nurse. This Nurse Advice Line is available to direct members to receive care within the network.

The nurse line vendor also forwards reports weekly to the BCBSKC Case Management Department with information on any pregnant caller. These reports are then reviewed by the prenatal nurse coordinator for opportunities to enroll these members in the Little Stars Prenatal Program or refer them for more individualized follow-up by a case manager. The Nurse Advice Line may offer BA+ members the assistance that they need without having to incur an emergency room visit. In FY2009, 1,597 individual members utilized the Nurse Advice Line. Utilization increased by 22% in comparison to FY 2008 (1,308 individual members).

For FY2008, BA+ has not received any complaints from members in regards to accessing services after hours. BA+ maintains policies and procedures that assist with the timeliness of requests for services.

Open/Closed Panels

BCBSKC/BA+ conducts an annual geographic analysis of the physician network. To be compliant with BCBSKC standards, this analysis should show that at least 90% of members have access to at least two primary care physicians (PCPs) within 10 miles for members in the urban service area, within 20 miles for members in the basic service area, and within 30 miles for members within the rural service area. Below are the results of the analysis for the past three measurement periods.

Access to PCPs (at least 2)	2007	2008	2009
Within 10 miles in the urban service area	100%	100%	100%
Within 20 miles in the basic service area	99.6%	99.8%	99.9%
Within 30 miles in the rural service area	99.7%	99.5%	100%

BA+ has continued to exceed the PCP access standard of 90%, with the most recent results showing that 100% of members have access to PCPs in two out of the three categories.

In addition, BCBSKC monitors the ratio of members to physicians. Below are the standards and BA+'s results for 2007, 2008, and 2009.

	PCP			OB/GYN			Cardiology			Orthopedics		
			Members PER Physician			Members PER Physician			Members PER Physician			Members PER Physician
Plan Name	Members	Physicians	RATIO	*Members	Physicians	RATIO	Members	Physicians	RATIO	Members	Physicians	RATIO
HMO Standard			500			1,000			1,000			1,000
BA+ (2007)	27,858	321	86.79	5,072	117	42.97	27,858	86	323.93	27,858	31	898.65
BA+ (2008)	28,673	353	81.23	4,840	115	42.09	28,673	92	311.66	28,673	34	843.32
BA+ (2009)	29,220	367	79.62	5,222	108	48.35	29,220	91	321.10	29,220	41	712.68

* Population includes only women over 18 and under 64.

From 2007 to 2009, BA+ has seen an increase in the number of PCPs and the number Orthopedic Physicians, therefore decreasing the member to physician ratio.

Cultural Competency

Provider Network Composition – The current BA+ network is 60% female. The Missouri Standard Credentialing Application does not support providing information about the ethnic

background of providers. Providers do include the primary language spoken: Within the BA+ network, there are 982 providers and 62 speak languages other than English.

Interpretive Services – BCBSKC/BA+ uses the AT&T Language Line when a member speaks a language other than English. This allows BCBSKC staff the opportunity to communicate with members in their preferred language.

Translated Documents - BA+ has some documents in Spanish for those members who use Spanish as their preferred language.

NEW DIRECTIONS BEHAVIORAL HEALTH (NDBH)
Cultural Competency Activities – NDBH has been involved in the promotion of cultural competency for BCBSKC's provider networks since 2000 by promoting workshops and presentations for area health care professionals.

In CY2007, New Directions collaborated with two other organizations to present a culturally focused 4-hour workshop featuring a nationally recognized cognitive behavioral therapist.

In CY2008, New Directions presented several small workshops on cultural competency topics such as suicide awareness across population mixes, bullying and violence in school settings, and a major four hour workshop "Family Clinical Interventions for Adolescent Suicidality with Special Emphasis on Latinas: A Cultural Competency Perspective."

In CY2009, New Directions has begun a collaborative initiative with the University of Washington in St. Louis, school of social work to obtain a grant to study cultural implications in providing evidence based clinical services to members on an outpatient setting. Researchers at University of Washington will analyze the professional services approaches of select providers on the New Directions' panel. The grant initiative will include evaluation of present practices, education, observation and feedback components. The actual initiative is expected to begin in early CY2010.

In addition, in CY2009, New Directions has cosponsored luncheon workshops on challenges military veterans and their families face and a full day workshop on August 7, 2009 on Mindfulness-Based Cognitive Therapy.

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Further, New Directions continues to focus on a collaboration with local school district to provide immediate services for students counselors and social workers identify as having behavioral health issues and has facilitated an arrangement for a full service provider (outpatient to inpatient services) to provide on-site and in home services to the school district. Additionally, a collaborative initiative is underway with a non-profit organization, Kansas City Suicide Awareness and Prevention Programs (KC SAPP) to survey the district students around violence and suicide issues and to provide educational, preventive and timely individual services.

Requests to Change Practitioners
BA+ has established a standard operating procedure to allow a member to change their primary care provider. The standard operating procedure guides staff in assisting a member who wants to change their primary care provider. Children in COA 4 are allowed to change primary care providers as often as needed. Members who are not in COA 4 are allowed two PCP changes per calendar year. Members are informed of the process to change primary care providers in the Member Handbook.

Children's Mercy Family Health Partners

Customer Service Availability
Customer Service is 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.

Thirty percent of the Customer Service representatives are bilingual and all Spanish language calls are directed to these representatives first before going to a non-Spanish speaking representative. Should a representative not fluent in the member's preferred language need to answer the call, the customer service representative will then connect the member to Propio, our contracted language line service for a three way conversation.

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. 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.

The phone statistics and total calls for Fiscal Year 2009 are below. Many call centers will not count hang up calls up unless the caller is on hold for a specified amount of time. 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 (i.e., if a caller hangs up after 10 seconds, the call is counted in our service levels). CMFHP has an automatic call distribution system (ACD) to monitor and track our telephone statistics in the Customer Service Department. CMFHP measures telephone statistics for call abandonment rate and average speed of answer (ASA) rate on a daily basis and aggregates this information into a monthly report.

Average Speed of Answer
CMFHP's goal is for all calls to be answered within 30 seconds.

Total calls answered per quarter Fiscal Year 2008			
1st Quarter 7/1-9/30/07	**2nd Quarter 10/1-12/31/07**	**3rd Quarter 1/1-3/31/08**	**4th Quarter 4/1-6/30/08**
17,968	**16,184**	**17,836**	**15,853**

Average speed of answer per quarter Fiscal Year 2008			
12 seconds	**11 seconds**	**8 seconds**	**8 seconds**

Total calls answered per quarter Fiscal Year 2009			
1st Quarter 7/1-9/30/08	**2nd Quarter 10/1-12/31/08**	**3rd Quarter 1/1-3/31/09**	**4th Quarter 4/1-6/30/09**
16,991	**15,688**	**18,972**	**18,588**
Average speed of answer per quarter Fiscal Year 2009			
7 seconds	**7 seconds**	**11 seconds**	**12 seconds**

Call Abandonment Rate

CMFHP's goal is that for all calls, 5% or less will be abandoned.

Total Calls abandoned and abandonment percentage per quarter Fiscal Year 2007			
1st Quarter 7/1-9/30/06	**2nd Quarter 10/1-12/31/06**	**3rd Quarter 1/1-3/31/07**	**4th Quarter 4/1-6/30/07**
399 calls at 3.19%	**378 calls at 3.82%**	**463 calls at 7%**	**236 calls at 4%**
Total calls abandoned and abandonment percentage per quarter Fiscal Year 2008			
1st Quarter 7/1-9/30/07	**2nd Quarter 10/1-12/31/07**	**3rd Quarter 1/1-3/31/08**	**4th Quarter 4/1-6/30/08**
901 calls at 4%	**600 calls at 3%**	**691 calls at 3%**	**432 calls at 2%**

CMFHP has been consistent in meeting goals for calls abandoned as well as average speed of answer. In January 2007, CMFHP implemented a new telephone system. This system allows us to more efficiently answer, monitor and route calls from members and providers and provide improved quality control. In Fiscal Year 2009, even with an increase in call volume, all phone statistics were met consistently for the 12 month period.

Routine Needs Appointments

Children's Mercy Family Health Partners informs and monitors participating providers' compliance with the guidelines for routine appointment availability. This is completed through the re-credentialing process, the Customer Service department, the member grievance system, and the provider complaint, grievance, and appeal processes. During Fiscal Year 2009, there were no significant issues identified with members being unable to access providers for routine appointment needs.

Overall, the Children's Mercy Family Health Partners' network of providers are compliant with the appointment access standards and deliver care to our members on a timely and consistent basis.

Non-Routine Appointment Needs and Access to Emergent and Urgent Care

Children's Mercy Family Health Partners' policy addresses non-routine appointment needs as follows:

- Routine Care, without symptoms – within 30 days from the time the enrollee contacts the provider

- Routine Care, with symptoms – within 5 business days from the time the enrollee contacts the provider
- Urgent Care for illnesses/injuries which require care immediately, but which do not constitute emergencies as defined by 354.600, RSMo – within twenty-four hours from the time the enrollee contacts the provider
- Emergency Care – a provider must be available twenty four hours per day, seven days per week, however our literature and customer service representatives and Nurse Advice instruct enrollees to seek care at the nearest emergency room or call 911 in the event of a health care emergency.
- Obstetrical Care – within 1 week for enrollees in the first or second trimester of pregnancy; within three days for enrollees in the third trimester

Monitoring Access to Care
During Fiscal year 2009, in the re-credentialing process, CMFHP routinely reviewed each office's procedures for scheduling appointments. During the review process, no deficiencies were noted. In addition, our Provider Administrative Manual outlines the appointment standards. Finally, through our Customer Service department, no significant trends were noted in complaints from members who were unable to access the participating provider network for non-routine appointments.

Internal Standards, Process Improvement and Projects
In Fiscal Year 2009, the following enhancements to improve quality within the Customer Relations department were implemented:

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 have made 2,960 outbound attempts and have contacted 808 members (27.30%). This program has shown a 96.63% 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 administer an automated Post Call Satisfaction Survey through our phone system. 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 since this program started in December of 2008 are 96% with 1,834 members completed the survey (as of 10/31/09).

Plastic Key Fob for Key Ring and Magnet
CMFHP developed a combination removable key fob and refrigerator magnet with important telephone numbers and the well child periodicity schedule. This is distributed to members in the new member enrollment packets. The plastic key fobs contain key phone numbers, such as the transportation vendor, Customer Service, and the 24 hour nurse advice line in both English and Spanish. The fobs can be placed on a key ring for handy reference. The magnet also has a place to enter PCP name and contact information.

Website
A new CMFHP website was designed and implemented December 2008. The new design enhances CMFHP's branding elements. The new site also features quotes from members that illustrate our commitment to customer service. The home page has our "Who We Are and What We Do" statement, allowing visitors to get an understanding of the CMFHP mission.

Some of the web functionality includes:

- Portals for our three audiences - members, providers and member advocates - are on the home page. There are also links to frequently used items on the home page, such as:
  - for members, links to find providers and health resources
  - for providers, links to the secure login page and claim adjustments
  - for member advocates, links to events and recent newsletters

- The member section features detailed information about benefits offered by CMFHP, including transportation, the 24-Hour Nurse Advice Line, urgent care (along with a map of urgent care facilities) and how to maintain coverage. Links to find or change a primary care provider are on every member page. Member handbooks are online as PDF files and as cross-referenced HTML links. Members can also change their PCP on the website.

- Spanish content was added in March 2009 for all member materials.

- An eligibility section explains the difference between state eligibility and CMFHP enrollment. Also, links to applications and CMFHP literature are available.

- A Health Resources section features podcasts, articles on health topics, information about coaching programs, and links to additional online resources. The HeLP healthy lifestyles, Lead Poisoning Prevention and Asthma Management programs are highlighted here.

- Online provider tools include Prior Authorization forms, practice change forms, and contact information for provider relations. There is also a Provider Announcements section that displays the current date and time, and any provider specific updates. All of this creates one

location with several basic provider office functions, allowing access to more information without requiring multiple steps. Providers can also print member ID cards from the website.

- Provider directories are available on line as a PDF file and as a searchable real-time provider directory.

- The member advocate section of the site features an expanded event listing, up-to-date newsletters and information on presentations and Continuing Education Units.

Audio Programs
CMFHP provides several audio programs that highlight our health initiatives and disease management programs. The intent of the audio programs is to educate our members on their benefits and programs available to help them manage their health. Knowing that portions of our membership have a low literacy level, we are optimistic that members will take advantage of the ability to listen to information rather than read that same information. The programs are available for listening on the website, downloading to a computer, or the member can request a CD that can be mailed to him/her. These CDs are also distributed at community events. The information is recorded in an interview format with subject matter experts explaining the topic and covering frequently asked questions regarding the topic. To date, topics available on the website include: Non-Emergency Transportation, our Healthy Lifestyles (HeLP) program on childhood obesity, our First Touch OB program, our Lead Management program and our Asthma program. We are in the process of translating these programs into Spanish with a goal to have all of them recorded by Q2 of 2010.

Network Adequacy – Provider/Enrollee Ratios
Children's Mercy Family Health Partners (CMFHP) filed its network composition with the State of Missouri Department of Insurance, as required in RSMo 354.603 and 20 CSR 400-7.095, by March 1, 2009. The State reviewed the CMFHP network and indicated the Children's Mercy Family Health Partners network was in compliance with the regulations that require the provision of adequate access to care.

Specifically, the overall results were:

Primary Care Physicians	100% overall compliance
Specialists	100% overall compliance
Facilities	100% overall compliance
Ancillary Services	99% overall compliance
Overall	100%

Compliance with the above categories by the Western Region counties was:

County	PCP Rate of Compliance	Specialist Rate of Compliance	Facilities Rate of Compliance	Ancillary Services Rate of Compliance	Overall Network Compliance
Bates	100%	100%	100%	100%	100%
Cass	100%	100%	100%	100%	100%
Cedar	100%	100%	100%	100%	100%
Clay	100%	98%	100%	100%	100%

Henry	100%	100%	100%	100%	100%
Jackson	100%	99%	100%	100%	100%
Johnson	100%	100%	100%	100%	100%
Lafayette	100%	100%	100%	100%	100%
Platte	100%	100%	100%	100%	100%
Polk	100%	97%	100%	100%	99%
Ray	100%	100%	100%	100%	100%
St. Clair	100%	100%	100%	100%	100%
Vernon	100%	100%	100%	80%	95%

24 Hour Access/After Hours Availability

On an annual basis, Children's Mercy Family Health Partners Provider Relations department conducts a telephonic survey to determine how our Primary Care Provider offices handle their availability after normal business hours. All PCP offices are monitored on their contractual obligation to provide access to their assigned members 24 hours a day, 7 days per week. For the purposes of this measurement, CMFHP defines normal business hours as between 9:00 a.m. and 5:00 p.m, Monday through Friday. Our PCP offices were contacted after routine business hours to determine compliance with this requirement. These access monitoring calls were made to one hundred percent of our Primary Care Providers using the information from our credentialing database. The CMFHP verified that appropriate instructions for after hours care was provided when the office is closed. All offices were scored on their afterhours coverage using the following scoring system:

1= office is fully compliant, no additional follow up required
2= office is partially complaint, additional information needed to ensure office is compliant
3= office is non compliant

An office was considered compliant and given a score of one (1) if any one of the following situation(s) occurred:

- call is answered by an answering service or nurse advice line
- call is forwarded to a pager or a direct access telephone number for the provider is given
- call is automatically transferred to the hospital operator
- answering machine tells member how to contact the provider on call, gives a phone number of a local hospital to contact for assistance, or gives the telephone number of the provider on call

Offices that were deemed non-compliant were assigned a numerical score of three (3). An office was considered non-compliant if any one of the following situation(s) occurred:

- call is not answered
- answering machine only tells the caller to call "911"
- answering machine advises caller to call back during business hours
- answering machine message does not provide information for the caller to contact someone for medical advice

Offices that did not meet the above criteria of a score of one (1) or three (3) were deemed partially compliant and were assigned a numerical score of two (2). This included offices where the caller had an option to leave a message for the provider. Providers with a score of 2 were contacted by the Provider Relations Representative to obtain a better understanding of the afterhours coverage system. This additional information was used to determine if the provider should then be scored as a one (1) or a three (3).

All 235 Primary Care offices were surveyed. Initially 233 scored a one and were fully compliant. Two offices scored a two and after further investigation were determined to be a scored a one, and fully compliant. All CMFHP providers provided adequate after hour availability, twenty-four hours a day/7 days per week.

CMFHP monitors member access to primary care providers by monitoring customer service complaints, and monitoring member grievances related to access concerns. During July 1, 2008 through June 30, 2009, there were no significant issues identified with member access to providers.

Nurse Advice - Program Review
Children's Mercy Family Health Partners (CMFHP) recognizes the importance to members of having access and availability to appropriate medical advice. CMFHP has a 24 hour-a-day/7 day-a-week Nurse Advice Line. Members or member parents are encouraged to call the nurse advice line for questions, concerns and supportive information related to non-emergent care for themselves or their children.

Since 1997, CMFHP has coordinated the afterhours program with Children's Mercy Hospital Nurse Advice Line and McKesson Health Solutions Call Center.

Data and Trends
CMFHP meets quarterly with both vendors. The Nurse Advice oversight committee meetings include an overview of standard call center statistics and benchmarks. In addition, CMFHP reviews the inbound and outbound reports, member redirection reports, demographics report and algorithm utilization.

The following items are a 12 month summary of the results reported at the quarterly oversight meetings (date – date):

- Adult call center Average Speed to Answer within 30 seconds: 89%
- Pediatric call center Average Speed to Answer within 30 seconds: 100%
    - Additional information demonstrates all calls are answered in less than 4 seconds and an average length of call of 11.8 minutes
- Pediatric Inbound calls: 7227 calls
- Adult Inbound calls: 1984 calls
- Pediatric Outbound calls: 1786 calls
- Welcome Call outbound calls: 1173 calls
- Pediatric member redirections:
    - 60% for home care;

    - 32% for appointment with healthcare professional;
    - 4% urgent care; and
    - 4% for professional advice
- Adult member redirections:
    - 40% for professional advice;
    - 24% self care; 15% urgent care;
    - 10% for appointment with healthcare professional; and
    - 11% for ER
- Callers for pediatric nurse advice were evenly divided between male and female
- 70% of pediatric calls were for members between the ages 0 to 5 years
- Callers for adult nurse advice services were dominantly female (87.31%)
- 76% of adult care callers were between the ages of 18-44
- The pediatric top five algorithms were: colds; cough; fever; asthma attack; vomiting
- The adult top five algorithms were: upper respiratory infection; pregnancy suspected labor; pregnancy vaginal bleeding; abdominal pain; and chest pain.

Analysis
CMFHP's Nurse Advice Call Centers received an increased number of calls in the FY2009. Nurse Advice Call Centers received and resolved member inquiries within anticipated timeframes. CMFHP received no member grievances regarding Nurse Advice Call Centers.

- CMFHP identified a spike in call volume related to the H1N1 outbreak in Spring 2009.
- CMFHP issued key fobs with the nurse advice number in new member welcome packets to increase awareness of this service.
- Pediatric outbound calls increased due to an initiative by Children's Mercy Hospital to obtain pre-appointment medical records and medication histories. This supports the hospital's effort to facilitate efficient and effective appointment time within its clinics.
- Call abandonment rate and speed to answer were both well within the acceptable ranges for the year.

Strengths
CMFHP utilizes two established and consistent nurse advice call centers to address adult and child illnesses.

Weaknesses
CMFHP identified no weaknesses within this program during the reporting period.

Opportunities
CMFHP uses the analysis of complaints, grievances and appeals as a mechanism to identify areas for improvement. No member or provider grievances were received in FY2009 related to the nurse advice call centers.

Children's Mercy Family Health Partners continues to monitor the effectiveness of the nurse advice call centers and to work with each of the vendors to identify initiatives that will result in process improvement.

Open/Closed Panels
Children's Mercy Family Health Partners tracks open/closed provider panels monthly. However, since State enrollment and eligibility is performed on a daily basis, CMFHP recognizes the need to ensure that the data are current when members select a Primary Care Provider (PCP).

During July 1, 2008 to June 30, 2009, CMFHP had 523 PCPs in our network. Of those providers, 52, or 10%, had closed panels (14 pediatricians, 30 family practice, 6 internal medicine, 1 general practice, and 1 nurse practitioner). With an open panel rate of 90%, CMFHP meets our internal quality goal of an 85% or higher open panel rate.

One of the primary roles of the provider relations staff is to recruit and maintain an available and accessible provider network. The staff encourages providers to have their practices open to CMFHP members. The staff also looks for opportunities to recruit new primary care providers into the CMFHP network. We increased our Primary Care Provider participation by 56 providers during the July 2009 to June 2009 time period.

All CMFHP staff has access to the Cactus provider data base, which contains the most current provider panel status. This enables staff to provide timely and accurate information to our members who call the health plan for information about a PCP's availability. Our web site has an on-line provider directory that is created from the Cactus database, thus giving members access to the most current provider information.

Cultural Competency
Children's Mercy Family Health Partners has initiated an innovative outreach that utilizes cooperation with stakeholders and local public health agencies to reach all cultural populations within the Western region.

With numerous cultural populations living in the Kansas City area, education was needed on differing cultural beliefs and practices, particularly as they relate to health care. This education would help increase awareness and understanding of local cultural populations and ultimately help reduce any potential health care disparities within the CMFHP membership and throughout the Western region.

A close look at Kansas City area demographics compiled during the 2000 U.S. Census revealed an increase in the number and the diversity of cultural populations. In 2000, nineteen cultural populations were represented in the Kansas City area with at least 500 individuals from that cultural background. Contact with the local public health agencies confirmed this increase. CMFHP staff and its provider network needed increased awareness and understanding of cultural populations present within our membership.

Effective communication of CMFHP services was necessary for all families in the area (including current members); this communication needed to be culturally sensitive to the background of the member.
CMFHP identified the following interventions to address the above findings, with the added intent to reduce the possibility of racial and ethnic health care delivery disparities:

- In 2006, we began utilizing the services of two full-time bilingual Community Relations representatives to enhance the education of the Spanish speaking community within the Western region about CMFHP services. We still have two full-time bilingual Community Relations representatives and 30% of our Customer Service telephonic team are fluent in Spanish and English.
- Use of communication materials to explain MO HealthNet managed care and CMFHP services. The materials are disseminated to families located in the Western region who visit local public health agencies. These include brochures in English and Spanish, MO HealthNet applications in English and Spanish and audio health topics on CD (soon to be in Spanish).
- Communication materials on CMFHP services were distributed at local public health agencies to immigrant families living in the Western Region. These materials include brochures in English and Spanish , MO HealthNet applications in English and Spanish and the member handbook in English and Spanish,
- The CMFHP website was updated to include a Spanish section containing marketing materials, health information and the member handbook.
- Communication materials were made available for all members, regardless of background or physical condition, including but not limited to:

  ~ Propio Language Line for members with limited English proficiency
  ~ Member handbook and other member materials in Spanish language
  ~ TTY/TDD services for hearing impaired members
  ~ Member materials (including handbook) in alternative formats (including CD's) for visually impaired members upon request.
  ~ Bilingual member newsletters
- Held Diversity training in conjunction with Children's Mercy Hospital to educate our staff on managing diversity within our organization.
- Educated staff and providers using the Cross-Cultural Health Care Resource Guide that contains topics such as:

  ~ Background and history of 19 cultures
  ~ Health beliefs and practices
  ~ Communication style
  ~ Religion
  ~ Languages spoken
  ~ Family structure
  ~ Food practices/diet
  ~ Children's issues

Through our outreach efforts at local public health agencies and other community locations, we reached a large number of cultural backgrounds with information on MO HealthNet managed care and Children's Mercy Family Health Partners. We will continue our outreach efforts and make material available to anyone in the community from varied cultures and backgrounds. The Cross-Cultural Health Resource Guide has been a valuable education tool for both staff and providers and has encouraged culturally sensitive health care. We have distributed more than 20,000 guides in 2008 and 2009 and continue to receive additional requests throughout the health

care community. CMFHP is currently working with Children's Mercy Hospital to update this resource guide and the revised version will be available for distribution in 2010.

Requests to Change Practitioners

Children's Mercy Family Health Partners (CMFHP) allows members to change primary care providers (PCP) at any time. CMFHP does monitor members who change PCPs more than five (5) times to ensure that members aren't abusing benefits or services; however it has discovered limited abusive practices from this report.

Members can change PCP's via the CMFHP web site or by calling Customer Service. For new members, a PCP change card is included in the welcome packet that can also be completed and mailed to CMFHP for a PCP change.

Harmony Health Plan of Missouri

Average Speed of Answer

Call Abandonment Rate

Harmony's Member Service department posted solid results for both the Average Speed of Answer (ASA) and Call Abandon Rate metrics for the 2008-2009 contract year. Compared to the to the 2007-2008 contract year, the ASA and call abandonment increased slightly from 17 to 21 seconds and from 2.1% to 2.4%. A service level requirement has been introduced starting with the 2009-2010 contract year which requires 90% of all calls to be answered in 30 seconds or less. This should decrease the ASA and call abandonment rate and should have a positive impact on accessibility into the Member Service department.

MO Medicaid-Member	Jul-07	Aug-07	Sep-07	Oct-07	Nov-07	Dec-07	Jan-08	Feb-08	Mar-08	Apr-08	May-08	Jun-08	**2007-2008 Totals**
Accepted Calls	595	643	626	769	877	984	1684	1367	1302	1256	1143	1090	**12336**
Answered Calls	585	631	613	761	850	966	1660	1340	1280	1207	1110	1072	**12075**
Abandoned Calls	10	12	13	8	27	18	24	27	22	49	33	18	**261**
Average Speed of Answer	14	14	15	15	18	17	15	15	14	24	21	21	**17**
Abandoned Call Rate	1.7%	1.9%	2.1%	1.0%	3.1%	1.8%	1.4%	2.0%	1.7%	3.9%	2.9%	1.7%	**2.1%**

MO Medicaid-Member	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09	Apr-09	May-09	Jun-09	**2008-2009 Totals**
Accepted Calls	1319	1300	1526	1565	1225	1352	1644	1284	1480	1566	1384	1527	**17172**
Answered Calls	1271	1259	1496	1509	1194	1312	1612	1270	1448	1532	1357	1506	**16766**
Abandoned Calls	48	41	30	56	31	40	32	14	32	34	27	21	**406**
Average Speed of Answer	24	27	22	27	23	23	15	15	26	18	18	18	**21**
Abandoned Call Rate	3.6%	3.2%	2.0%	3.6%	2.5%	3.0%	1.9%	1.1%	2.2%	2.2%	2.0%	1.4%	**2.4%**

Non-Routine Needs Appointments
Routine Needs Appointments

Availability & Accessibility
Timely Access Report

COMPANY:	Missouri (Medicaid)	
REGION(S):	All	
AUDIT INTERVAL:	Semi-Annual I	
AUDIT REPORTING PERIOD:	2008 Round 1	
LINE OF BUSINESS:	MMD	
AUDIT DATE(S):	November- December 2008	
APPOINTMENT STANDARDS:	PCP Urgent Sick Care:	</= 24 hrs.
	PCP Sick Care:	</= 5 days
	PCP Routine Well Care:	</= 30 Days
	PED Urgent Sick Care:	</= 24 hrs.
	PED Sick Care:	</= 1 week
	PED Routine Care:	</= 3 weeks
	OBGYN 1st Tri:	</= 7 days
	OBGYN 2nd Tri:	</= 7 days
	OBGYN 3rd Tri:	</= 3 days
	OBGYN High Risk:	</= 3 days
	GYN Only:	</= 30 Days
	Specialist Appt.:	</= 30 Days

METHODOLOGY SUMMARY:

- WellCare currently uses The Results Companies, Inc., an outside vendor, to complete the Accessibility and Availability audits.

- Audits are performed annually and consisted of two rounds which are defined as follows:
    - Round 1 is also known as the initial round. This is when the audit first commences.
    - Round 2 represents the re-audit of all active providers found to be noncompliant during Round 1.

- The Missouri Health Plan population is comprised of physician PCPs, OB/GYNs and Specialists. PCPs are defined as providers with a primary specialty type of Family Practice, Internal Medicine, Pediatrics and General Practice. They must be identified as a PCP provider in Peradigm and have an active contract as a participating provider on the 1st day of the month following the day of the population extract.

- The Missouri Medicaid OB/GYN population consists of physician OB/GYN providers. They must be identified as "OB/GYN", "OBS" or "GYNE" specialists in Peradigm and have an active contract as a participating provider on the 1st day of the month following the day of the population extract.

FINDINGS:

Quality Standard	Benchmark	Round 1
PCP Adult (urgent-sick visit)	24 hours	79.2%
PCP Adult (sick visit)	5 days	89.6%
PCP Adult (routine visit)	30 days	97.9%
GYN Only	30 days	100%
1st Trimester	7 days	12.5%
2nd Trimester	7 days	37.5%
3rd Trimester	3 days	37.5%
High Risk	3 days	50%
After-Hours	Various	66.9%

ANALYSIS OF FINDINGS:

- Of the 48 Primary Care Providers only 79.2% of the providers were in compliance with the urgent care. 89.6% were in compliance with the sick care and over 97.9% were compliant with the routine care availability standards.
- 100% were compliant for GYN only appointment availability. 12.5% were in compliance with the first trimester, 37.5% were in compliance for the second trimester and 37.5% complied with the third trimester availability standards.
- 121 Primary Care Providers were audited under the after-hours availability standards and 66.9% were in compliance.

CORRECTIVE ACTION PLAN FOR NON-COMPLIANT PROVIDERS:

- WellCare Provider Relations Representatives will make every effort to contact each non-compliant provider to explain the audit results and re-enforce the need to comply with the appointment availability & accessibility standards.

- For any provider found to be out of compliance as a result of the second audit, a written notification will be sent requesting their corrective action plan within 30-days of receipt of our communication.

- Those providers identified as being noncompliant for the second time, and who fail to respond to WellCare's request for a corrective action plan, will be referred to the Missouri Medical Director and the WellCare Provider Relations Director for further contact and additional action.

- Those providers who provide an acceptable corrective action plan, written notification will be sent confirming that sufficient documentation has been provided and their status will then be changed from noncompliant to compliant.

ACTIONS TO IMPROVE PROCESS

- Provider Relations is responsible for researching and resolving provider demographic discrepancies such as "no longer with office", "no longer with plan", "wrong number", etc. that result in an incomplete call.

- Provider Relations is responsible for educating providers on their contractual obligation and adherence to availability standards as set forth in the WellCare Provider Manuals.

Operations Compliance will continue to identify opportunities to streamline the audit process to improve efficiency and accuracy

Access to Emergent and Urgent Care

Harmony has established contractual relationships with providers in each of the twelve eastern region counties and St. Louis City. Though the network is sufficient by all requirements put forth by state of MO, Division of Insurance, regarding primary care providers and hospitals, Harmony will continue to identify areas for continued growth based upon the Plan's review of the network.

As required by the contract, Harmony members may obtain emergency services without prior authorization at any hospital facility. Harmony continues to establish contracting opportunities with urgent care facilities in order to increase urgent care availability to our members. Additionally, Harmony has been reviewing our open/closed panel reports and PCP availability and accessibility reports to identify potential urgent care access issues. Upon identification of a non-compliant provider, Harmony educates the provider and follows the corrective action plan protocol identified under the Non-Routine and Routine needs appointments section of this Annual Report.

Harmony will continue contracting efforts to grow the network to further improve urgent care access for our membership.

Network Adequacy – Provider/Enrollee Ratios

Harmony has established contractual relationships with providers in each of the 14 eastern region counties and St. Louis City. Though the network is sufficient by all requirements put forth by state of MO, Division of Insurance, Harmony continues to identify areas for continued growth based upon the Plan's review of the network under the following metrics:

a. Eligibles to specialist ratio vs. our target membership to specialist ratio
b. Distance/drive time showing all-sufficient
c. Referral patterns of the PCPs

Harmony's current provider/enrollee ratio as of June 30k 2009 is 17 members to every one PCP. This ratio was derived from the membership of 14,967 and a PCP network of 386 as of June 30, 2009.

24 Hour Access/After Hours Availability

Access and Availability Audit Results
(Harmony did not provide an analysis)

STATE:	**Missouri**		*Created/Revised Date:*	*04/17/2009*
MARKET:	**All**			
LINE OF BUSINESS:	**Medicaid (MMD)**			
APPOINTMENT STANDARDS:	**PCP Urgent Sick Care:**	</= 24 hrs.	**OBGYN 1st Tri:**	</= 7 days
	PCP Sick Care:	</= 5 days	**OBGYN 2nd Tri:**	</= 7 days
	PCP Routine Well Care:	</= 30 Days	**OBGYN 3rd Tri:**	</= 3 days
	PED Urgent Sick Care:	</= 24 hrs.	**OBGYN High Risk:**	</= 3 days
	PED Sick Care:	</= 1 week	**GYN Only:**	</= 30 Days
	PED Routine Care:	</= 3 weeks	**Specialist Appt.:**	</= 30 Days

Statistically Valid Sample Size	**Benchmark / Sample Size**
PCP Adult	**159**
OB/GYN	**40**
After hours	**159**
Total	**358**

	ROUND 1	
Audit Results for Appointment Availability:	**Count**	**% Completed**
PCP Adult - Total Calls Complete	48	30.2%
PCP Adult - Total Calls Incomplete	107	67.3%
OB/GYN - Total Calls Complete	8	20.0%
OB/GYN - Total Calls Incomplete	32	80.0%
Audit Results for After Hours:	**Count**	**% Completed**
Total Calls Complete	121	76.1%
Total Calls Incomplete	34	21.4%

AUDIT INTERVAL:	**Semi I**
AUDIT DATE:	**November 2008**
AUDIT REPORTING PERIOD:	**Round 1**

Appointment Availability

Audit Details:	Count Initial Audit	% Initial Audit (Round 1)
PCP Adult		
Total Calls Complete	**48**	
Urgent Sick Care Pass	38	79.2%
Urgent Sick Care Fail	10	20.8%
Sick Care Pass	43	89.6%
Sick Care Fail	5	10.4%
Routine Well Care Pass	47	97.9%
Routine Well Care Fail	1	2.1%
Reasons for Incomplete Calls		
Total Calls Incomplete	**107**	
Disconnect	6	5.6%
Do Not Call	0	0.0%
Fax/Modem	0	0.0%
Hang Up	0	0.0%
HOSPITAL/ER Office	0	0.0%
Language Barrier	0	0.0%
Max Attempts (3 attempts)	77	72.0%
No Longer with Office	6	5.6%
No Longer with Plan	1	0.9%
Cell phone	1	0.9%
Refused to Answer Audit	14	13.1%
Wrong Number	2	1.9%

OB/GYN		
Total Calls Complete	**8**	
GYN Only Pass	8	100.0%
GYN Only Fail	0	0.0%
1st Trimester Pass	1	12.5%
1st Trimester Fail	6	75.0%
2nd Trimester Pass	3	37.5%

2nd Trimester Fail	4	50.0%
3rd Trimester Pass	3	37.5%
3rd Trimester Fail	4	50.0%
High Risk Pass	4	50.0%
High Risk Fail	3	37.5%
Reasons for Incomplete Calls		
Total Calls Incomplete	**32**	
Disconnect	2	6.3%
Do Not Call	0	0.0%
Fax/Modem	0	0.0%
Hang Up	0	0.0%
HOSPITAL/ER Office	6	18.8%
Max Attempts (3 attempts)	19	59.4%
No Longer with Office	1	3.1%
No Longer with Plan	1	3.1%
Privacy Guard	0	0.0%
Refused to Answer Audit	0	0.0%
Wrong Number	3	9.4%
After Hours - Total Sample Size:	**155**	
Audit Details:	**Count Initial Audit**	**% Initial Audit (Round 1)**
Total Calls Completed:	**121**	
After Hours Pass	81	66.9%
After Hours Fail	40	33.1%
Audit Details:	**Count Initial Audit**	**% Initial Audit (Round 1)**
Total Calls Completed:	**121**	
Answering service that will page PCP or on-call physician for a member (Live Contact) / **PASS**	18	14.9%
Advice Nurse with access to PCP or on call physician (Live Contact) / **PASS**	0	0.0%
Answering system with option to page physician / **PASS**	40	33.1%
Answering system that pages provider once number is left /	0	0.0%

PASS		
Message that provides number to page physician / **PASS**	23	19.0%
Answering system that only takes a message / **FAIL**	3	2.5%
Answering service that is unable to reach provider or on-call physician / **FAIL**	0	0.0%
Advise nurse without access to the PCP or on-call physician / **FAIL**	0	0.0%
A message that recommends calling during business hours / **FAIL**	24	19.8%
A message recommending treatment through the E.R. / **FAIL**	6	5.0%
Recommends going to Urgent Care or E.R. because there is no after-hours access to PCP or on-call physician / **FAIL**	1	0.8%
A message recommending a participating care center that is not open 24 hours / **FAIL**	0	0.0%
A message to contact a participating Urgent Care Center / **FAIL**	6	5.0%
Reasons for Incomplete Calls		
Total Calls Incomplete:	**34**	
Disconnect	6	17.6%
Do Not Call	0	0.0%
Fax/Modem	0	0.0%
Hang Up	5	14.7%
HOSPITAL/ER Office	0	0.0%
Language Barrier	0	0.0%
Max Attempts (3 attempts)	20	58.8%
No Longer with Office	1	2.9%
No Longer with Plan	1	2.9%
Privacy Guard	0	0.0%
Refused to Answer Audit	0	0.0%
Wrong Number	1	2.9%

Open/Closed Panels

Harmony has established contractual relationships with providers in each of the twelve eastern region counties and St. Louis City. Though the network is sufficient by all requirements put forth by state of MO, Division of Insurance, regarding primary care providers and hospitals, Harmony will continue to identify areas for continued growth based upon the Plan's review of the network under the following metrics:

a. Eligibles to specialist ratio vs. our target membership to specialist ratio
b. Distance/drive time showing all-sufficient
c. Referral patterns of the PCPs

Harmony has processes to support monitoring of provider access to members for availability 24 hours a day, 7 days a week. Harmony actively recruits nurse practitioners for inclusion in the provider network. Mental health and substance abuse providers, as well as dental, pharmacies, emergent and non-emergent transportation providers meet the standards as put forth by the state of MO, Division of Insurance.

Harmony Heal Plan of Missouri (MMD)	
As of 06/30/09	
Total PCP	389
# of PCP Sites	619
PCP Open Panel	97%
PCP Closed Panel	3%
Total SPEC	1,753

Cultural Competency

WellCare has a Cultural Competency Program that is modeled on the CLAS standards promulgated by HHS's Office of Minority Health. Our program's goals are to meet the unique and diverse needs of all members, ensure that the staff of WellCare and its vendors value diversity within the organization and for its members, and ensure that members with limited English proficiency have their communication needs met. In addition, WellCare is committed to ensuring that our providers fully recognize and care for the culturally diverse needs of the members they serve.

Cultural competency is a key component of WellCare's continuous quality improvement efforts. We expect to realize tangible gains in member satisfaction and health outcomes resulting from the measures set forth in this plan. Both of these aims tie directly to the fundamental mission of our company

The specific objectives of WellCare's Cultural Competency Program are to:

- Identify members that face cultural or linguistic barriers for which alternative communication methods are needed;
- Utilize culturally sensitive and appropriate educational materials based on members' race, ethnicity and primary language spoken;
- Make resources available to meet the language and communication barriers that confront members;
- Ensure providers care for and recognize the culturally diverse needs of the population;
- Ensure WellCare employees and vendors are educated and value the diverse cultural and linguistic differences within WellCare and the populations we serve.

Purpose

The Cultural Competency program aims to ensure that:

- WellCare meets the unique diverse needs of all members in the population.
- The staff of WellCare value diversity within the organization and for the members that the plan serves.
- Members with limited English proficiency have their communication needs met.
- Our provider partners fully recognize and are sensitive to the cultural and linguistic differences of the WellCare members they serve.

Objectives

The objectives of the Cultural Competency program are to:

- Identify members that may have cultural or linguistic barriers for which alternative communication methods are needed.
- Utilize culturally sensitive and appropriate educational materials based on the member's race, ethnicity and primary language spoken.
- Ensure that resources are available to overcome the language barriers and communication barriers that exist in the member population.
- Make certain that providers care for and recognize the culturally diverse needs of the population.
- Teach staff to value the diversity of both their co-workers inside the organization and the population served, and to behave accordingly.

Plan Components

The main components of WellCare's Cultural Competency program are:

1. **Needs Assessment** – Activities we conduct to identify the cultural and linguistic needs of the communities and members we serve, as well as health disparities present in the enrolled population and the community at large.

2. **Organizational Readiness** – Steps WellCare takes to make certain that the health plan has the platforms, systems, and people skills needed to operate in a culturally competent manner.

3. **Program Development** – The implementation of programs to link WellCare to community resources, to enhance the cultural and linguistic capabilities of our provider partners, and to educate members so that their experience with the health system is more positive and their health outcomes are more favorable.

4. **Performance Improvement** – Ongoing identification of opportunities to improve the operation of the Cultural Competency program, or to improve health outcomes through new responses to cultural and linguistic needs of members.

Multilingual Service

Missouri Interpreter Services Process

Customer Service Representatives may receive a call from a member or provider requesting the use of an interpreter when a member has an appointment with a health care provider.

Harmony will utilize LAMP to provide language interpretation and Deaf Interlink for hearing impaired individuals.

To Access Language Interpretation Services

- If a provider is calling for interpretation services please give them the telephone number to LAMP, 314-842-0062. Ask the provider to call LAMP directly to coordinate the services.
- If a member is calling for interpretation services obtain their provider's name and number. Inform the member that you will contact the provider to coordinate the services and that the provider's office will call the member with an appointment. Contact the provider and give the telephone number to LAMP. Ask the provider to coordinate the services

To Access Interpreter Services for Hearing Impaired Members

- If a provider is calling place a conference call with Deaf Interlink at 314-837-7757 to schedule an interpreter.
- If the member is calling obtain the provider's telephone number and place a conference call with Deaf Interlink and the provider to schedule the services. Contact the caller with an appointment time if necessary after the conference call.

- Inform Deaf Interlink that Harmony Health Plan has previously used their services. The billing address is 23 Public Square, Belleville, IL 60220
- Contact Karen or Steve if there is any difficulty scheduling the services.

In addition to providing interpreter services in the physician offices, Harmony has an established a separate phone queue for individuals whose primary language is Spanish. Fifty-nine percent of Harmony's Member Service Representatives are fluent in Spanish. Each of Harmony Member Service Representatives also has access to a language line for individual whose primary language is not English or Spanish.

Requests to Change Practitioners

Requests to change a Primary Care Provider (PCP) increased (14%) in volume compared to the 2007-2008 contract year. Outbound calls are made to new members to welcome them to Harmony, review benefits and ensure satisfaction with their assigned PCP. When necessary, the PCP is changed to accommodate the member. Member who cannot be reached by phone are sent a letter identifying their assigned PCP and encouraging them to contact Harmony to go over their benefits. The Member Service department emphasizes member satisfaction with their PCP and allows members to change their PCP in an effort to maintain that satisfaction.

MO Medicaid-Member	Jul-07	Aug-07	Sep-07	Oct-07	Nov-07	Dec-07	Jan-08	Feb-08	Mar-08	Apr-08	May-08	Jun-08	**2007-2008 Totals**
PCP Change Requests	136	154	167	217	153	163	240	205	205	218	210	207	**2275**
Changes per 1k Members	22.8	24.1	24.1	28.6	18.9	19.4	26.6	19.8	19.5	20.7	19.0	18.6	**21.5**

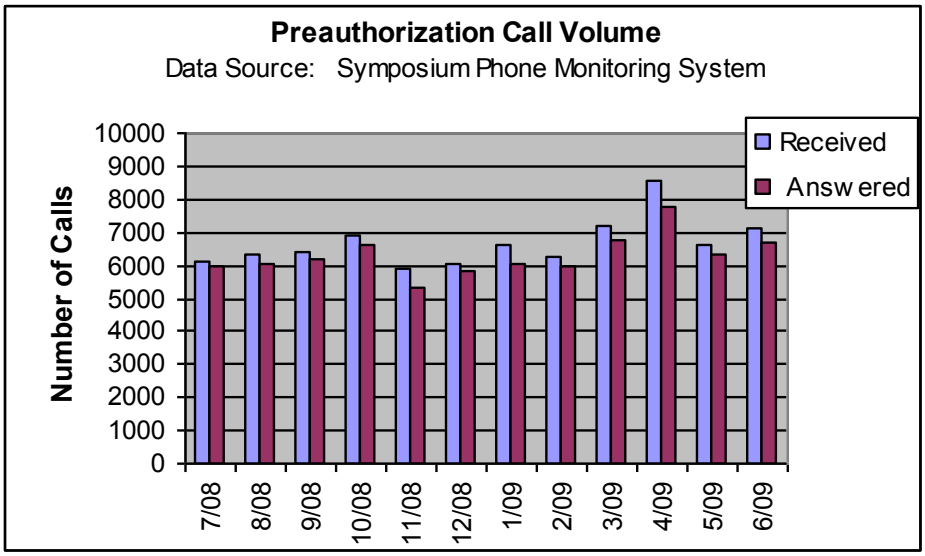
MO Medicaid-Member	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09	Apr-09	May-09	Jun-09	**2008-2009 Totals**
PCP Change Requests	252	241	281	379	286	326	365	337	368	409	356	384	**3984**
Changes per 1k Members	21.5	19.4	22.8	29.8	21.5	23.6	26.9	24.4	26.1	28.0	23.6	25.2	**24.5**

HealthCare USA

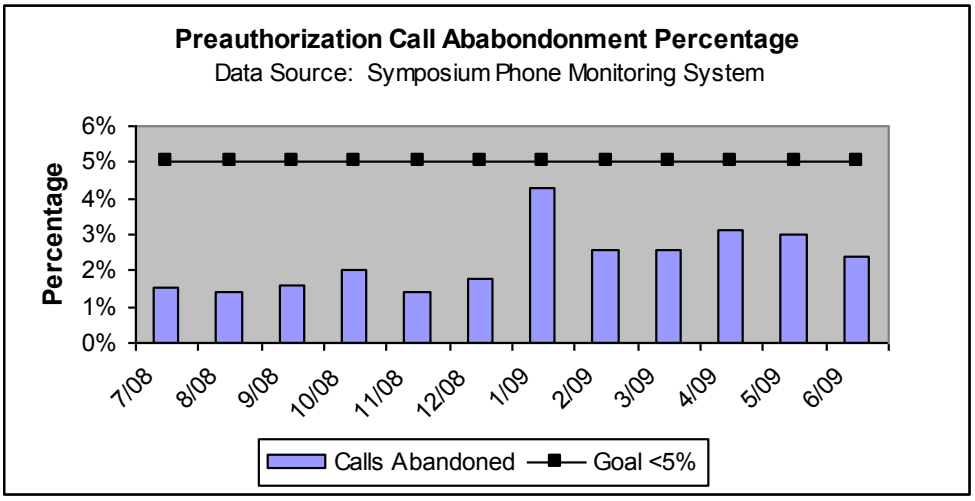
Average Speed of Answer and Call Abandonment Rate

Pre-authorization Department

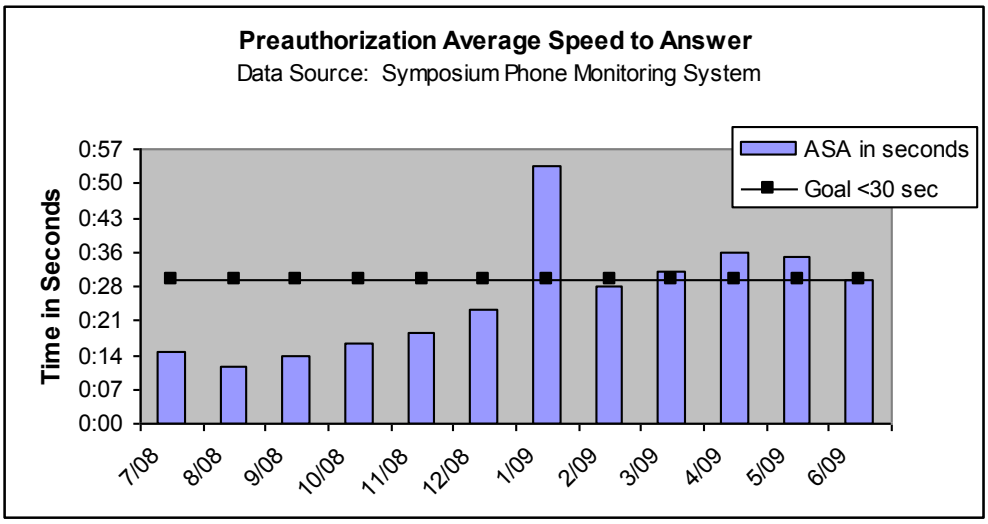
The pre-authorization staff uses an automatic call distribution system (ACD) to monitor and track telephone statistics. In FY 2009, abandonment rate and average speed to answer were measured and analyzed.



There was a 16 percent increase in the volume of calls in March and April of 2009.



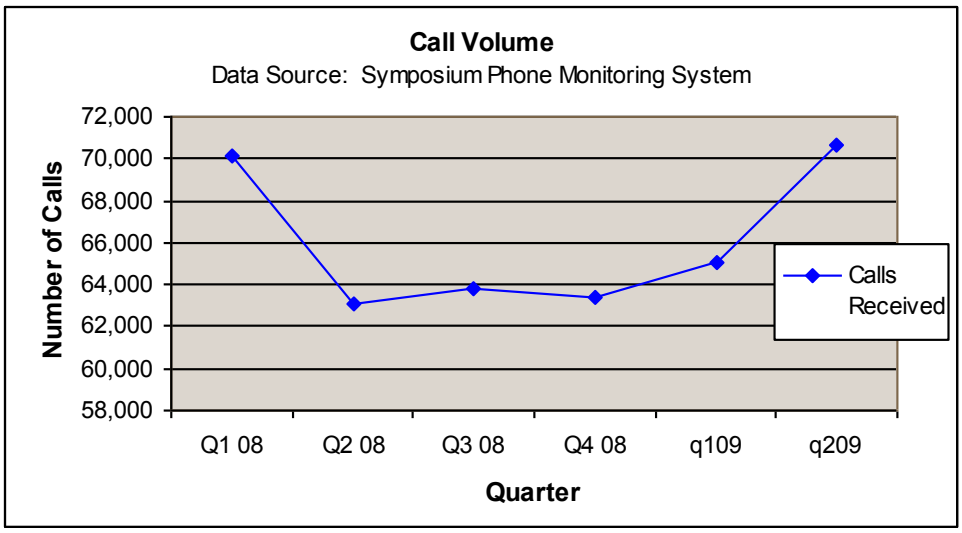
The call abandonment rate has remained better than the goal of 5% for FY 2009 despite an increased call volume and staffing variations.



The average speed to answer (ASA) was worse than the goal of 30 seconds in January due to staffing losses. March through May of 2009 also had an increase in the time to answer because of the increase in call volume and staffing variations.

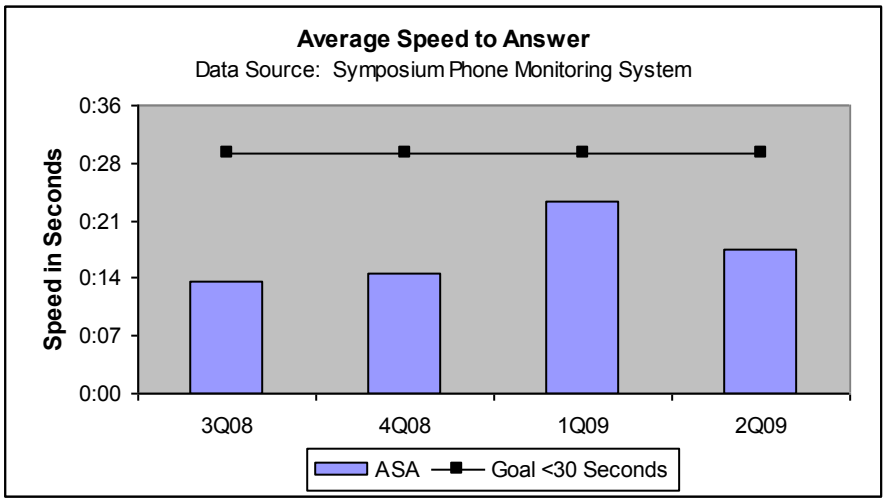
Customer Service Organization

The Customer Service Organization (CSO) at HealthCare USA continued to focus in 2008 and 2009 on ensuring high-quality customer service as evidenced by ongoing measurement and review of key call process and outcome metrics. Throughout FY 2009, the CSO monitored call volume, call processing indicators, average speed to answer, abandonment rate, and call accuracy.

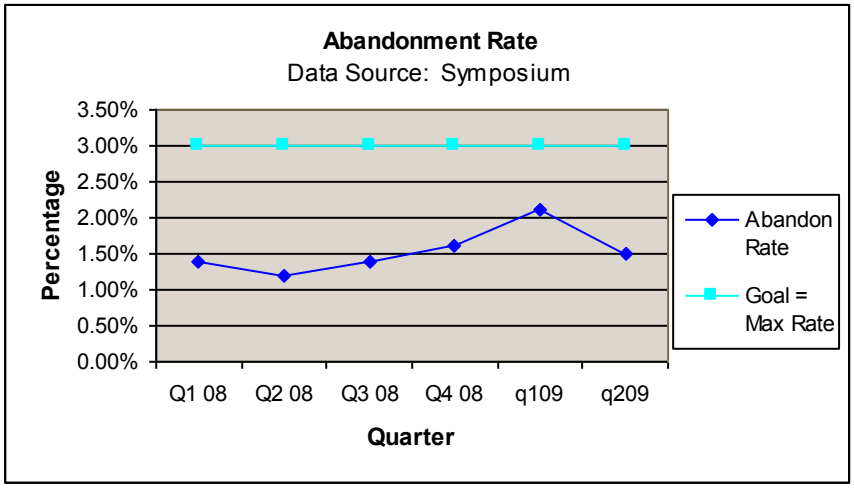


All phone metrics goals were met or exceeded the goal through the 2nd Quarter of 2009. Calls received increased from the previous quarter by 9.2% due to an increase in claims inquires from providers. The top three provider claims inquiry were all HCA hospitals for: claim status from

providers 10,326 inquiries; member eligibility from providers 811 inquiries; and PCP change 5,069 inquiries.



Despite an increase in call volume, the average speed to answer (ASA) has remained better than the goal of less than 30 seconds.



The call abandonment rate remained consistent in exceeding the performance goal. The CSO holds bi-weekly team meeting with all staff members to review all policies and procedures on a continuous basis and to assess and resolve any current and potential future barriers to meeting and exceeding key aspects of service.

Management staff review top provider calls on a monthly, quarterly and yearly basis to identify any trends related to calls, this includes reviewing requests to change PCP. The top four call reasons during FY 2009 are as follows:

- Eligibility
- Claim Status
- PCP Change

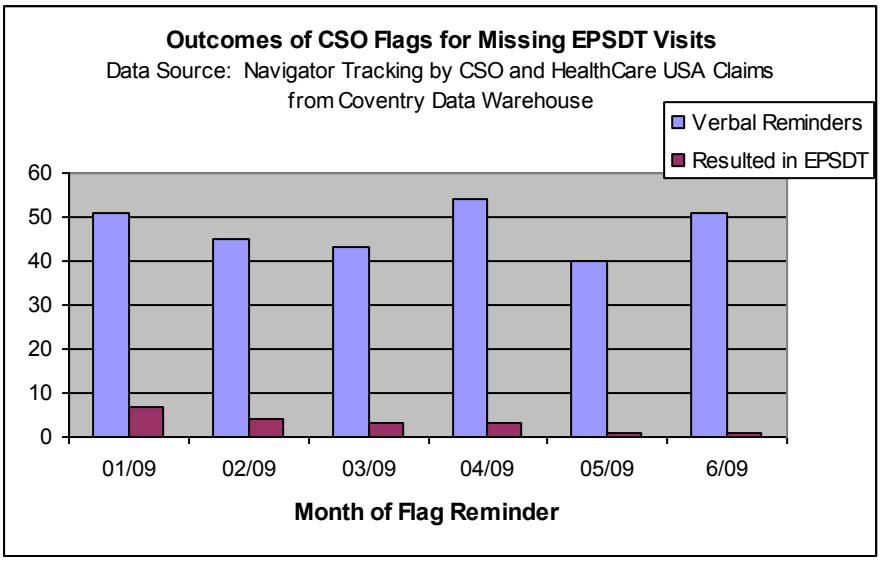
- Sticker Pilot Program

The CSO will continue to assess for opportunities to improve and on-going successes. In FY 2009, the process for ongoing monitoring was improved through the implementation of new web based programs used to monitor member service calls for quality and improved tracking and trending purposes.

Six (6) to eight (8) week training classes are conducted for all new hires that encompasses system overview, benefit review, contract review, provider selection, HIPAA guidelines, navigator review, customer service standards, call tone, documentation, complaints and appeals, member rights, remittance advices, web services, transportation, boys and girls clubs, direct provider and call monitoring procedures. All employees are brought back to training after 90 days to receive additional training on claims processing.

Training programs continue in 2009, with a focus on employee career development, including but not limited to, call tone, documentation, grammar and outbound call monitoring. A learning management system has been implemented to deliver training for
Training programs continue in 2009, with interest in career development of employees, including but not limited to, call tone, documentation, grammar, and outbound call monitoring. A learning management system has been implemented to deliver training for the development of current staff and enhance learning opportunities for staff with an interest in growth in the organization. In 2007, a pilot study was completed to see if attaching a sticker to member ID cards requesting that the participant call member services as soon as they receive the ID card to update demographic information would prompt the member to call HealthCare USA and provide updated demographic data. The pilot project was so successful, as evidenced by the number of calls to update demographics and a reduction in the bad demographics as a barrier to clinical staff attempting to contact members that it is now a permanent part of new member ID cards.

EPSDT Pop Up Program
The EPSDT pop up program began in January 2009, with a goal of increasing EPSDT participation ratios by providing member reminders about missed visits when the member calls the CSO. When a member, parent or guardian calls in the CSO about a member, and that member is non-adherent to the American Academy of Pediatrics (AAP) recommended schedule for EPSDT visits per claims information, then a flag is displayed for the CSO staff. The flag prompts the CSO staff member to alert the caller of a missed well care appointment. The CSO can then assist in setting up transportation, scheduling the appointment or transferring the caller to schedule the appointment or find a PCP.



All flags are tracked and reported in the graph above by the month of the call. Of the members whose parent/guardian received a reminder when calling in, EPSDT claims during the month of the call or after are pulled. Almost 7 percent of verbal reminders resulted in an EPSDT visit after the reminder.

Since the program began, enhancements have been made to improve tracking of outcomes. The CSO staff has received feedback on how to maximize their communication with the parent/guardian.

Non-Routine and Routine Needs Appointments, Access to Urgent and Emergent Care, 24 Hour Access/After Hours Availability

2009-2009 Access and Availability Study

The provider access study included a random sample of primary care providers, OB/GYN providers and high-volume specialists across all three regions of the network. Of all types, 680 network provider practices were represented.

Primary Care Providers	400
OB-Gyn Providers	119
High-volume Specialists	161

Source: HealthCare USA Access/Availability Study Database

Provider Relations conducted random provider visits and provider telephonic surveys in all 3 regions to assure access and compliance with contractually required appointment standards, as noted in the Provider Accessibility Standard section of the 2007-2008 Provider Manual. In addition, calls were conducted after-hours to ensure compliance with after hour's availability standards.

Provider Access Standards

Appointment Standard - Primary Care

- PCPs will have emergent appointments available immediately.
- PCPs will have urgent, but not life-threatening appointments available the same day.
- PCPs will have routine care, with symptoms, appointments available within 1 week or five (5) business days, whichever is earlier.
- PCPs will have routine care without symptoms appointments within one month.

Appointment Standard – OB/GYN

- OBs will see a first trimester member within seven (7) calendar days of first request.
- OBs will see a second trimester member within seven (7) calendar days of first request.
- OBs will see a third trimester member within three (3) calendar days of first request.
- OBs will see a member identified as "high-risk" within three (3) days or immediately if emergency exists.

Appointment Standard – Specialist

- Specialists will see a member immediately for emergent care.
- Specialists will see a member within 24 hours for an urgent care appointment.
- Specialists will see a member within one week or five (5) business days, whichever is earlier, for routine care, with symptoms, appointments.
- Specialists will see a member within one month for a routine care, without symptoms, appointment.

Provider After Hours Access Standard

- Participating providers are required to ensure that access to care is provided twenty-four hours per day, seven days per week and to maintain phone line coverage after normal business hours.

Study Results

- Primary Care - Appointment Standards
    - 99% of providers surveyed met these appointment standards
- Primary Care - After Hours Access Standards
    - 95% of providers surveyed met the after hours availability access standard
- OB/Gyn - Appointment Standard
    - 100% of providers surveyed met these appointment standards
- OB/Gyn - After Hours Access Standard:
    - 99% of providers surveyed met the after hours availability access standard
- High-volume Specialist Appointment Standard:
    - 100% of providers surveyed met these appointment standards
- High-volume Specialist After Hours Access Standard:
    - 96% of providers surveyed met the after hours availability access standard

Providers identified in this study as not meeting the required standard for access and availability were contacted by their regional Provider Relations Representative and additional education was provided regarding the standards and the provider's obligation to comply. Demographic updates such as phone number changes, physicians who left the practice, etc. were also identified and corrected.

For the providers identified as not meeting the required after-hours access or coverage, follow-up contacts via Provider Relations revealed errors by provider's office staff such as failure to roll phones over to the afterhours phone service, outdated after hours messages, disconnection issues, issues related to rural location and high-volume specialists who wouldn't have a need for members to contact them directly. At the end of this review period, a need was identified to implement a policy, which drafted to recognize "rural" providers and high-volume specialists who could apply for an exception, which would be reviewed on a case-by-case basis for approval by the Medical Director. In each case, the provider responded to feedback from HealthCare USA and corrected the issue immediately.

Following each survey, Provider Relations staff also gave feedback to the randomly selected providers regarding the results of their assessment.

Provider Relations will continue ongoing monitoring of the Primary Care, OB/Gyn and high-volume network providers for appropriate access and availability, and implement interventions as necessary. The policy to review rural providers and high-volume specialists not meeting after hours access has been implemented and will be utilized during the next review period.

Network Adequacy – Provider/Enrollee Ratios

Geo-Access Report HealthCare USA

Network adequacy is a key area in performance monitoring for appropriate access to health services for our membership. HealthCare USA reviews and analyzes network adequacy and availability throughout the year and performs a formal geo-access analysis annually. This provides management, contracting, and provider relations necessary information to establish priorities in developing the network and closing any gaps in access that may occur.

Provider Access

HealthCare USA submits an annual Network Adequacy filing to the Missouri Department of Insurance (MDI) for analysis and scoring. For period ending December 31, 2008, HealthCare USA members had 100% access to Primary Care Providers in Central, Eastern and Western regions in Missouri. This report is completed by the last day of the calendar year. For this reason, 2009 results are not available.

Primary Care Providers for Period ending 12/31/08				
Region	**Central**	**Eastern**	**Western**	**Total**
# Providers	460	745	511	1716
Member to Provider Ratio	37.7	143.4	60.17	90.28
Specialty Care Providers for Period ending 12/31/08				
Region	**Central**	**Eastern**	**Western**	**Total**
# Providers	770	3611	1146	5527
Member to Provider Ratio	25.52	29.59	26.83	28.03
Hospital Providers for Period ending 12/31/08				
Region	**Central**	**Eastern**	**Western**	**Total**
# Providers	21	30	34	85

Data retrieved from GEO access report results

Primary Care Providers for Period ending 6/30/09				
Region	**Central**	**Eastern**	**Western**	**Total**
# Providers	448	767	550	1765
Member to Provider Ratio	38.71	139.29	55.90	87.78
Specialty Care Providers for Period ending 6/30/09				
Region	**Central**	**Eastern**	**Western**	**Total**
# Providers	724	3514	1123	5361
Member to Provider Ratio	23.95	30.40	27.38	28.90
Hospital Providers for Period ending 6/30/09				
Region	**Central**	**Eastern**	**Western**	**Total**
# Providers	21	30	34	85

Data source: HealthCare USA Geo Access report results

The preceding data represents the distribution of Primary Care Providers, Specialists and Hospitals across the Central, Eastern and Western regions.

HealthCare USA's Network Adequacy data was sent to the Missouri Department of Insurance for scoring and analysis. For period ending December 31, 2008 HealthCare USA received the following scores for network adequacy.

Provider Type	Central Region	Eastern Region	Western Region
Primary Care	100%	100%	100%
Specialists	100%	99%	100%
Facilities	99%	100%	98%
Ancillary	100%	100%	100%
Overall Score	100%	100%	100%

Data source: HealthCare USA Geo Access report results

HealthCare USA recognizes that access and availability monitoring is important in ensuring appropriate health care for members and will continue to monitor in 2009 and 2010.

Dental Provider Network

Doral completes a quarterly Geo-Access report and submits the results to HealthCare USA for review and analysis. In addition, Doral reports overall number of dental providers, percentage of open/closed practices and member/provider ratios to the QMC no less than quarterly. Doral also completes a telephonic provider survey measuring emergent, urgent and routine availability on a quarterly basis to maintain compliance with appointment standards and identify areas for improvement. The survey is completed via "secret shopper method" to ensure accurate reporting of availability by providers. These measures are reported overall and by region to identify areas to focus network development efforts, and presented at the oversight meetings. Network development updates are presented and discussed at each quarterly oversight meeting and include discussion of specific providers who have joined the network in each region, specific providers who have opened their practices and began seeing HealthCare USA members, etc.

Doral provides HealthCare USA with an updated provider directory for each Missouri region on a monthly basis. Timely corrections to provider demographic information, addition of new providers and removal of termed providers are completed, allowing for accurate provider information for HealthCare USA members and staff. Doral also completes an annual provider directory verification project to ensure accuracy of the provider directories. Each network provider is contacted to verify demographic information, days/hours of operation, languages spoken, ages seen, status of accepting new members, and any other information specific to the provider.

Doral accomplished the following in FY 2009 to improve HealthCare USA members' access to dental services:

- Retained the previous Provider Relations Representative as a Plan Account Executive located in Missouri to maintain positive relationships with current providers and actively recruit new providers across the State. A local representative allows for office visits to be made in person and has proven to enhance relationships with providers.
- Added 64 providers to the network (23 in the Central region, 28 in the Western region, 13 in the Eastern region).
- Increased participation in State and community sponsored events and health fairs, in conjunction with HealthCare USA, to provide MO HealthNet Managed Care members with additional information regarding their dental benefits and implement preventive health related initiatives. Doral attended health fairs in all regions distributing oral health education, toothbrushes, toothpaste and providing dental hygienists for dental screenings to approximately 1,500 participants.
- Continued the Member Placement Program, in collaboration with HealthCare USA staff to provide individualized assistance in locating a dentist and scheduling a dental appointment within the mandatory time frames. 102 members were successfully placed through this program during FY 2009.
- Maintained contracts with mobile dental units in all three regions. The mobile units provide preventive and restorative to members in their school. Mobile units in FY2009 provided 54,183 services to HealthCare USA members.
- Considerably increased the utilization of school-based services and performed quality audits on all providers to assure appropriate care and services are provided.

HealthCare USA will continue to closely monitor Doral on an on-going basis to assure adequate access and availability is maintained, through review of the activities noted above. Access and availability and network development will also continue to be discussed at the quarterly oversight meetings with Doral, or more often as needed.

Mental Health Network

HealthCare USA subcontracts mental health services to MHNet. MHNet and HealthCare USA work collaboratively to ensure appropriate access and availability of mental health providers across all three regions of the network. MHNet and HealthCare USA meet quarterly to discuss key performance indicators, network changes and all other processes as necessary.

MHNet's final Geo Access study revealed 97.78% of members in Central Missouri had desired access to a mental health provider, 97.83% of members in Eastern Missouri had desired access and 95.21% in Western Missouri had desired access. MHNet continues to actively recruit providers in all three regions to strengthen the provider network.

MHNet also monitors provider accessibility through monthly telephonic surveys, which allow for 100% of MHNet's network to be surveyed during the calendar year. These surveys include questions regarding provider appointment availability for new members, including crisis appointments, as well as updating of demographic information and specialties. This information is entered directly into MHNet's referral database to allow for expedited and well-matched referrals.

Open/Closed Panels

In reviewing providers with closed panels in 2008, HealthCare USA had an overall percentage of 26% closed PCP panels. Provider Relations staff contacted providers with closed panels to confirm the reason for the provider's closed panel and to determine if there were any opportunities to open the panel.

- 4% closed to all new patients
- 19% closed to all Medicaid patients
- 3% closed to only HealthCare USA patients

In 2009, Provider Relations attempted to better determine what percentage of panels are truly closed.

Provider Relations runs a report out of the Coventry Provider Database (CPD) to identify all PCP provider records identified as having a Panel status = "N". Every provider record listed with an "N" is then reviewed by Provider Relations staff to validate including it in the PCP Closed Panel Study based on the following factors:

- Closed panel record is set up b/c members are assigned to a group record
- PCP has since terminated since report was run
- Provider record is set up as PCP in error

Once a validated list of closed panel PCP's is gathered, Provider Relations Staff contact each PCP with a closed panel to verify:

1) Is the provider closed to all payors?
2) Is the provider closed to all Medicaid?
3) Is the provider only closed to HealthCare USA?
4) Is the provider able to open their panel to take additional HealthCare USA patients?

Provider Relations also reviews the panels of PCP providers with over 1000 members and reviews Navigator to determine if there have been the volume of quality of service issues reported by HealthCare USA members in order to determine if the provider's panel size limit needs to be adjusted.

This information is then collected and reported to the Network Development management team. In follow-up to the study, any providers who indicate a willingness to open their panel are updated in CPD to reflect their new status. Providers who are closed to only HealthCare USA are educated about the requirement in the HealthCare USA provider manual requiring the provider to be closed to all payors if they are closed to HealthCare USA. Any large panel size providers with quality of service for accessibility will be reviewed with the Medical Director to determine the corrective action plan or for a recommendation for updating the panel size limit.

Results 2009
At the beginning of this study, 1,768 (80%) out of 2,208 Primary Care Physicians statewide had open panels for HealthCare USA. There were 440 (20%) provider records that were set up as closed panels.

Upon further review of each of these closed panel PCP records:

- Fifteen (15) percent were set up as closed because they are providers associated with a clinic or physician group where the membership panel is assigned to the group/clinic record.
- Thirty-six (36) percent of the closed panel records were provider set-up errors.

There were 221 validated PCP records that were considered "closed panel" PCP providers. This indicates 90 percent of the participating PCP's across the HealthCare USA network are accepting new HealthCare USA patients and sets our rate of closed panels at 10 percent overall.

Mental Health Network
MHNet monitors open and closed panels on a quarterly basis. This information is included in the quarterly reports, as well as reported during the HealthCare USA Quality Management Committee meetings. Providers with closed panels are noted as not accepting new members in MHNet's referral database to prevent inappropriate referrals. As of June 30, 2009, the following information was compiled regarding open/closed practices.

	Physician Practices		Allied Health Practitioner (AHP) Practices	
	Open	**Closed**	**Open**	**Closed**
Eastern	114	11	618	36
Central	22	3	187	4
Western	96	5	527	25

Cultural Competency
A multi-disciplinary Cultural Competency Committee was established in December of 2008. The purpose of the committee was to establish and implement a plan to gain adherence to the US Dept of Health and Human Services Office of Minority Health's "National Standards for Culturally and Linguistically Appropriates Services in Health Care (CLAS)". All HealthCare USA departments and regions are represented on the committee.

By May of 2009, our committee had developed a multi-level HealthCare USA CLAS based strategy/program for reducing racial and ethnic disparities in health care in our population. Interventions are focused on three areas: member, provider and employee/organizational.

Members

- Ensuring appropriate language access/oral and written communication.
- Work to reduce health disparities that may exist between various ethnic and cultural groups that are part of our Medicaid membership.
- Ensure that members' cultural needs are addressed when members receive care or services and for those who participate in case or disease management.
- Address the needs of members of various cultural groups when conducting outreach activities and conducting outreach that effectively reaches these groups.
- Continuously assess how successful efforts have been to implement cultural competency initiatives for members, including member surveys.

Providers

- At least annual provider educational opportunities focusing on cultural competency.
- Cultural Competency issues and HealthCare USA outcomes in provider newsletter.
- Provide access to language service resources.

Employee/Organizational

- Diversity and cultural training specific to groups prevalent in the Medicaid population served, as well as general healthcare disparities.
- Yearly self and organizational assessments.
- On-going employee education to assure that employees are aware of all resources available to them when communicating with members of various cultural and ethnic groups.
- At least monthly all employee push emails with information about holidays and other events from around the world and across ethnic populations. Push emails have included Diwali, Yom Kippur, Juneteeneth, Feast of Assumption, Ramandan, World Health Day, Besak Day, and International Women's Day, to name a few.

The committee continues to meet at least monthly and more often when necessary. Major milestones over the last year include:

- Completed organizational and individual staff surveys on cultural competency.
- Established more effective data collection process by monitoring use of language services, data sharing with Barnes Jewish Hospital (BJH), and a new Health Risk assessment form identifying primary language sent to new members.
- Provider outreach and support for BJH Center for Diversity and Cultural Competency's sponsored organization and provider seminar on Cultural Competence in Healthcare by Dr. Joseph Betancourt. This was attended by over 300 community providers in addition to HealthCare USA and Barnes Jewish Health System employees.
- Organization-wide seminar onsite for HealthCare USA employees by Dr. Joseph Betancourt "*Culturally Competent Care: A Critical Approach in Health Care."*
- Established schedule for on-going organization-wide/all staff cultural competency in-services presented by LAMP on specific ethnic populations (Hispanic, Bosnian, Vietnamese).

- Established a central clearinghouse for any culturally relevant activities or opportunities throughout each region.
- HealthCare USA employees participated in a poverty simulation exercise.
- Provided all new employees diversity training program online.
- Educated staff and provided a "cheat sheet" to keep at hand for accessing language services.
- Inclusion of language services on provider and member websites and newsletters.
- "Identify Your Language" handout offered at provider offices with information on accessing language services through HealthCare USA.
- Routine e-mails "Diversity Fun Facts" sent out organization-wide providing education and awareness about diverse holidays, observances, and traditions. Employees also volunteer to recognize several of these observances with bulletin boards in the break areas.
- Partnering with Barnes Jewish to identify Limited English Proficient (LEP) members at ED and hospitalization – Barnes Jewish employs their own language assistance services that would otherwise not be captured by HealthCare USA.
- Language Access Brochure in Spanish and Bosnian that addresses how to access general information, provide address and phone number updates, learn about member benefits, eligibility questions, grievances and appeals, scheduling health care appointments, getting answers to your medical questions and transportation benefits.
- Quality Interactions - a corporate e-training initiative to provide cultural competency education for both clinical and non-clinical staff that interact with member and providers on an intimate and ongoing basis.

Future Goals and Areas of Focus

- Establishing an on-going relatively automated data stream to track cultural competency related measures and for on-going assessment for possible healthcare disparities within our member population.
- Working in conjunction with our community and provider partners to continue existing efforts and add additional interventions to address healthcare disparities in minority populations.

As we continue to focus on providing education about cultural competency and health care disparities to our employees and community providers and implement additional interventions, we anticipate increased utilization of our language assistance services, well care, and preventative services in our LEP population. We also anticipate a decrease in over-utilization of emergency room services. As we expand our database/identification of LEP members (data from Barnes Jewish and providers with their own language services in Western region), we anticipate that our outcome measures will also improve.

Requests to Change Practitioners

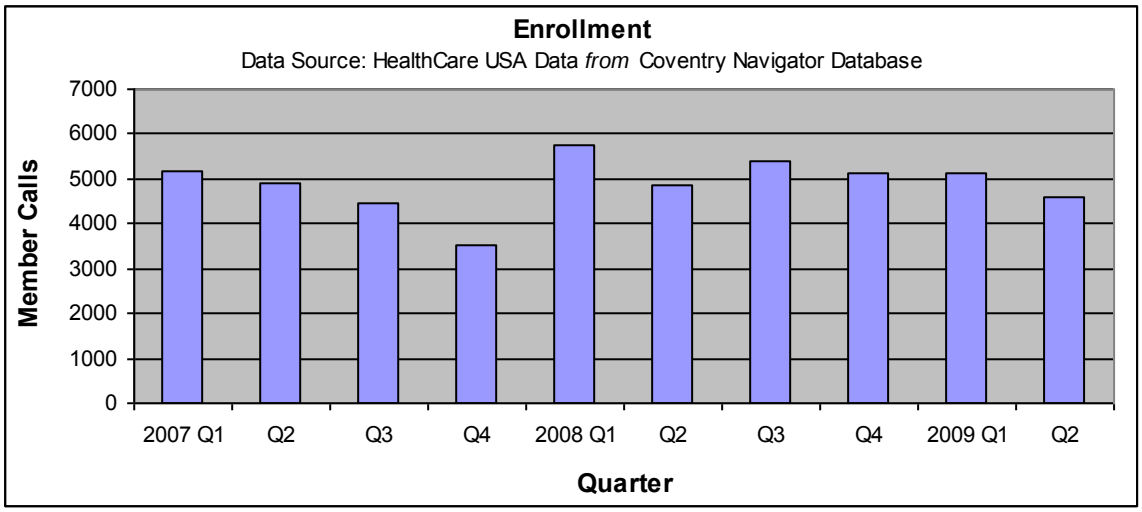
Requests to change Primary Care Provider (PCP) are tracked by the CSO. These requests are reported and tracked by provider, member, and reason. Quality of Care concerns are investigated and tracked by Quality Improvement staff. Reasons for change are categorized as follows:

	2007 Q1	Q2	Q3	Q4	2008 Q1	Q2	Q3	Q4	2009 Q1	Q2
Enrollment	5178	4915	4464	3522	5738	4853	5400	5132	5119	4610
Other	2664	2436	4144	3864	2916	4562	4062	3698	4196	4876
Quality of Care	27	43	62	66	35	15	13	5	11	6
Provider Request	91	85	69	14	5	2	2	2	15	12
Quality of Service	25	20	35	47	13	18	9	1	14	2

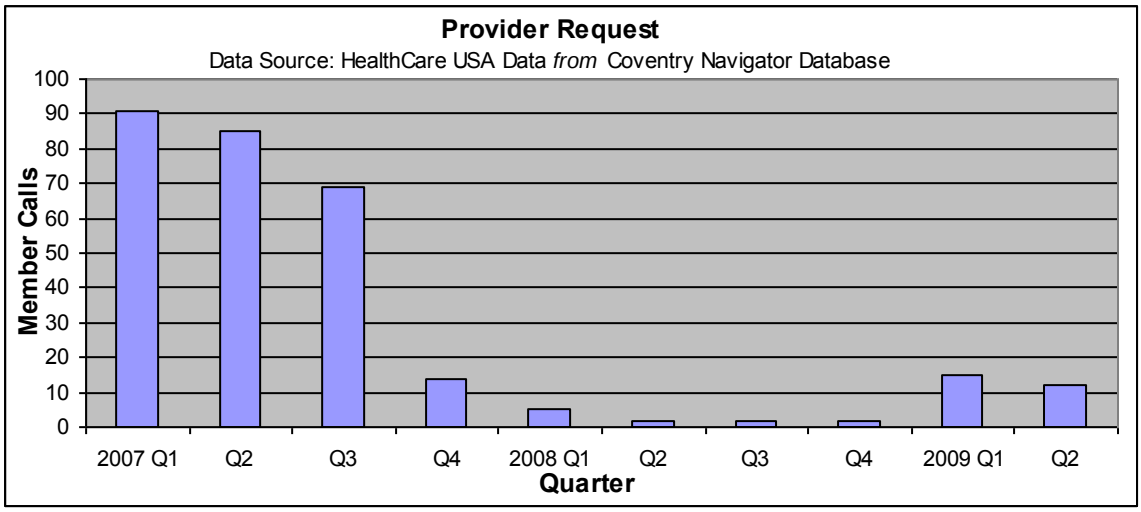
Data Source: HCUSA data *from* Coventry Navigator Database

There was in increase in requests to change PCP in first quarter 2008. This is most likely a result of the county expansion and members being auto-assigned a PCP and then changing after enrollment in a plan.

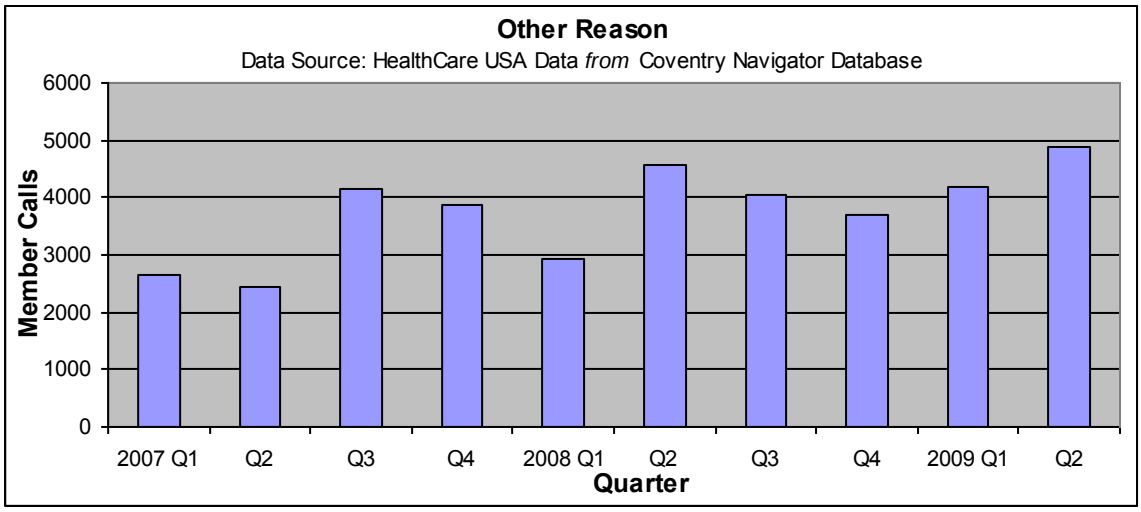
Requests to change are also reviewed for identification of potential fraud and abuse. Frequent member requested changes may be an indication of fraud and abuse. These are tracked to determine the number of PCP change requests made and the reasons for the requests. Cases with frequent changes are investigated and forwarded to the compliance analyst when appropriate.



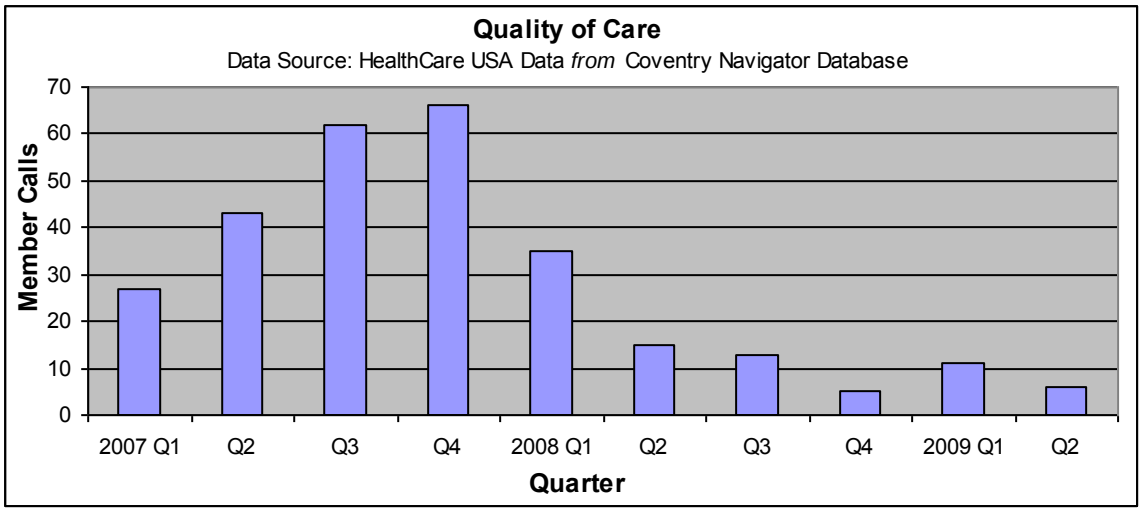
PCP changes due to Enrollment Reasons peaked in 2008 Q1 (5738) and have trended down overall through Q2 ’092 (4610). The most common reason for an enrollment change in 2009 Q2 is "Auto-Assignment" (2297).



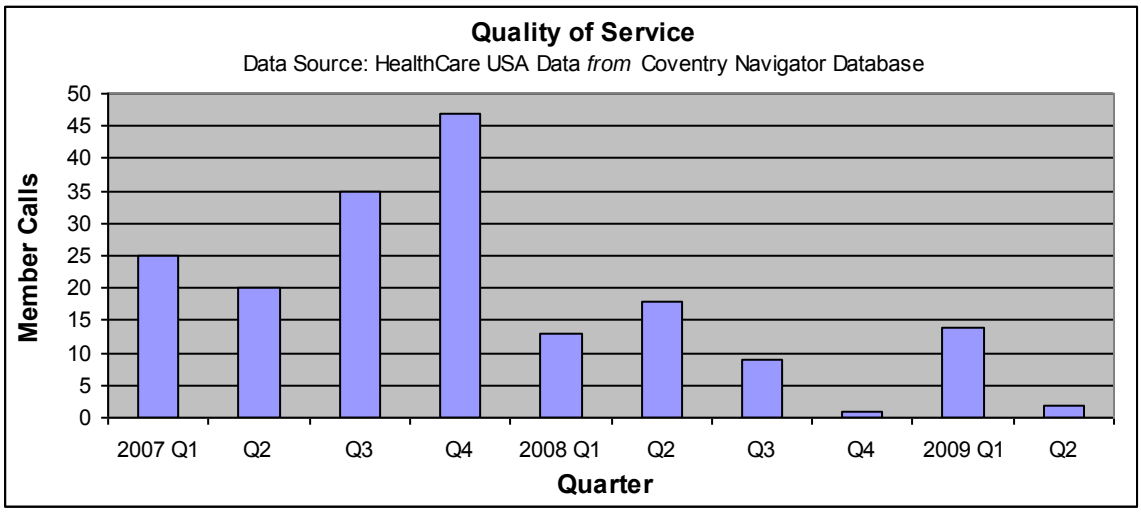
PCP changes due to Provider Request peaked in 2007 Q1 (91) and have trended downward into 2009 Q2 (12). The most common reason for a provider request change in 2009 Q2 is "Provider Requested" (12). Providers can request a change as a result of member non-compliance and other reasons that the database is not currently set up to define.



PCP changes due to Other Reasons has varied from quarter to quarter. The most common "Other Reason" for change in 2009 Q2 (4876) is "PCP change without reason" (3519). Detail surveys show that members who are auto-assigned frequently change providers and when new members are added to managed care through county expansions, for example, there is an increase in the number of requests to change.



PCP changes due to Quality of Care peaked in 2007 Q4 (66) and has trended downward through 2009 Q2 (6). The most common reason Quality of Care reason in 2009 Q2 is "Other Quality of Care" (6). Investigations of these complaints have not resulted in identification of a true quality of care issue.



PCP changes due to quality of service peaked in 2007 Q4 (47) and trended downward. There were 2 changes due to quality of service in 2009 Q2. The reasons for 2009 Q2 were "Waiting Time" and "Provider or Staff Attitude".

Missouri Care

Average Speed of Answer
The average answer times in SFY 09 were as follows:
- Prior Authorization - 18 seconds
- Behavioral Health - 18 seconds
- Member Services - 13 seconds

In SFY 09 average answer times were slightly longer than the answer times in SFY 08, and all departments were well below the industry standard of 30 seconds. Missouri Care has dedicated staff committed to delivering the highest level of service.

Call Abandonment Rate
The average abandonment rate during SFY 09 for Prior Authorization, Behavioral Health and Member Services Departments, was 1.97 percent, 3.69 percent and 1.32 percent, respectively. All were well below the industry standard of 5.00 percent.

Non-Routine Needs Appointments
Routine Needs Appointments
Access to Emergent and Urgent Care
Missouri Care members have a right to the timely provision of health care services. In support of this, Missouri Care adheres to the following appointment availability standards:
- Urgent care, within 24 hours
- Routine care, with symptoms, within 5 business days
- Routine care, without symptoms, within 30 calendar days
- For mental health and substance abuse services, aftercare appointments within 7 calendar days after hospital discharge

Members are informed of these standards in the Missouri Care Member Handbook.
To monitor appointment availability within the provider network, Missouri Care conducts an annual telephonic survey of PCPs and behavioral health professionals. In the most recently completed survey from 2008, a random sample of 153 PCPs and 98 behavioral health providers was surveyed: all 153 PCPs and 97 of the 98 (93 percent) behavioral health providers were found to be compliant with appointment availability standards. Corrective action letters were sent to the non-compliant providers to address the problem areas, with resurvey to ensure compliance to occur in 2009.

Network Adequacy – Provider/Enrollee Ratios
Missouri Care has steadily grown its network over the SFY 09. In July 2008, Missouri Care had a provider network consisting of 599 primary care providers (PCPs), 1,957 specialists, and 547 behavioral health professionals. By June 2009, the network had grown to 678 PCPs, 2.377 specialists, and 644 behavioral health professionals.

In July 2008, the ratio of members per PCP stood at 64:1, while that of members per behavioral health professional was 71:1. By June 2009, the ratio of members per PCP had fallen to 60:1, and that of members per behavioral health professional to 63:1.

24 Hour Access/After Hours Availability
As part of the annual appointment availability survey, Missouri Care also monitors the availability of providers after normal business hours. Of the 251 sampled providers (153 PCPs and 98 behavioral health providers), 242 (96 percent) made arrangements for after hours availability of a health professional. The vast majority of providers utilized answering machines that directed callers to an alternative number providing access to the provider or a covering provider, while some utilized answering services or call forwarding to allow after hours access to the provider or a covering provider and a few referred members to a contracted 24-hour nurse triage and advice line. Corrective action letters were sent to the non-compliant providers to address the problem areas, with resurvey to ensure compliance to occur in 2009.

Open/Closed Panels
Missouri Care monitors the status of PCP panels on a monthly basis. In 2009, the proportion of PCPs with open panels has remained very stable, ranging from 88% to 90%.

Cultural Competency
Missouri Care Health Plan is committed to establishing multicultural principles and practices throughout its organizational systems of services and programs as it works toward the critical goal of developing a culturally competent service system. The Cultural Competency (CC) plan is integral to the Missouri Care's quality improvement process and as such, employs a health plan and system-wide approach to integrating core cultural competence principles into our daily operations as well as in our day-to-day interactions with members.

Program Mission
To improve health outcomes and member satisfaction through promoting the delivery of culturally competent, linguistically sensitive health care, and services that respect the cultural backgrounds, beliefs, and literacy levels of our diverse membership.

Program Purpose
The purpose of Missouri Care's CC program is to:
- Participate in the State's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds
- Ensure that all health plan members receive equitable and effective treatment in a culturally and linguistically appropriate manner
- Ensure that the health plan exhibits congruent behaviors, attitudes, and policies that come together in a system that enables effective work in cross-cultural situations
- Comply with MO HealthNet Division (MHD) Cultural Competency requirements (RFP No:B3Z09135, Section 2.3) and DHSS standards for Culturally and Linguistically Appropriate Services (CLAS).

Program Activities - SFY 2009
In SFY 09 Missouri Care promoted the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds. The following items were addressed:
- Followed phone procedures to use the AT&T phone line for any member who requires

translation services. In addition, members were able to call using TTY.
- Assessed the number of members by primary language spoken (see Languages Identified, page 14 for details).
- Made interpreter services available when members called Informed Health Line 24-hour nurse advice line.
- Translated (or made available) materials in Spanish on the following topics:
    - Member Handbook
    - "Your Pregnancy" Booklet
    - "You and Your Baby" Booklet
    - EPSDT Reminder Postcards and Flyers
    - Lead prevention/education materials
    - Immunization schedules and booklets
    - Disease management education materials
- Provided mandatory staff training on cultural competency

Program Plans – SFY 2010

In May 2009, Missouri Care created a new Cultural Competency (CC) plan designed to improve health outcomes, increase member satisfaction, enhance operational efficiencies, and comply with MO HealthNet contract requirements and federal standards for Cultural and Linguistically Appropriate Services (CLAS). The Quality Management Department is responsible for preparing the CC Plan and Work Plan and submitting them for review and approval to the newly developed Missouri Care Community Outreach Advisory Council on Health (COACH). At least quarterly, COACH participants will review the work plan to monitor progress and update or revise activities as necessary. The outcomes of the quarterly reviews will be reported to the Quality Management Oversight Committee (QMOC).

The 2010 CC Work Plan includes an annual project plan, which specifies projected CC activities, designated staff and/or departmental responsibilities, and the resources required to complete the work plan within anticipated time frames. The CC Work Plan is used as an action plan to document specific goals for the coming year. For 2010 these include:
- Provide members with culturally competent, linguistically sensitive services and care through our provider network
- Educate providers on culturally competent practices that improve member adherence to prevention and wellness and treatment recommendations
- Support providers in assisting members in achieving improved health outcomes and satisfaction
- Build a solid communication bridge between members and providers for all aspects of health care
- Empower members to participate in their own health care through improved health literacy, satisfaction and health outcomes
- Implement practices to enhance Missouri Care's ability to meet language and disability needs of members
- Improve health plan capabilities to meet federal and state Limited English Proficiency (LEP) and the Americans with Disabilities Act (ADA) requirements
- Identify areas of strength and weakness in the organization's and providers' cultural competence and health literacy knowledge and practices

- Identify opportunities to remove linguistic, cultural, and accessibility barriers to care through key initiatives and services such as Language Line®
- Increase internal awareness of activities that will increase the cultural competence and health literacy of the organization
- Implement practices to improve health literacy
- Maintain staff diversity
- Implement systems and processes for monitoring and evaluating the care and services members receive through the health delivery network
- Meet state and federal regulatory agency requirements
- To the extent possible, strive to develop and maintain a provider network that mirrors the racial, ethnic and linguistic composition of our membership

Multilingual Services

Missouri Care members have access to a certified translation service through the Member Services Department via Language Line® Services. The Member Services department accepts calls from Relay Missouri in order to provide accommodations for members with a hearing impairment. Special assistance is also available for cognitively impaired members or their caregivers. The health plan communicates the availability of the translation service through the Member Handbook and Provider Manual. Member services staff are oriented to this and reinforce translation service availability when talking to both members and providers. Missouri Care's interpreter services support the MO HealthNet Division's guiding principle of emphasis on the individual person.

Requests to Change Practitioners

Missouri Care members have the right to change their primary care provider two times a year without cause. During SFY 09, there were a total of 2,874 PCP changes. Of these changes, 2,465 requested to change to a familiar provider, 112 changed as a result of a location change of the member or provider, and 297 changed for other reasons.

Molina Healthcare of Missouri

Average Speed of Answer

Molina Healthcare of Missouri's (MHMO) Member Services and Medical Management departments' Average Speed of Answer (ASA) are reflected below. The Member Services telephone statistics are reviewed by the Member/Provider Satisfaction Committee (MPSC) and the Quality Improvement Committee (QIC), while the Medical Management telephone statistics are reviewed by the Utilization Management Committee (UMC), Clinical Quality Improvement Committee (CQIC) and QIC. The health plans' goal is to answer 85% of all calls within thirty (30) seconds or less. With the exception of three (3) months, Member Services met the goal. In October 2008, the Member Services Department experienced longer talk times as a result of the name change from Mercy CarePlus to MHMO as well as subcontracted vendor changes. In January and April 2009 the department experienced staffing challenges which has been rectified. Medical Management continues to review the data and determine methods for meeting the goal.

Member Services ASA

ASA	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
	97%	96%	87%	81%	87%	87%	83%	88%	86%	80%	88%	89%

Medical Management ASA

ASA	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
	82%	56%	54%	31%	39%	80%	78%	85%	81%	77%	81%	84%

Call Abandonment Rate

The average goal of <5% of calls abandoned was met and exceeded by Member Services. Medical Management did not meet the abandonment rate goal for several months during the conversion to a new pharmacy computer system. Following the conversion, the department met the goal.

Member Services Abandonment Rate

Abandonment Rate	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
	0.4%	0.5%	2.0%	3.7%	2.0%	2.0%	3%	2%	2%	3%	1%	1%

Medical Management Abandonment Rate

Abandonment Rate	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
	2.2%	6.5%	7.1%	16%	11%	2%	3%	2%	2%	2%	2%	1%

Non-Routine Needs Appointment

Practitioners make every effort to see the patient within an average of one hour from his/her scheduled appointment. This includes time spent both in the lobby and in the examination room before being seen by the provider. Providers can be delayed when they incorporate urgent cases, when a serious problem is found, or when a patient has an unknown need that requires more services or more education than was estimated at the time the appointment was made. In addition, members who are late for their appointment may not be able to be seen within the one-hour period. MHMO requires its participating providers to meet contractually required access standards as set forth below:

Appointment Type	Standard
Routine care without symptoms	30 Days
Routine care w/symptoms	Within 1 week or 5 business days whichever is earlier
Urgent, non-life threatening care	Within 24 Hours
Emergent (Serious) Medical/Behavioral Health Services	Available immediately twenty-four (24) hours seven (7) days per week
Maternity Care	
First trimester appointment	Within 7 days
Second trimester appointment	Within 7 days
Third trimester appointment	Within 3 days
High risk pregnancy	Within 3 days

Emergency	Immediately
Mental Health	
Behavioral Health Non-Emergent	5 business days
Behavioral Health Upon PCP's request	Within 72 hours
Behavioral Health and substance abuse after care	Within 7 days after hospital discharge

Routine Needs Appointments
See appointment standards information above.

Access to Emergent and Urgent Care
See appointment standards information above.

Network Adequacy – Provider/Enrollee Ratios
MHMO has developed a geographically accessible network for members throughout the three-region service area. It is of sufficient number, range, and depth to ensure that covered benefits are available to members in a timely manner. MHMO providers include hospitals, physicians, advanced practice nurses, mental health providers, substance abuse providers, pharmacies, dentists, emergent and non-emergent transportation services, emergency medical services, dental health care, and ancillary health care services.

MHMO tracks and monitors its provider network adequacy on an on-going basis. Various reporting tools are used to identify areas of improvement. Member grievances and appeals are monitored by the MPSC for trends in network adequacy. In addition, the network is reviewed using the state-required distance standards as set forth by the Department of Insurance, Financial Institutions & Professional Registration in 20 CSR 400-7.095. Appointment standards and waiting times are also tracked and trended using member inquiries and grievances.

24 Hour Access/After Hours Availability
MHMO offers 24-hour toll-free Nurse Advise Line (NAL) to accommodate all members across the three regions to ensure access to twenty-four (24) hours per day health care. The NAL provides medical and parenting advice to members using nationally recognized phone triage systems. The toll-free NAL includes telecommunication service to accommodate deaf participants. The MHMO Nurse Advice Line is a medical triage line available to all MHMO members' 24-hours per day, including weekends, and holidays. The NAL offers resources to help members decide when it is appropriate to use the emergency room or urgent care, contact the on-call physician or wait until the next day to call the Member's primary care provider (PCP) (the Medical Home).

MHMO requires that all participating Primary and Specialty Care Practitioners be available to assist/direct members' needs twenty-four (24) hours a day, seven (7) days a week. Primary and Specialty Care Practitioners should have office hours at least 20 hours per week, preferably over the span of four (4) days per week. An annual phone survey is completed for all PCPs, OB/GYNs, and other health plan-designated providers. Providers are called after-hours to determine if the provider meets their contractual requirement. Provider Service Representatives visit identified providers who do not appear to meet the standard and review a corrective action

plan with the provider and staff. The Provider Service Representative follows up on the corrective action plan to assure adherence.

Additionally, providers are required to include on the Counsel for Affordable Quality Healthcare (CAQH) Form during the credentialing and re-credentialing process detail of their 24-hour access and after hours availability. If a provider's description of access and availability does not meet the access and availability standards, the designated Provider Service Representative will contact the provider to discuss appropriate access.

Open/Closed Panels

PCPs may define the number of members they want to have assigned to their care, or close their panel by submitting written notification to MHMO. Currently, the state of Missouri limits the number of patients per physician to 1,500 patients.

During the reporting period, MHMO had 2,446 participating PCPs in its network. Of all providers, 85% had open panels. This results in a PCP to participant ratio of approximately 1:37. MHMO acknowledges when providers must limit patient panel load due to extenuating circumstances as such conditions could compromise patient care.

Providers may request member removal from the provider's panel for cause, however providers are expected to make every effort to resolve incompatible patient relationships and notify their Provider Relations Representative prior to making a decision to remove a member from the panel. Reasons for cause include family continuity, abusive behavior, a documented pattern of non-compliance, and failure to keep or cancel scheduled appointments. The provider must notify MHMO in writing indicating reason for the request. When this occurs, Member Services immediately contacts the affected members to assist them in finding a new PCP and takes the appropriate action to resolve the dispute including but not limited to filing a grievance on behalf of the member.

Cultural Competency

MHMO incorporates cultural competency training into its training for employees. During a scheduled all employee training day, the Molina Institute for Cultural Competency visited MHMO and presented a cultural update on the subject of diverse communities with reference to the Bosnian and Latino communities. MHMO has plans for additional cultural competency training for employees.

Multilingual Services

MHMO examines opportunities for continuously improving multilingual services offered to its members with English language barriers. MHMO tracks data on the volume of members who have been identified as speaking a language other than English. MHMO's current membership reports reflect a total of 200 or 5% of eligible members that speak Spanish as well as English. Incorporated into MHMO's practitioner orientation program is education on processes to access interpreters for members.

Requests to Change Practitioners

Members are allowed to change their PCP up to two (2) times per year after the initial assignment. MHMO considers any request that exceeds the allowed 2 per year on a case-by-case basis. If the PCP change requests exceed 2 per year, consideration is given to issues of provider's accessibility, attitude, and quality of care, enrollment and acts of insensitivity. In cases where the PCP has left the plan, members are given the option of choosing a new PCP before being assigned to a new provider. MHMO notifies all affected members in writing at least thirty (30) days in advance of the change, and issues a new member identification card once the member is assigned to a new PCP. This is not considered as one of the 2 times members are permitted to change per year without cause. If the provider's termination does not allow the required advance notice Member Services takes the liberty of calling to notify members to ensure they are reassigned to a new PCP as soon as possible and educate our members on the importance of having a PCP home to effectively manage their care.

Fraud and Abuse

The following information was taken from the MO HealthNet Managed Care health plans' SFY 2009 Annual Evaluations:

Blue Advantage Plus of Kansas City

Prevention, Detection, Investigation

Blue Cross and Blue Shield of Kansas City (BCBSKC) established the Special Investigations Unit (SIU) in 1986 and it has been in continual operation since that time. The SIU has multiple goals:

- To prevent and deter fraud and abuse through acts committed by providers, members, employees and any other BCBSKC business constituents.
- To deter unnecessary medical services.
- To demonstrate the company's strong commitment to honest and responsible provider and corporate conduct.
- To facilitate compliance with state law, federal law, accreditation agency requirements, contractual requirements, and Blue Cross and Blue Shield Association requirements.
- To prevent processing of fraudulent or abusive claims.
- To facilitate a more accurate view of risk and exposure relating to fraud and abuse.
- To minimize the financial impact of fraud and abuse to BCBSKC and its clients.
- To meet the customer expectations that we will reimburse only for services that are appropriate and do not constitute fraudulent or abusive activity.

We execute this mission through strong inter-departmental processes and communication procedures, supplemented by fraud and abuse detection technology, and supported by appropriate policies and procedures. Currently, the SIU has three full time staff members. The SIU Manager is a Licensed Practical Nurse and a Certified Professional Coder (CPC). The Fraud Investigation is working on completion of a degree in Investigations from Bellevue University. The Clinical Fraud Investigator is a Licensed Chiropractor; a Certified Professional Coder (CPC) and holds an accounting degree.

The SIU has other resources available on an as-needed basis, including claims auditors, registered nurses, medical directors, pharmacists, quantitative analysts, IT support personnel, and financial analysts. If required, the SIU has access to external resources such as investigators and independent review organizations for determination of medical necessity and validity of medical records documentation.

The SIU is a department within the Audit Service and Compliance Division (AS&C) under the management of the Director of Audit Services and Blue-Advantage Plus – Annual Appraisal of the QI Program – Program Year SFY2009 41 Compliance Officer. The Director of Audit Services and Compliance Officer reports to the Senior VP of Financial Services Group and has a direct line of reporting to the Board of Directors Audit Committee.

Other activities undertaken by the AS&C Division include:

- Conducting regular reviews and audits of operations to guard against fraud and abuse.
- Assessing and strengthening internal controls to ensure claims are submitted and payments are made properly and that the company‟s assets are appropriately protected.
- Establishing and maintaining organizational resources to respond to complaints of fraud and abuse.
- Establishing procedures to process fraud and abuse allegations.
- Establishing procedures for mandatory reporting requirements.
- Developing procedures to monitor utilization/service patterns of providers, subcontractors, and beneficiaries.

The SIU currently uses STARSentinel™ software. "STARSentinel is an automated „early warning‟ system that applies both standard and user defined rules to identify billing patterns that differ dramatically from a provider's past history of the norms for a given condition or specialty" (2003 ViPSSM). The software provides a more timely and accurate in house data mining capability to identify and investigate trends and indicators of fraud and abuse. The STARSentinel software was upgraded to include the pharmacy module in first quarter 2009. This additional capability will provide the SIU with a more complete view of members and providers.

The SIU may receive referrals or identify instances of potential fraud and abuse from any of the following sources:

- Members, providers, other insurers, and the public.
- Personnel in the BCBSKC claims, customer service, medical management, provider services, audit services, underwriting, and any other BCBSKC departments.
- Data studies conducted by BCBSKC and/or contracted external data analysis vendors.
- The BCBSKC Anti-Fraud Hotlines.
- The Code of Business Conduct Hotline.
- The Federal Employee Program (FEP) Anti-Fraud Unit.
- Law and regulatory enforcement agencies such as local police departments, the Missouri Department of Insurance, Financial Institutions & Professional Registration, the Program Integrity Unit, the FBI, or other such agencies.
- The Blue Cross and Blue Association National Anti-Fraud Department (NAFD).
- Federal Anti-Fraud Task Forces.
- Local and/or national media sources.

Employees may report improper activity to their supervisors, the General Counsel, the Director of Audit Services and Compliance Officer, the Deputy Compliance Officer, SIU staff, or a member of the Compliance Committee. In accord with the federal False Claims Act, the Corporate Compliance Program expressly prohibits retaliation against those who, in good faith, report concerns or participate in the investigation of compliance violations. Employees are allowed to report anonymously.

As a part of the credentialing/recredentialing process, BCBSKC screens providers against the Office of Inspector General (OIG) debarred providers list as well as the Office of Foreign Asset Control (OFAC) anti-terrorist list

in compliance with Executive Order 13224. Likewise, BCBSKC screens new and existing employees, members, brokers, and vendors against the OFAC lists and conduct background investigations on all new employees. Certain employees (including those involved in government programs) are subject to repeat background checks at five year intervals.

In general, the coordination or departments throughout the organization, the use of technology, the skills, and abilities of experienced personnel, and the support of executive management combine to provide a comprehensive approach to the prevention, identification, and investigation of fraud and abuse in the BCBSKC service area.

Training and Education

BCBSKC conducts fraud awareness training to highlight the issues of fraud, the red flags that may indicate potential fraud or abuse, and the means to report suspected instances of fraud and abuse. BCBSKC employees are informed about fraud detection and reporting during Code of Business Conduct training and through required compliance training sessions.

BCBSKC notifies providers about issues of fraud and abuse in the Provider Office Guides. As necessary, topics of fraud and abuse will be communicated via provider newsletters and through provider advisory committees.

Fraud and Abuse Cases

Case 1

A local Kansas City, MO Walgreen‟s Pharmacy called to report a patient who was forging prescriptions using a doctors DEA number. The doctor filed a police report with Green Valley Police Dept. The doctor had not seen this patient for approximately three years and believed the member was printing false computer generated prescriptions for hydrocodone w/APAP 10-325mg.

Placed on pharmacy lock-in 04/04/2008.

Correction: the fraudulent claims were not being billed to the BA+ program. Notified the State requesting advice since this did not impact State funds, BA+ did not feel they had a right to place on lock-in program. Eventually the State changed pharmacy benefit managers and BCBSKC was no longer responsible for pharmacy lock-ins effective 7/1/08.

Note: law enforcement referral was made by the physician whose name the member was using to forge prescriptions.

Outcome: Member is no longer monitored per the change in policy mentioned above.

Case 2

In September 2007 Dr. Martha Hurley notified BCBSKC in writing that a nurse mid-wife obtained their provider number in Dr. Hurley's name without her permission and associated it with the Suzanne Ryan Midwifery Services in Leavenworth, Kansas. Ms. Ryan obtained the number in May 2007 and had been billing claims for BA+ members. In a conversation with Ms.

Ryan she acknowledged she forged the signature on a letter to BCBSKC requesting the billing number as Dr. Hurley. The number was termed upon notification by Dr. Hurley. A demand letter was sent to Suzanne Ryan for $9,306.00 4/29/08. Ms. Ryan reimbursed the monies and refiled the claims for her services under her own rendering number. Further action pending.

Actions Taken
9/2007 Provider Dr. Hurley number termed.
9/2007 Provider Suzanne Ryan placed on Pre-Payment review.
9/2007 to 12/31/08-Claims history reviewed and documented. Analysis of claims processed through Blue Card and through BCBSKC.
1/31/08 Met with Legal to discuss case.
4/23/08 Demand letter sent to Suzanne Ryan for return of $9,306.00 paid under Dr. Hurley's number.
4/28/08 Received check for repayment of the $9,306.00.
5/28/08 Claims sent to Operations for adjustments.
8/15/08 Continue to monitor claims from provider. Provider is nonparticipating.

Outcome: Quarterly reports submitted to State on Suzanne Ryan indicated the SIU closed her case effective 5/15/2009 after monitoring her claims.

Children's Mercy Family Health Partners

Prevention, Detection, Investigation
Fraud and Abuse Plan Overview
The Fraud and Abuse Plan requires that fraud and abuse concerns are reported, investigated, resolved and tracked. As part of this process fraud and abuse case data is compiled quarterly with the Compliance Program data and then summarized annually to evaluate the effectiveness of the Program. This information is presented to the Board of Directors. The Chief Executive Officer, Corporate Compliance Officer and Compliance Committee provide oversight of the Compliance Program.

Prevention and Detection
Children‟s Mercy Family Health Partners‟ (CMFHP) Fraud and Abuse Plan outlines specific methods of prevention and detection of suspected, alleged, potential or actual fraud and abuse. Some of the methods used are (1) claims software that identifies anomalies in provider billings or that do not meet the billing payment requirements, 2) delineation of job responsibilities between departments to ensure checks and balances of processes, 3) routine review of member enrollment and dis-enrollment to ensure accuracy of membership data, 4) strong credentialing and re-credentialing processes that evaluate provider‟s participation in federal and state programs, 5) strong internal processes such as annual employee conflict of interest review, and 6) ongoing training regarding compliance/fraud and abuse identification and reporting.

Tracking Compliance/Fraud and Abuse Cases and Concerns
The CMFHP Fraud and Abuse Committee is comprised of representatives from the Compliance, Customer Service, Health Services, Claims, and Provider Relations departments and is

responsible for investigating suspected cases of fraud and abuse. Cases are referred to the Committee by various internal and external sources including all CMFHP departments, physician offices, pharmacies, state agencies, community health centers, CMFHP beneficiaries and more. In July of 2009, CMFHP developed on-line database programs to enter, track and report compliance and fraud and abuse cases. Data access and security for the Children‟s Mercy Family Health Partners database is limited to the CMFHP Compliance Officer and other members of the CMFHP Fraud and Abuse Committee. The information on the log is used to create the aggregate quarterly and annual compliance/fraud and abuse case reports.

The development of the database has also provided tools for tracking issues that did not meet the compliance/fraud and abuse case file criteria, but are issues that the Compliance Officer feels should be monitored. The compliance database has a monitoring log that is used in these situations. This provides the Compliance Officer with tracking of recurrent issues that may require additional staff training or education or further operational evaluation.

Fraud and Abuse Case Activity
Starting in 2004 with the use of the database, compliance/fraud and abuse case activity is now available through the reporting function of the compliance/fraud and abuse database. The following represents the fraud and abuse case data for Fiscal Year 2009 (July 1, 2008 – June 30, 2009):

- There were 9 fraud and abuse cases investigated in Fiscal Year 2009, 1 provider and 8 members
- Of the 9 cases, all were resolved during FY 2009
- There were 5 CMFHP member cases of fraud and abuse substantiated. All of those cases were referred to DMS in order for it to make lock-in determinations
- There were 3 CMFHP member cases of alleged fraud and abuse that were investigated but not substantiated
- There was 1 provider/subcontractor case of fraud and abuse substantiated.
- There were no provider/subcontractor cases of fraud and abuse that were investigated but not substantiated.
- All cases were rated as low risk

Training and Education
The database also features a module that can be used to track training and education conducted by the Compliance Officer. This includes annual compliance plan and fraud and abuse plan trainings, employee newsletter articles, provider newsletter articles, etc. The following training and educational activities related to fraud and abuse were completed in FY 2009:

- New employee orientation (CMFHP specific orientation provides the employee with basic knowledge and expectations related to fraud and abuse identification, detection and reporting)
- Annual Education Fair (employees are required to attend an annual education fair or complete the training on line through the Children‟s Mercy Hospital Online Education System, called CHEX. Both of these venues provide information on fraud and abuse identification, detection and reporting).

- Annual Corporate Integrity Plan training (CMFHP employees are required to attend the annual Corporate Integrity Plan training, which occurred in May and June 2009. The training includes review of the Compliance and Fraud and Abuse Plans)
- Newsletter Articles (employees are required to read the monthly In the Know employee newsletter. Information is routinely submitted from the Compliance department regarding topics related to fraud and abuse).

HealthCare USA

Prevention, Detection, Investigation

The fraud and abuse program continued throughout FY 2009 by maintaining, as well as updating, the previous year‟s work. HealthCare USA continues activities to prevent, identify, investigate and resolve fraud and abuse among members, providers and employees of the health plan.

The Compliance Management Committee, which encompassing the fraud and abuse program, continues to meet to review fraud and abuse issues and updates. Coordination, prevention and detection activities and any open cases are discussed during Compliance Management Committee meetings. This committee is multi-disciplinary and interdepartmental. Feedback about fraud and abuse issues is received from all HealthCare USA departments. Additionally, information may be found in member and providers complaints and other survey content, through claims review, quality of care investigations and through on-going provider monitoring.

All fraud and abuse policies and procedures documenting the processes for the fraud and abuse program continue to be adhered to and reviewed on an annual basis, at minimum. These policies, as well as all HealthCare USA policies, are maintained on a shared drive where all employees can access them.

Processes for fraud prevention, detection and investigation continue to evolve throughout the company, as well as with external parties. Processes for obtaining information related to suspected fraud and abuse investigations also continue to be reviewed and opportunities to improve the processes identified and implemented. Internal departments that are most likely to encounter or detect fraudulent activities related to members include, but are not limited to, Customer Service Operations (CSO), the Pharmacy Department, Case Management, Disease Management, Quality Improvement and Provider Relations.

The Special Investigations Unit (SIU) runs reports to detect and investigate potential provider fraud and abuse cases. With the implementation of a new fraud and abuse software StarSentinel in September “08 the SIU has better capabilities to utilize retrospective claims data to identify irregular or suspicious practice patterns. Retrospective claim data originates from claims for services that were previously rendered. Providers are compared by specialty and region, in order to identify those with irregular billing and/ or high utilization patterns.

External parties HealthCare USA works with to investigate, monitor and/or report suspected fraud and abuse activities include, but are not limited to subcontractors, physicians, pharmacists,

family members of enrollees, case workers, the State agency and the Office of Inspector General. Individuals who are reported receive education and/or corrective action as necessary.

When a referral is received from anyone, an investigation is immediately initiated. The Regulatory Compliance Analyst initiates investigations by receiving all applicable information from the referring party and contacting other parties as necessary, including primary care providers (PCPs), pharmacists, etc. An initial contact is made to suspected members via an initial notification letter to offer assistance. Members are referred to Case Management or other medical management services if needed.

All cases initially opened due to pharmacy issues are reviewed with the Pharmacy Director to assess and determine next steps. In severe cases when the lock-in program is appropriate, members will be locked in to one provider to obtain all services and/or medications. Cases that deal with mental health/substance abuse are referred to MHNet, HealthCare USA‟s mental health subcontractor. All open cases are continually monitored. Updates related to open cases are reported to the State at least quarterly until all fraudulent and/or abusive activities cease and the case is closed. As a result of the transient nature of the MO HealthNet population, HealthCare USA maintains an open case for three months after a member opts out of this plan.

The table below shows the number of cases reported throughout the last four (4) quarters:

Quarter	Cases Opened	Cases Closed
Q1 '08	13	36
Q2 '08	15	3
Q3 '09	7	7
Q4 '09	9	0

Data Source: HealthCare USA Fraud and Abuse Database

Of all fraud and abuse cases reported, pharmacy continues to have the highest volume. Due to the high volume of cases that relate to pharmacy, we continue to monitor cases at least quarterly and seek input from corporate Coventry pharmacy directors as needed.

The pharmacy lock-in program is maintained for a minimum of twelve (12) months, regardless of whether the member opts out of the plan or not. After twelve (12) months, pharmacy cases are reviewed to evaluate the outcome of the lock-in program and determine if the lock-in process should be extended or not. In cases where the member opted out of the plan for three months or longer, the case is closed.

The outcomes of the Compliance Management Committee, encompassing the Fraud and Abuse Committee, and any updates on the fraud and abuse program, are reported to the State agency and HealthCare USA‟s QMC and Executive Quality Committee at least annually and recommendations are received from these committees.

Assuring timeliness of investigations and accuracy of data collection and reporting continues to be high priority. HealthCare USA continues to assess and improve processes related to fraud and abuse detection and investigations through on-going research and evaluation of new ways to

minimize fraudulent and abusive activities and implementation of enhancements to the fraud and abuse program.

Training and Education
HealthCare USA is committed to ongoing training and education for all employees. Listed are some examples of training and education that took place throughout FY 2009.

- A Compliance and Ethics Training Program is sent out on an annual basis to all employees' to complete. This program includes training on fraud and abuse.
- Privacy and Security Week includes daily activities learning activities developed by Coventry for all its employees. HealthCare USA also had daily internal educational activities (puzzles/quizzes) with a daily drawing for a gift card.
- *The Investigator* is sent to all employees. This publication, from Coventry's internal Special Investigation Unit (SIU), is published quarterly to increase awareness about SIU and how fraud, waste, and abuse impacts not only Coventry and HealthCare USA, but also all its providers, members, and employees.

Missouri Care

Prevention, Detection, Investigation
Missouri Care personnel or any other party (including Missouri Care members, government agency or the public) can identify and report a potential compliance issue or concern. The identified potential compliance issue or concern is communicated to the Missouri Care compliance officer as a report (hotline call, telephone call, e-mail, written correspondence or other means). The Missouri Care compliance officer logs and documents all compliance issues or concerns that have merit. In SFY 09 there were 3 fraud and/or abuse issues reported. Issues are placed under one of three categories: provider, member or employee.

Provider
There were 3 examples of alleged provider fraud and abuse in SFY 09. The first case was a request from MHD for information regarding a particular provider. The second case was regarding a pharmacy which allegedly and inappropriately charged members a dispensing fee. The third case was a request from MHD for claims data and information regarding DME equipment and supplies.

Member
There were no incidents of member fraud and abuse reported in SFY 09.

Employee
There were no incidents of employee fraud and abuse reported in SFY 09.

Training and Education
Each employee participates in the Missouri Care Compliance Program training seminar conducted once per calendar year. Part of this training addresses Fraud and Abuse. Attendance

for all employees at this annual Compliance Program training seminar is mandatory. An attendance log is maintained for each training seminar conducted.

Training in SFY 09 included defining fraud, abuse and waste, a summary of the types of fraud and abuse that should be reported to the compliance officer, whistleblower protections. Examples of fraud and abuse were discussed from the previous year and used as training aids.

Molina Healthcare of Missouri

Prevention, Detection, Investigation
Molina Healthcare of Missouri (MHMO) is committed to preventing, detecting, investigating, and reporting suspected fraud and abuse activities by providers, subcontractors and members. MHMO monitors provider fraud for underutilization of services and beneficiary/provider fraud for over utilization of services. MHMO may identify provider fraud and abuse by reviewing for a lack of referrals, improper coding (up coding and unbundling), billing for services never rendered or inflating the bills for services and/or goods provided. MHMO may identify member fraud by reviewing access to services, such as improper prescriptions for controlled substances, inappropriate emergency care or card sharing.

MHMO‟s fraud and abuse activities include the following:

- Conducting regular reviews and audits of operations to guard against fraud and abuse
- Assessing and strengthening internal controls to ensure claims are submitted and payments are made properly
- Educating employees, network providers, and members about fraud and abuse and how to report it
- Providing effective organizational resources to respond to complaints of fraud and abuse
- Maintaining procedures to process fraud and abuse complaints
- Maintaining procedures for reporting information to the state agency
- Monitoring utilization/service patterns of providers, subcontractors, and members
- Implementing corrective action plans to strengthen internal control of fraud and abuse activity

All suspected fraud and abuse activities are reported to MHMO‟s Compliance Committee as appropriate. They are reported to the state agency on a quarterly basis. During FY2009, there were nine (9) cases of suspected fraud and abuse and there were 16 members who were entered into a pharmacy lock-in.

Training and Education
MHMO maintains a comprehensive Fraud and Abuse Program, which is accountable for special investigative processes in accordance with federal and state statutes and regulations. The Fraud and Abuse Program, directed by the Compliance Department, is responsible for the detection, prevention, investigation, and reporting of potential health care fraud and abuse. Federal and state laws, statutes, and regulations require MHMO to report potential fraud and abuse to

appropriate regulatory and/or law enforcement agencies. In addition, the Fraud and Abuse Program fully cooperates with any investigative process undertaken by a regulatory and/or law enforcement agency.

MHMO provides training and education for its Director of Compliance, employees, management, board members, and subcontractors. Training may take many forms, such as seminars, web-based learning content, written materials; provider education includes provider newsletter content, provider manual content, and website material. The Corporate Compliance Office held quarterly mandatory meetings for Compliance Directors at the plan level at which time they provided ongoing training, updated on new policies or regulations and information on available resources around Fraud and Abuse, Health Insurance Portability and Accountability Act (HIPAA) compliance and other related issues.

In accordance with MHMO‟s Anti–Fraud and Deficit Reduction Act policies, all new employees during this period completed fraud training within 60 days of employment. New hire employees attended anti-fraud training as part of the New Employee Orientation process. This training stresses the duty of all employees to report suspected incidents of fraud and abuse. To facilitate the identification and prevention of fraud and abuse, the training covers:

- The definitions of fraud and abuse
- Examples of types of fraud and abuse that employees might encounter specific to their job functions
- Examples of actual cases of fraud and abuse
- How to report suspected cases of fraud and abuse through confidential reporting mechanisms including hotline, fax line and e-mail
- Reprisal protection for “whistle blowers”
- Fines and other disciplinary actions

In late 2009, MHMO will conduct the annual employee anti-fraud training via the Molina intranet Molina E–Learning System (MELS). The Molina Anti-Fraud MELS training reinforces and expands upon the fraud and abuse training provided to new employees during employee orientation. All employees must complete a post-test through MELS that is located on the intranet. For employees to receive credit for the training year, they must pass the post-test with a score of 100%. Employees who fail the post-test must continue to retake the exam until achieving a passing grade. The Compliance Department maintains electronic logs of employee training and test results to track compliance with MHMO‟s training requirements.

For providers, MHMO makes available an array of information about fraud and abuse that is published in multiple mediums. Specific information about anti-fraud issues is provided upon request. The Provider Manual and provider web site also educate providers on how to identify, report, and curtail fraud and abuse. This information is reinforced by periodic articles in the Provider Newsletter. The health plan‟s Fraud and Abuse activities also include regular reviews and audits of operations, and provider and member conduct to guard against fraud and abuse. Routine and unexpected office visits are part of the ongoing monitoring process.

Similarly, the Member Handbook and Member web site inform members about what they can do to identify, report, and curtail fraud and abuse. This information is reinforced by periodic articles in the Member Newsletter.

Harmony Health Plan of Missouri

Prevention, Detection, Investigation

Fraud and Abuse Program

The Company is committed to comply with applicable federal and state laws, rules and regulations related to fraud, waste and abuse. The Company has created and fully supports a Special Investigation Unit ("SIU"), and has given the primary responsibility to this unit for the detection, prevention, investigation, reporting, correction and deterrence of FWA. The SIU will report to the Chief Compliance Officer ("CCO"), and accordingly, will maintain clear lines of communication with the CCO at all times. The SIU will maintain written policies, procedures, and adhere to standards of conduct that articulate the organization's commitment to comply with all applicable federal and state standards. The SIU will maintain effective training and education materials specific to FWA, in support of the overall Company Compliance Program, and will assist in providing training to all employees, business partners, and downstream entities. The SIU will promote the immediate reporting of suspected incidents of FWA by establishing clear lines of communication with employees, business associates and downstream entities. The SIU will assist in supporting and enforcing established Company compliance standards which are clearly communicated through well-publicized disciplinary guidelines. The SIU will be diligent and alert and will immediately report findings related to potential compliance issues related to internal monitoring and auditing. The SIU will immediately report, as defined by state and federal guidelines, all suspected or confirmed incidents of FWA, and will assist state and federal investigative agencies on FWA investigations upon request.

Responsibilities:

The SIU is responsible for the following:

- Screening all reports of suspected fraud and abuse
- Establishing a file for each case of known or suspected fraud or abuse detected
  Inform the Regional Director of Regulatory Affairs of known or suspected cases of FWA in order to allow for the reporting to the appropriate state and federal agencies
- Obtaining necessary supporting documentation for all case files, including copies of medical records, member applications, correspondence, policies, medical bills and claim forms, corporate records, background reports, and other relevant documents
- Conducting investigations to conclusion in accordance with the procedures established by the SIU
- Maintaining records for a period of not less than ten years
- Educating and correcting providers, institutions, and or business partners on proper billing codes and/or procedures when FWA is identified
- Coordinating with the Legal Department during the course of an investigation as needed

Investigations consist of performing the extended procedures necessary to determine the occurrence of potential FWA activities as suggested by schemes, indicators, facts, and evidence. The investigative process includes gathering and verifying sufficient information in order to determine whether or not evidence suggests that fraud or abuse may have been committed.

The SIU reports directly to the Chief Compliance Officer, and is one component of the Company‟s overall Compliance Program. The SIU functions and responsibilities are broken down as follows:

- Education & Training
- Prevention and Detection
- Reporting
- Investigation
- Correction, Recovery and Resolution

Pre-payment Prevention and Detection:
The SIU utilizes an analytical tool called „Payment Optimizer‟ (“PO”), which is a fraud prevention/detection program developed by the Fair Isaac Corporation. The web based program uses advanced logic and statistical probability to identify potential professional claim lines that warrant further review. These claims lines have passed through all edits and are sitting on the check run tables primed for payment. The claim lines are „scored‟ each morning, and the results of the review are made available to the SIU. From 07/01/08 to 06/30/09 the SIU denied 91 claim lines for Missouri Medicaid recipients resulting in a net savings of $39,858.14. This savings is ten times higher than the 2008 amount of $3,934, and can be attributed to enhanced skill sets, specialized training, and a focus on J-Codes and Infusion Therapy treatment.

On a daily basis, the SIU Fraud Specialists, who are the designated staff responsible for working the pre-payment program, will review the identified claim lines with the goal of determining the validity of the claim. The Fraud Specialists use a combination of claims expertise, Current Procedural Terminology (“CPT”) knowledge, International Classification of Disease-Ninth Edition (“ICD-9”) knowledge, local and national coverage determinations, member history, provider history, contract language, Correct Coding Initiatives (“CCI”) edits, and Company Business Decision Documents (“BDDs”) to make the determination of allowing or denying payment.

If after review the examiner does not approve payment, the claim line in question is placed on hold, and will be transferred to our internal claims personnel to make the final decision on denial. This allows the claims personnel the autonomy to override the SIU suggestion. If the claims personnel concur with the decision the claim line is denied and the provider is notified on the check Explanation of Benefits (“EOB”) page for the claim. The provider may submit medical records in support of the denied claims, which will prompt clinical and coding review.

If the provided documentation supports the previously denied claim line, the Fraud Specialist will reverse the decision and allow payment.

A secondary aspect of the PO tool is the historical data and report capability it provides. This allows the Fraud Specialists to quickly search for aberrant historical billing patterns related directly

to the pre-payment activities they are working. Fraud Specialist continually provide the investigative team information on suspect providers which triggers a post pay review.

Based on the success of our pre-payment program we are again increasing staff, and will be adding 2 more SIU Fraud Specialists in October 2009. This will increase our capacity and will result in increased savings for 2009-2010.

Post-Pay Data Analysis:
The SIU Senior Data Analyst is responsible for creating specialized queries that allow investigators to identify members and providers with suspicious activity or unusual patterns of behavior that can indicate fraudulent or abusive behavior. The SIU utilizes a series of conditional queries, which were developed by the SIU Data Analytics staff, through Statistical Analysis Software ("SAS"), and run against our main data repository.

They include but are not limited to the following: „Up-coding", „Under-utilization", „Unbundling", „Misuse of Modifiers", „Unusual CPT Codes", „Over-utilization", „Double Billing", „Inclusive Evaluation and Management Services Billed Separately within Global Period", „Services Outside Scope of License", „EPSDT Frequency", „Inappropriately Billed Vaccine and Chemotherapy Administration Codes", „Anesthesiology Units Excessive or Unusually High", „Inpatient Admission and Emergency Room Evaluation and Management Codes Billed Same Day", „Basic Versus Emergent Ambulance Care", „Prolonged Service Codes Used Inappropriately", „CPT and Diagnosis Codes Mismatch", „Pharmacy Abuse", „Infusion Drug Usage", „Services by Unlicensed Individuals", „Technical and Professional Radiology Billing Abuse", and „Impossible or Unreasonable Time in a Day Based on Excessive Service Counts".

Once a provider has been identified as an FWA concern, a more detailed set of reports is generated, allowing investigators to view the entire billing and claims history for that provider. To maximize detection, the SIU thoroughly reviews the entire billing history of the provider, and attempts to identify all areas that are unusual or suspicious. This may result in expanded investigations with multiple allegations. The following reports are run on available to investigators through our SAS tool:

- „CPT Report", which is a summary report of the provider"s highest paid codes, dollars descending

- „Diagnosis Code Report", which is a summary report of the diagnosis codes most utilized by the provider, dollars descending

- „Top Paid Days", which is a summary report of the provider"s highest paid days, dollars descending

- „Claim Lines Billed", which is a summary report of the numbers of claim lines the provider bills per day

- „Top Member History", which is a summary report of the members that the provider has received the highest compensation for, dollars descending

- „Age Band Report", which is a summary report of the breakdown of dollars paid to the provider by age group, dollars descending

- „Detail History", which is the complete detail of all the provider"s billing, and includes all claim detail

Clinical and Coding Review:
Once an investigation has been triggered and medical documentation is reviewed the SIU is able to detect an array of FWA concerns as a result of clinical and coding expertise. The SIU has a full time Registered Nurse, a full time Coding Auditor, as well as having the full support of the Company Medical Directors. Through chart and patient interviews, clinical expertise and decision making enhance the ability to detect inappropriate treatment plans, unnecessary services, and underutilization of service and misuse of ICD-9 resulting in improper payment. The following are examples of FWA detected during the clinical and coding review: „Services Not Rendered", „Quality of Care", Medical Necessity", „Incorrect Diagnosis Codes", „Improper CPT Selection", „Services By Unlicensed Individuals", „Under-utilization", „Unnecessary and Excessive Labs and Testing", „Diagnosis Related Grouper ("DRG") Manipulation", „Hospital Caused Illness", and „Hospital Errors Resulting in Additional Surgery". The SIU has a full time Registered Nurse, as well as having the full support of the Company Medical Directors. Clinical review is imperative to a successful post-pay detection program.

The SIU Coding Auditor works directly with the SIU Clinical Nurse to review medical documentation. This combination is vital in gaining the complete understanding of the care provided to the patient as well as the code submitted on the claim. Findings are escalated to SIU management often resulting in expanded investigations. Additionally, the findings may be communicated to the SIU data team for further analysis.

It is a requirement for each SIU team member to attend a Certified Professional Coder (CPC) course within their first 18 months. From 07/01/2008 to 06/30/2009, 11 SIU staff attended such training, and 7 of the 11 passed the American Academy of Professional Coders (AAPC) CPC exam, thus gaining their professional accreditation in the process. The WellCare SIU has established a corporate membership through AAPC and believes it is vital to stay heavily engaged with the coding and billing community. Additionally, SIU team members are also required to pursue medical specialty specific training, allowing greater knowledge into the top medical specialties in the industry. Initial focus has been placed on Pharmacology, OB-GYN, Anesthesia and Pain Management, and Radiology. During the course of an investigation, the SIU also may choose to utilize expert peer review to clarify complex coding issues.

Internal Referrals:
The SIU receives multiple referrals from employees of the organization. Employees are trained to look for unusual or suspicious activity, and immediately report such activity through the Company Compliance Program. Employees are given multiple options for reporting suspected FWA and are informed of the rights and protections as whistleblowers as specified in the Deficit Reduction Act ("DRA") of 2005, and as part of the State False Claims Acts that resulted from the DRA of 2005. Indicators employees come across in their daily duties include but are not limited to the following:

- Paper claims with forged or altered signatures, dates, dollar amounts, or other material changes.
- Facilities, groups, and/or individual providers that do not provide an itemized bill identifying diagnosis, procedures, treatment modality, even after numerous requests.
- Facilities, groups, and/or individual providers that continuously postpone a medical record audit or refuse to allow a medical record audit, particularly if the reason given is vague or evasive.
- Medical bills that appear padded or inflated to cover forgiven co-payments or deductibles.
- Medical bills that are submitted on different dates, but each show the same date of service or overlapping dates of service.
- Dates of service in the medical records do not match dates of service on the bill.
- Medical bills list duplicate procedures or unbundled procedures to maximize payment.
- Medical treatments are unrelated to, or inconsistent with, the diagnosis.
- Facilities, groups, and/or individual providers that routinely render medical treatment that is not medically necessary or provides services unrelated to the diagnosis.
- Medical bills that show an unusual number of procedures, length of stay, irregular patterns of consecutive treatment days, or similar indicators.
- Medical and or pharmacy services billed but member calls to say the EOB reflects services that were never received
- Provider has never seen the patient on the dates indicated on the bill nor has no knowledge of the patient
- Facilities, groups, and/or individual providers that provide services to the member and his/her family members on the same date of service or dates of service close to the member‟s date(s) of service. This is particularly prevalent in mental health claims and chiropractic services.
- Medical bills show treatment on days either before of after the effective dates of eligibility and enrollment
- Referring facility, group, and/or individual provider and the treating facility, group, and/or individual provider share the same address.
- Members with date spans for inpatient stay in two facilities on the same day or series of days
- Referring facility, group, and/or individual provider and the treating facility, group, and/or individual provider share the same Federal Employer Identification, Tax Identification Number, DEA Number, Provider Identification Number, or Group Identification Number for billing
- Referring facility, group, and/or individual provider and the treating facility, group, and/or individual provider belong to the same professional corporation, subsidiary, or other business entity
- Providers changing patient diagnosis and clinical information after initial authorization request was denied; then resubmitting with new information in second attempt
- Number of prescriptions, or quantity per prescription, or number of refills is unusually large or if the drug is even refillable (narcotics are not refillable).
- Medications prescribed are not directly related to the diagnosis or standards of treatment.
- Location of the pharmacy is geographically different from claimant‟s residence or work place.

- Prescriptions are phoned into the pharmacy, but the prescribing physician has no record of calling them in.
- Pharmacy dispensed generic medications while brand name medications were billed.

All employees have the following avenues available to report suspected FWA:

- Informing their Supervisor
- Informing Regional Compliance Directors
- Contacting Corporate Compliance directly
- Calling the Compliance Hot-Line at 866-678-8355
- Utilizing the „E"-Hot Line"; http://wellcarelink.wellcare.com/sites/Trust_hotline
- Contacting the Chief Compliance Officer
- Providing written correspondence through Company mail
- Sending an e-mail to the #SIU e-mail address or e-mailing any of the SIU staff
- Calling the SIU staff directly or meeting an investigator and verbally reporting the concern

External Referrals:

The SIU receives multiple referrals through our external contacts. Providers, business partners and downstream entities have several methods to choose from to contact the Company with concerns related to FWA. Information sharing with state and federal agencies, other insurance companies and professional associations, can be very beneficial. Public information sources such as newspapers, public websites, and television news often have information related to physician arrests, member arrests and Class Action Suits. For Medicare Part D, coordination with the Medicare Drug Integrity Contractor ("MEDIC") as well as the Pharmacy benefit Manager ("PBM") will generate leads for Company investigators to target. As a member of the National Health Care Anti-Fraud Association ("NHCAA"), the Company has access to the information sharing website hosted by the organization which includes input from well over 100 insurance companies and the regular posting of current activities ranging from indictments to convictions on providers nationwide. This warehouse is constantly updated with new schemes, providers, and or institutions that have been identified by investigators from other member companies. By sharing information, companies and agencies are able to see the „whole" picture, thus exposing all aspects of possible exposure to "FWA".

The Company, through delegated vendor relationships, have specialized personnel with oversight of claims, dental, pharmaceutical, vision, behavioral health and other areas. Many of those vendors have responsibility to detect, prevent, investigate and correct FWA as well. Through oversight of the delegated vendors, the Company is responsible to ensure that FWA activities are carried out with all business partners, vendors and downstream entities. Clear lines of communication are vital for this element of the program.

The following avenues are available for external referral

- Calling Customer Service
- Calling 866-678-8355
- Contacting the Corporate Compliance Department
- Contacting the Chief Compliance Officer
- Providing written correspondence through US mail

- https://www.harmonyhpm.com/fraudabuse/fraudabuse/report
- Contacting the Company in any manner

Maintaining the Ability to Prevent, Detect and Adapt:
The SIU will continually adapt to new schemes through continued education and awareness, gains in technological platforms and overall expertise. The SIU will be proactive in attempting to prevent and detect FWA and will work closely with the Chief Compliance Officer, as a component of the Company Compliance Program, in support of meeting or exceeding state and federal guidelines for addressing FWA. Deficiencies and areas of weakness will continually be addressed by SIU leadership with the goal of maintaining a robust and well rounded FWA Program.

Reporting: The SIU is required to immediately report all suspected incidents of FWA to the Regional Director of Regulatory Affairs. Quarterly reports are also submitted which includes all complaints received. Confirmed cases of fraud will immediately be reported to State and Federal Agencies to include HHS-OIG.

Investigation: The SIU is staffed with 17 highly skilled personnel specializing in investigations, medical expertise, data analytics, pre-payment review, claims and CPT coding. Through patient interviews, review of medical documentation, data analysis and intelligence and information gathering, investigators are able to drive cases to resolution. The Company is committed to full cooperation with State and Federal Agencies and remains a member of the National Health Care Anti-Fraud Association ("NHCAA"). Investigative steps include but not limited to:

Providers:

- Search the HHS-OIG exclusion database
- Search the NHCAA SIRIS database
- Search for public records and leads on the internet
- Utilize Diamond, Sidewinder and Payment Optimizer to collect all internal data
- Document Par/Non Par as well as Cap or Fee for Service
- Document specialty type and verify medical license via state portals
- Verify and document the provider"s NPI number
- Verify and document the provider"s DEA number
- Verify and document Medicaid ID and Medicare ID
- Search public Division of Corporations websites for provider affiliations
- Log WellCare assigned Provider ID#, Vendor#, and Tax ID#
- Run the Top CPT and Top ICD-9 reports through ACCESS
- Record total monetary exposure for the entire history with the provider
- Run Accurint check as needed

Members:

- Pull all membership data from the Company database to include eligibility data, LOB, addresses and priority notes
- Search for public records and leads on the internet
- Pull member utilization reports for medical and pharmacy

- Run Accurint check as needed

Business Partners, Contractors and Downstream Entities:

- Search the HHS-OIG exclusion database
- Search the NHCAA SIRIS database
- Search for public records and leads on the internet
- Utilize Diamond, Sidewinder and Payment Optimizer to collect all internal data
- Document specialty type and verify medical license via state portals
- Verify and document the provider"s NPI number
- Verify and document the provider"s DEA number
- Verify and document Medicaid ID and Medicare ID
- Search public Division of Corporations websites for affiliations
- Run Accurint check as needed

Correction, Recovery and Resolution: Driven by the Chief Compliance Officer, the Company is vigilant in its pursuit of FWA activity involving its employees, members, providers, business partners, contractors and delegated entities. Results can range from re-education to termination and referral to law enforcement agencies. This may result in application of the Civil Monetary Penalties Law, False Claims Act, Anti-Kickback Statute or debarment of participation in Federal Programs. It is imperative to partner with state and federal agencies as well as other health plans to leverage full power in battling FWA.

Training and Education

All Company employees are required to attend mandatory fraud, waste and abuse „awareness, prevention and detection" training upon new hire and annually thereafter. In spring 2009, the annual FWA training was provided to all associates. The course content includes an in-depth overview of the impact of fraud and abuse on the health care industry, prevention and detection techniques, state and federal laws, how to report incidents of suspected fraud and abuse, and key elements of the Deficit Reduction Act of 2005.

Facility, Group, Individual Provider, and Member Anti-Fraud Education and Training

The Company will occasionally publish information in a „Provider Newsletter" featuring articles of interest to facilities, groups, individual providers, and members. Articles written by the SIU and other employees or copied by permission that provide updates, newsworthy topics, and other related information regarding the prevention, detection, and reporting of fraud and abuse will be included in publications. Projected articles may include:

- Steps to take if fraud or abuse is suspected.
- Resources available to combat fraud.
- Transcripts of actual fraud and abuse cases.
- Statistical reports and surveys illustrating the effects of fraud.
- Publicity of anti-fraud measures and other deterrents.
- Federal and State laws.
- Definition of fraud and elements of proof.
- Fiscal impact of fraud on business operations.

- Anti-fraud policies and procedures.
- The many roles of the SIU.
- Implications of committing fraud.
- Contract requirements regarding the fraud, waste and abuse.
- The effect of fraud the cost of health care
- Common fraud schemes and indicators.

The Company will post information pertaining to fraud, waste and abuse on the organizations company website, which will include links to referral forms, links to affiliated sites of interest, and links to articles of interest. The company will also post the Compliance Hotline number, 866-678-8355 on all relevant materials.

The SIU staff are required to maintain their professional education in FWA topics to include, but not limited to, medical coding, regulatory requirements, healthcare related laws, statistics, interviewing, and latest trends, patterns and schemes.

Reference Materials

The Company will maintain reference materials related to the prevention, detection, investigation, and reporting of fraud and abuse on file in the SIU. These materials may be made available to facilities, groups, individual providers, members, and employees through FWA education and training seminars and periodic publications.

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Information Management

The following information was taken from the MO HealthNet Managed Care health plans' SFY 2009 Annual Evaluations:

Blue Advantage Plus of Kansas City

Claims Processing – Timeliness of Claims Payment
BCBSKC administers claims processing via policies and programming according to RSMo 376.383 and RSMo 376.384. FACETS is programmed to process claims in accordance with Medicaid requirements. Monitoring is done on a daily basis, measuring inventory levels and quality performance, which ensures claims are being processed correctly and accurately.

BA+ has experienced an increase in the number of claims processed during FY09 in comparison to FY07 and FY08. The increase is due to the policy change on claims processing for New Directions Behavioral Health. In previous years, New Directions Behavioral Health was responsible for processing claims. New Directions Behavioral Health processed claims through EPOCH, according to the requirements/Statutes above. Their timeliness was monitored by audit services and reported for oversight to the Delegated Oversight Committee. Due to the new policy change, which went into effect January 2009, BCBSKC assumed claims processing responsibilities for dates of service January 1, 2009 and after.

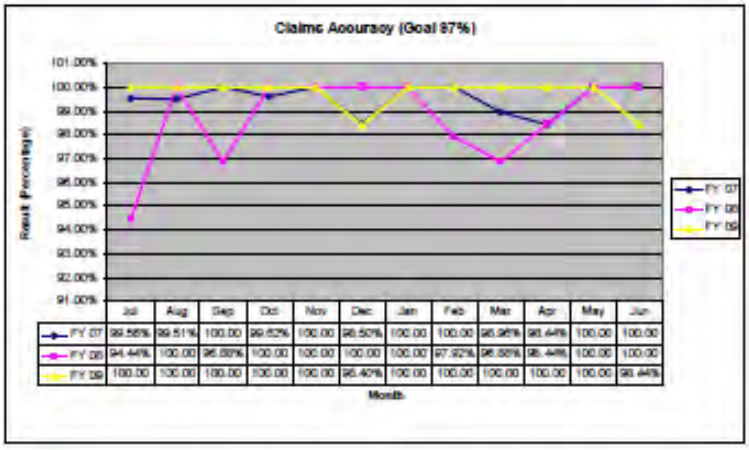
The table below indicates the number of claims processed for SFY07, SFY08, and FY09.

Year	Total Claims Processed
SFY07	313,264
SFY08	330,153
SFY09*	359,781

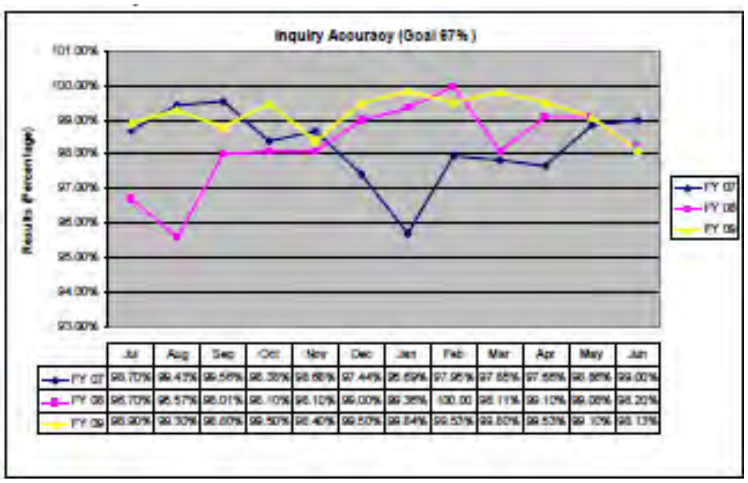
*BCBSKC began processing New Directions Behavioral Health Claims on January 1, 2009.

On a monthly basis, the BA+ Unit reports to the BA+ Oversight Committee the claims processing timeliness statistics. The statistics are generated by the Operations Performance Improvement Unit within BCBSKC's Operations Division. The BA+ Oversight Committee is managed by the Plan Administrator and Director of State Programs. The goal for claims and inquiry accuracy is 97%.

The graphs below indicate the claims accuracy and inquiry accuracy for FY07 through FY09.



BA+ has consistently met the 97% claims accuracy goal. In FY 09, BA+ received 100% accuracy for ten out of twelve months.



BA+ consistently exceeded the 97% goal for inquiry accuracy during FY09.

Membership

Membership is received nightly from the State of Missouri MO HealthNet Division and uploaded to FACETS. BCBSKC staff use this information to communicate with members. Currently, BA+ has approximately 30,000 members.

Providers

A listing of providers is provided to members at the time of enrollment into BA+. Members may contact BA+ Customer Service and request a copy of the Provider Directory as needed.

In addition, the listing of BA+ providers is located on the BCBSKC web site (www.BlueKC.com). Provider information is current in the FACETS system.

Changes to the provider network are sent through Infocrossing nightly. The entire file is sent weekly.

Children's Mercy Family Health Partners

Claims Processing – Timeliness of Claims Payment

Children's Mercy Family Health Partners (CMFHP) continues to refine and improve the claims processing system and work flow.

Below are the fiscal year claims processing results.

	Jul 08	Aug 08	Sep 08	Oct 08	Nov 08	Dec 08
Processed	41,671	36,648	48,509	38,021	45,974	36,873
Accuracy	99.8%	99.6%	99.6%	99.8%	99.6%	99.6%
Days to Pay	7.95	8.17	7.68	7.43	8.10	9.02

	Jan 09	Feb 09	Mar 09	Apr 09	May 09	Jun 09
Processed	45,240	43,630	52,540	38,939	41,291	50,216
Accuracy*	95%	98%	99%	99%	99%	96%
Days to Pay	6.43	6.82	6.32	6.02	7.48	6.64

* Department Quality Review methodology changed effective January 1, 2009

Children's Mercy Family Health Partners continued to enhance the quality review process to ensure that the claims data received from providers are accurately and timely processed for payment. This process looks at the scanning and imaging process and validation as well as the accuracy of system pricing tables and processing by each individual claims analyst.

Children's Mercy Family Health Partners uses coding detection software called Code Review. This software allows for the review of professional claims. It detects instances of unbundling procedural codes, services provided during a global surgical period, the appropriate use of multiple surgical procedures, and the accurate pricing and payment of those services. This is an ongoing refinement process to ensure that we are correctly interpreting current coding conventions.

Highlights of fiscal year 2009 were the consistent improvement in obtaining NPI information from providers, implementation of new production and quality standards for the claims department, improved appearance and layout of the remittance advice based on provider input, developed monthly duplicate claim payment reports, and conducted an audit of the pricing set up for all MO hospitals.

Membership
During Fiscal Year 2009, Children's Mercy Family Health Partners (CMFHP) made no changes in how membership data was received from the State and uploaded into our information management system. The Information Technology department continues to work in conjunction with the Customer Service department to ensure that daily data received from the State is readily available in the membership information/eligibility system. CMFHP employs a full time Eligibility Specialist to ensure that all member eligibility records are updated and maintained accurately.

Customer Service staff daily reviews the data indicating members who did not select a PCP and ensures that a PCP is selected (auto-assigned) to the member so that he/she will receive a member ID card within the specified time frame of five (5) days. CMFHP has a PCP assignment process that will auto-assign members to open panel PCP's without employee intervention Members can request Primary Care Provider (PCP) changes via the web site. Providers can also request member ID cards via the website if a member fails to present with his/her card. For each PCP assignment, ID cards are generated automatically.

Customer Service tracks returned mail and updates member addresses and phone numbers in a secondary field to increase the accuracy of mailings and outbound calls to members. The Customer Service staff also notifies MO HealthNet Division when members are identified who have mailing addresses outside of our service area.

In addition, Customer Service requests e-mail addresses from members to allow communication through e-mail as needed. When email is used to communicate with a member, encryption is used to ensure protection of PHI.

Additionally, Customer Service requests member language preferences and updates the language field in the eligibility software when a preference is obtained.

Providers
Children's Mercy Family Health Partners utilizes Cactus, a proprietary software, to maintain the provider credentialing database. The Cactus database allows the tracking of provider information including: languages spoken, licensure information, and educational background including residency information, office information, hospital privileges, and panel limits (if applicable). CMFHP can produce monthly provider directory updates that are inserted in the Member Handbook/Provider Directory and distributed to Customer Service staff who can then assist members who need help with selecting a provider or have questions about the provider network . CMFHP uses the data from the Cactus database to provide the information to our provider directory on our web site. This allows our on line directory to reflect the most current data available when accessed by our members or providers.

Children's Mercy Family Health Partners also maintains provider information in the claims system. With consistent communication between Provider Relations and the Data Quality staff who maintain provider change information in the system, the provider payment/contract information is kept current and accurate. Our claims payment system contains current Tax ID

Numbers, NPI numbers, contract arrangements and fee schedules, as well as billing and payment information.

Harmony Health Plan of Missouri

Claims Processing – Timeliness of Claims Payment

The Claims Department is responsible for institutional and professional claim activities.

These activities include:

- Processing pended claims that do not auto-adjudicate
- Researching and tracking claim issues
- Making final determination of issue/claims resolution
- Coordinating end-to-end resolution of operational related projects or correspondence
- Researching post payment claim issues and taking necessary action to resolve
- Working with provider relations team on operational issues
- Processing adjustments related to Projects or Correspondence

During the period of July 1, 2008 through June 30, 2009 the claims team performed at a 99.26% quality result. In regard to productivity the team performed at 100% of standard. Important to note is that during the past year activities were on-going to automate holds which reduced the overall volume of holds for the team.

The Departmental goals are to assist Provider Relations to recognize the provider's specific needs and maintain a mutually respectful relationship.

Claims are processed and paid in accordance with state, federal and MO HealthNet Managed Care contractual requirements. Clean claims are paid within 30 days from receipt or incur interest payments in addition to reimbursement.

WellCare operates in full compliance with regulatory requirements when dealing with provider complaints in accordance with all applicable rules and regulations.

Membership

Harmony Health Plan made significant enhancements to the information technology (IT) member enrollment processing during the contract year.

At the beginning of the contract year the Plan determined that we had a substantial number of members whose enrollment had been terminated from the State but whose enrollment was not terminated from our system because our 834 extract process did not match the State's process. Harmony Health Plan's 824 transaction file extract process only terminated members' eligibility in our system for members with effective dates and termination dates noted on the daily 834 files. However, for members who lose eligibility, that State sends enrollment terminations without entering the effective date on the transaction file. After multiple analyses and several

phone conversations with the State, we finally identified the root cause of the problem. Identifying the root cause, changing the programming, implementing the new extract, and accurately fixing our historical enrollment took most of the first half of the contract year. In 2009 the programming was changed and the membership was accurate.

During the contract year, we added members in the timeframe required.

Providers

Credentialing Process:

As detailed in the Quality Management section of this report, during the period of July 2008 – June 2009 Corporate Credentialing provided credentialing services to Harmony Health Plan of Illinois, Inc., - Missouri for the Medicare and Medicaid lines of business. Credentialing services included initial credentialing, re-credentialing, delegation of credentialing and oversight, disciplinary action monitoring, maintenance/compliance of credentialing documentation and full administrative support for the Credentialing and Peer Review Committee functions, agendas, reports, minutes, etc.

Initial Credentialing

During the period of July 2008 – June 2009 the target service level turn-around-time for new application processing was set at 93% of files to be completed within 23 business days. (Industry standard is 100% within 180 calendar days). Monitoring was performed on a monthly basis.

In the period of July 2008 – June 2009 214 new applicants were presented to Credentialing Committee on behalf of Harmony Health Plan of Illinois, Inc. – Missouri.

2008						2009						
Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total
0	63	28	14	17	19	6	12	8	22	0	25	214

Results – Eighty four percent (84%) or 180 files were processed within 23 business days, and sixteen percent (16%) 34 exceeded the 23-day processing timeframe however all files were completed within 180 days. A total of four files did not meet "clean" file criteria and were presented for in depth peer review. Internal quality review of credentialing files and database indicated 98% accuracy, with 2% minor keying errors identified such as transposed letters in street names or numbers in addresses.

Provider Portal on Harmonyhpm.com:

Providers now have the option to register on-line with Harmony to access web-based services. Once providers become registered users they can verify member eligibility, check claims status, and receive updates on authorization requests. Educational flyers, included with this document, have been distributed to and well received by, Harmony providers.

In addition, Harmony's newly enhanced IVR system can be used by providers to check the status of authorizations and claims or verify eligibility.

HealthCare USA

Claims Processing – Timeliness of Claims Payment

The claims department at Healthcare USA maintained a focus for FY 2009 to assure that high quality claims metrics were achieved and maintained. In 2008, the claims department monitored claims processed within 15 days, claims processed within 30 days, days in inventory, pends percent of inventory. For FY 2009, the CSO achieved and exceeded all production standards, except the percent pended.

Currently, the goals established are as followed:

- Claims Processed within 15 Days: 92.5%
- Claims Processed within 30 Days: 99%
- Days in Inventory: 2.5 Days
- Pends Percent of Inventory: 8.5%

Various system enhancements continue to be implemented in the HealthCare USA's claims processing area to ensure timely and accurate claim resolution for all claim types. Claims interest reports are reviewed and analyzed on a monthly and quarterly basis to identify any training issues related to claims payment or other opportunities for improvement.

Weekly quality meetings have been ongoing for FY 2009. Tracking and trending reports are run on a weekly, monthly, and/or quarterly basis to assess the following areas:

- High Dollar Errors
- Top Financial Errors
- Top Statistical Errors
- Top Errors by Examiner
- Modifiers
- GMIS
- COB
- Dollar Review
- Timeliness of Payment
- Adjustments
- Interest
- Quality
- Provider Billing Areas

Adjustment reports are analyzed and reviewed on a monthly and quarterly basis to identify adjustments by department, provider specialty, billing areas and claim status types. Employees receive feedback and additional training for ongoing professional development. Provider education is also completed when applicable.

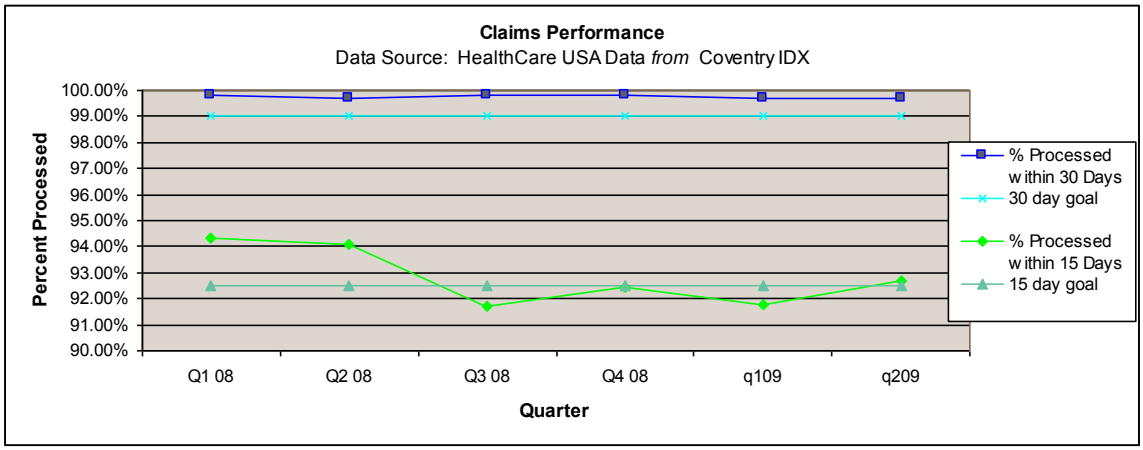
Continuous ongoing training has been emphasized during FY 2009. Training topics are as follows:

- Claims Training

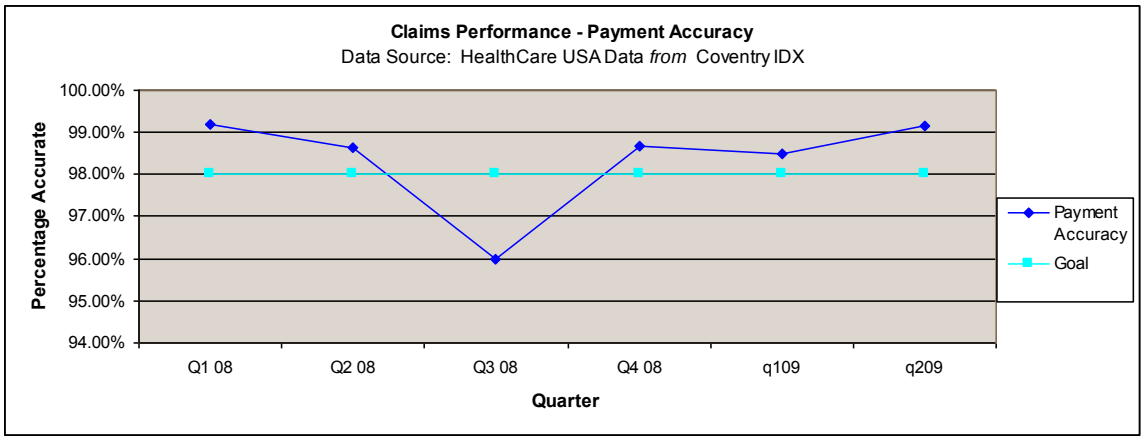
- Provider Billing Areas
- Adjustment Training
- COB Training
- Fatal Edit Training
- Navigator Training
- HIPPA Training
- Employee Rights
- Compliance and Ethics
- Fraud and Abuse
- Various Microsoft Applications

All new claims examiners receive a training class consisting of 8 to 9 weeks. They review provider selection, system overview, benefits, authorizations, navigator, remittance advice, GMIS, adjustments, ICD-9, CPT coding and COB. Cross training initiatives also took place in 2007-2008 between claims and customer service in an effort to maximize resources and gain efficiencies.

In addition to the above noted quality improvement initiatives, HealthCare USA's CSO has maintained outstanding service metrics with regards to both overall claim payment quality and timeliness throughout FY 2009. As we continue in 2009, the CSO is confident that by remaining focused on the day to day metrics, persistent application of enhancements and the continuous training of staff, HealthCare USA will continue to perform above expectations.



Continues to exceed goal.



Rate for first and second quarters 2008 did not meet goal. During this time there were several contracts that were being loaded and as a result, claims were forced to pend until testing and validation warranted that they could be released for processing.

Membership

The CSO handles all membership files for HealthCare USA. Files are downloaded daily from the State. Upon completion of this download, they are loaded and processed in the IDX software system. Listed below is a brief description of how each file is sent:

Reconciliation File:
HealthCare USA receives a reconciliation file from the State's IS Department (InfoCrossing) every Saturday. This file contains a snapshot of HealthCare USA's entire membership. This file is run every Monday or the first business day of the week only to add new members or term current members in the system.

Daily File:
HealthCare USA receives eligibility file from the State's IS Department (InfoCrossing) daily. This file contains all updates/changes on members' effective/termination dates as well as their demographic information. The file contains 3 components: an Eligibility file, a Health Assessment file, and a COB file. These files are loaded into an interface and processed each day.

Providers

PCP Assignment

All members are given the opportunity to select a PCP upon enrollment. Members are instructed to notify HealthCare USA, telephonically or by mail, of their choice of a PCP within fifteen (15) calendar days of receiving the enrollment packet from the state's enrollment broker. If no choice is made, a PCP is automatically assigned. Members can contact the CSO who can help members needing assistance in selecting a PCP.

Members that have disabling conditions or a chronic illness may request that their PCP be a specialist. The member's request to have a network specialist as a PCP is directed to the HealthCare USA's Medical Director for review. The requested specialist is asked if he/she is willing to accept the additional responsibilities of a PCP prior to the

approval of the request. The member is notified of the request determination verbally within ten (10) calendar days of the request. The written denial of a request is confirmed upon the verbal notification of the determination to the member. The written denial notification provides notice of the member's right to appeal and the process to initiate an appeal. The process for requesting a specialist as the PCP is not applicable to OB/GYNs when the OB/GYN has agreed to being the PCP for a member.

If the member does not select a PCP within fifteen (15) calendar days of receipt of their new enrollment packet, HealthCare USA makes an automatic assignment. HealthCare USA takes into consideration known factors and assigns the member to a provider that best meets the needs of the member. The factors considered include, but are not limited to: current provider relationship, age, language needs, location, special medical needs and panel size of the provider. If circumstances are such that the member does not have a PCP assigned on the effective date with HealthCare USA, HealthCare USA will not deny services or payment for any services.

HealthCare USA notifies the member of the PCP to whom they have been assigned. Members are given the opportunity to request a change of providers. The assignment of a new PCP under these circumstances is not considered as one of the two PCP changes allowed per year. HealthCare USA notifies the member of the PCP's name and address via the new member enrollment packet and the PCP's name and phone number via the member's HealthCare USA member ID card.

Maintenance of Provider Network Data

The Coventry Provider Database (CPD) is a windows-based IDX interface that is used across all Coventry plans. The CPD integrates the following:

- Provider credentialing
- Provider maintenance
- Provider contract instructions
- Rental network specifications
- Directory profiles

The Coventry Provider Database has the following features:

- Single point of entry for provider information (physicians, hospitals and ancillary providers) stored on a centralized provider database.
- Standardized credentialing process, including synchronizing credentialing for providers who are shared between multiple Coventry health plans.
- User-friendly mechanism for generating reports and extracts through Cognos
- Elimination of individual plan credentialing systems.
- Incorporates the current Electronic Provider Information Form (EPIF) and the many systems associated with the form.
- A method to proactively work towards increasing the quality of provider directories.

Encounter Data Submission

HealthCare USA has been conducting a performance improvement project for encounter data since 2005. This project was to meet the State's requirement of a 95% acceptance rate for all encounters sent to the State. The project focuses both on acceptance of claims and completeness

of claims. The original focus of the project was to meet the 95% acceptance rate. This was achieved in February 2005, and has been maintained through September of 2008, with the exception of two months when duplicate files were sent. The focus for 2007 was completeness of data. Interventions that resulted in improvements in the percent of encounters accepted are now a permanent part of the process for encounter data submission. Having achieved and sustained the goal of a 95% acceptance rate, the PIP was retired in the third quarter of 2009.

Missouri Care

Claims Processing – Timeliness of Claims Payment

Missouri Care received 535,768 unique claims for fiscal year 2008. Missouri Care utilized the QNXT 3.2 claim processing system developed by QCSI. In June 2009, Missouri Care upgraded the claim processing system to QNXT 3.4, also developed by QCSI. The health plan did not experience any significant downtime or disruption to either claim processing platform in the measurement period.

Membership

The Member Services Department performs daily and weekly audits to verify that member's enrollments are correct in our system. The audits compare the State eligibility file to QNXT and then QNXT to the State eligibility file, and capture any discrepancies in either file. Member Services makes the necessary changes to QNXT or works with the state to correct the eligibility file.

Providers

As part of daily operations, Provider Relations, Claims, Medical Management and Quality Management staff monitor the accuracy of provider records in QNXT. All errors or necessary changes are reported to the appropriate Provider Relations staff so that corrections or updates can be properly submitted to the Provider Information Management (PIM) team. All PIM system activity is audited by the Provider Relations staff who initiated the change request.

Molina Healthcare of Missouri

Claims Processing – Timeliness of Claims Payment

DATE	% of Clean Claims Paid Within 30/days	Average Turnaround Time
JUL 08	98.71	6.0
AUG 08	98.06	10.7
SEP 08	99.58	5.3
OCT 08	99.58	5.3
NOV 08	99.75	5.2
DEC 08	99.13	7.1
JAN 09	97.7	6.26
FEB 09	98.9	5.51

MAR 09	97.1	7.66
APR 09	99.3	5.56
MAY 09	99.7	4.92
JUN 09	99.6	5.40

Membership

Membership Activity	Member Count Per State Report	New Members Added	Terminations
JUL 08	75,952	2,505	4,274
AUG 08	76,944	*	*
SEP 08	77,375	*	*
OCT 08	77,866	1,855	*
NOV 08	77,606	1,678	*
DEC 08	77,314	4,849	6,633
JAN 09	77,606	4,544	4,234
FEB 09	77,782	4,411	4,212
MAR 09	77,810	5,056	4,840
APR 09	77,508	5,119	4,780
MAY 09	77,501	3,923	3,756
JUN 09	77,507	4,300	4,235

* Not available

Providers

During the reporting period, MHMO had 2,446 participating primary care providers (PCP) in its network.

Quality Management

The following information was taken from the MO HealthNet Managed Care health plans' SFY 2008 Annual Evaluations:

Blue Advantage Plus of Kansas City

Provider Satisfaction

The input of contracted physicians is vital for evaluating the services that BCBSKC offers to providers and members. HMO Physician Satisfaction Surveys are conducted, analyzed, and reported to the Quality Council with appropriate recommendations and action plans. Surveys were mailed to 2,265 physicians (specialists and primary care physicians) and office managers. The 2008 Physician Satisfaction Survey provided the following feedback:

a. Ninety-three percent (93%) of the primary care physicians, 96% of specialists, and 97% of the office managers rated BCBSKC‘s overall service as Excellent, Very Good, or Good.

b. Ninety-six percent (96%) of the primary care physicians and 99% of the office managers stated they would definitely or probably recommend BCBSKC to colleagues who were considering becoming network providers. Compared to 2006 and 2007 significantly more Specialist stated they would definitely recommend BCBSKC to colleagues who were considering becoming network providers (2008 55%, 2007 35%, 2006 37%).

c. Ninety-four percent (94%) of office managers from a PCP office and 92% of office managers from a Specialist office agreed that they could call Customer Service with claim questions and get an explanation of review.

d. Ninety-four percent (94%) of office mangers agreed that BCBSKC‘s Customer Service Staff answered there questions thoroughly. In addition, 92% of office managers agreed that BCBSKC‘s Customer Service Staff was easily accessible.

Case Management

Continuity and Coordination of Care – BCBSKC for BA+ maintains a comprehensive and integrated care management model in place of the traditional medical management programs. This program is built on the strengths of the core medical management functionality (Utilization and Case Management), and leverages state-of-the-art technology to integrate business processes, data and communications to allow a true patient-centric model across the care continuum.

The scope of products and services included in the transition from traditional medical management include case management, chronic condition management, and early detection of disease, prevention, and wellness. Using tools that enable us to identify members with future health risks such as predictive modeling and health risk assessments, we stratify members into risk categories, engage members in programs to reduce their health risks, proactively intervene with them and their physicians as appropriate, and evaluate the effectiveness of these programs.

BCBSKC/BA+ employs nine registered nurses, one dietitian, one social worker and one manager for the disease management programs. A dedicated registered nurse was hired to case manage the BA+ 0-6 year old population exclusively.

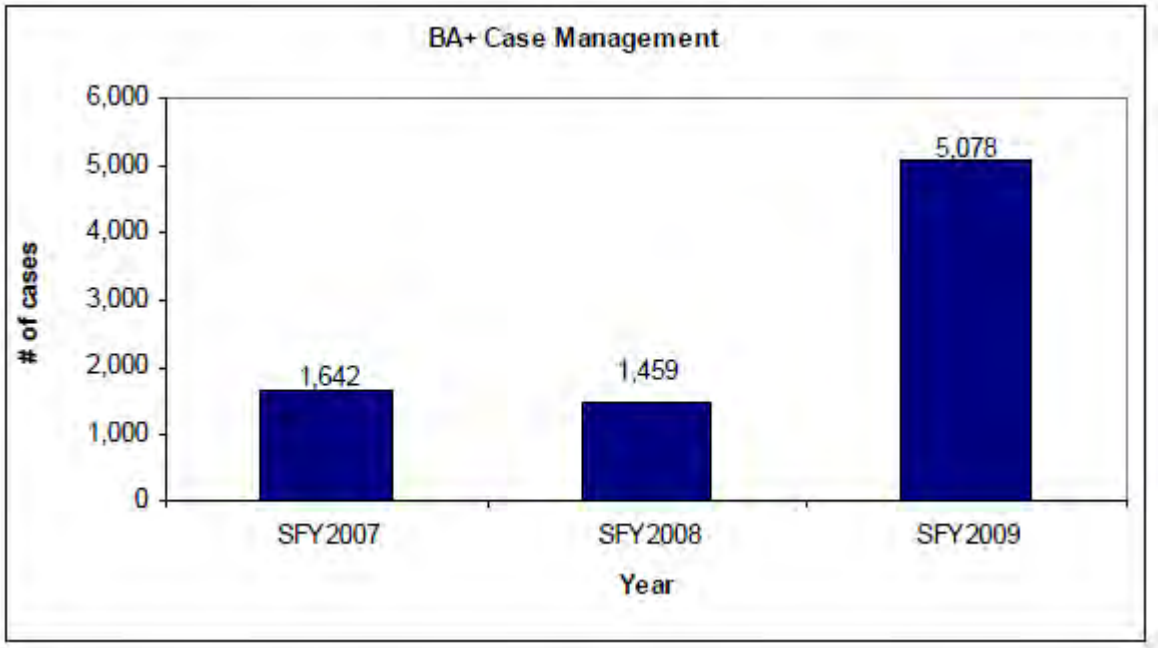
BCBSKC/BA+ measures network access and are compliant with section (4) of 20 CSR 400-7.095 for access and availability. The following is extracted from the Department of Insurance network approval letter of June 18, 2009.

Network Access	% of Members with Access to Services
Primary Care Physicians	100%
Specialist	99%
Facilities	91%
Ancillary Services	96%
Overall	97%

For BA+ members with coexisting behavioral and medical disorders, BCBSKC/BA+ has collaborated with New Directions Behavioral Health to implement a coordination of care process to ensure that case-managed members are receiving access to needed medical and behavioral services. An audit of cases handled by each group of care managers is conducted to identify opportunities to co-case manage appropriate patients, and to identify barriers to success. Care managers from BCBSKC and NDBH meet 4-5 times a year to review a representative sample of members. Several process improvements have been implemented because of this audit/review process. The Health and Behavioral Health Committee receives updates and reports of the co-case management activities.

Blue-Advantage Plus members are identified for case management services through multiple referral sources, which include disease management, discharge planners, utilization management, member self-referral and practitioner/providers. Case management is a collaborative process with our members in which the care managers assess, plan, implement, coordinate, monitor, and evaluate options and services to meet the member‘s health needs through communication and available resources to promote quality, cost-effective outcomes. The Case Management program is telephonically based with on-site management as needed. It is a dynamic process of on-going relationship building, communication and collaboration with clients, families, physicians and health care providers. The case management staff works to promote the optimum level of health for our members through referrals to disease state management programs, network management, benefits management and educational support. Patients with chronic, catastrophic, high-risk, or high cost conditions are referred to the Case Management Program for facilitation of an individualized plan of care. The pro-active Case Manager serves as an ongoing patient advocate, ensuring coordination of care and maximizing resources required to meet the Member‘s short and long term goals. There is a mechanism in place for Case Managers to respond on an urgent basis to situations that pose an immediate threat to the health and safety of the members. There are specialty nurse care managers for disease management, pediatrics, obstetrics, physical rehabilitation and transplants.

In FY2009, BA+ assisted 5,078 members with case management services. The number of members who received case management services in SFY2009 increased significantly in comparison to SFY2007 and SFY2008.



Analysis
The increase in the number of members who received case management services in SFY2009 can be attributed to the increased effort in screening more members for case management services and the addition of two full-time nurse case managers. By hiring more nurse case managers, BA+ was able to reach out to more members.

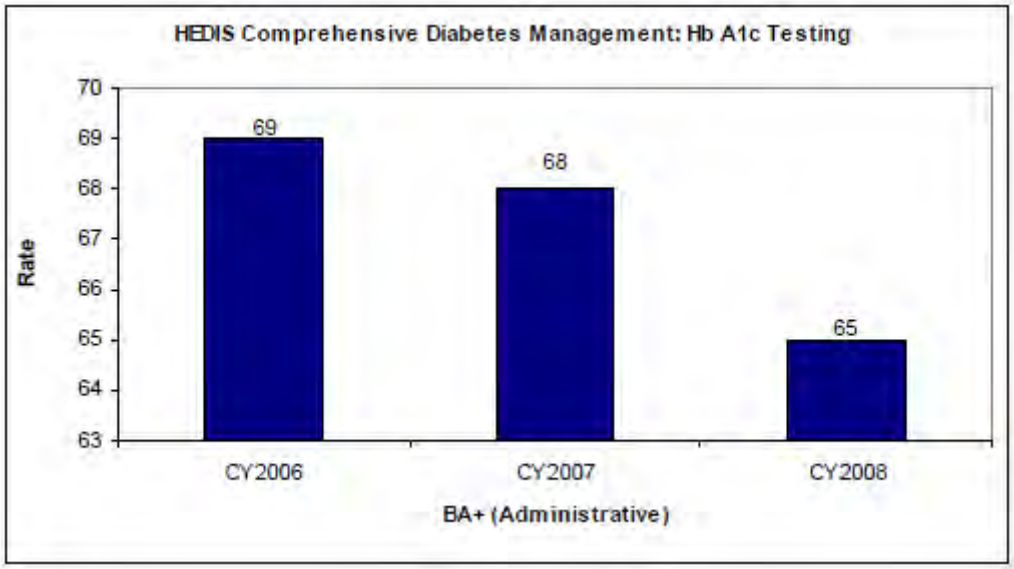
Disease Management Program
Healthy Companion Disease Management – The Healthy Companion Program is an education and care management support program for members with chronic disease. The Healthy Companion disease management program provides an ongoing support process that provides education and coaching to help members manage their conditions, which optimizes their health outcomes.

For the BA+ population, the targeted disease states are asthma, chronic obstructive pulmonary disease (COPD), diabetes, and heart failure. In October 2008, a disease management program for Coronary Artery Disease (CAD) was launched. Our programs educate members about recommended prevention and monitoring services to optimize their health status.

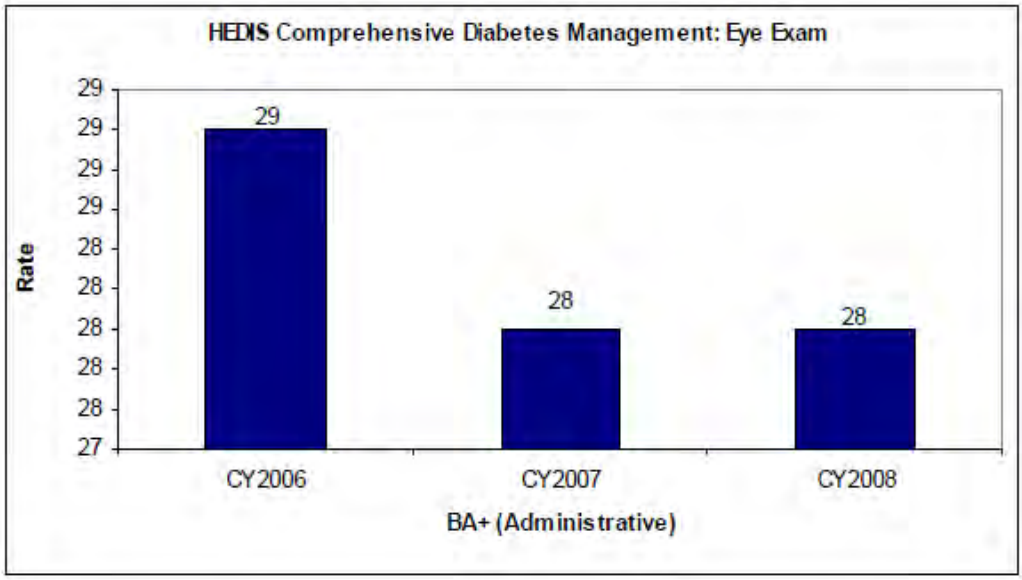
Explanation of HEDIS Measurement and Results
The following charts demonstrate our HEDIS results for 2008 (2007 claims experience) for BA+. Quality Compass benchmarks are shown, representing the 90th percentile of Medicaid HMO rates. Rates should be evaluated with the measurement methodology in mind, as the methodology can have a very significant impact on the results. Two methods are used for HEDIS measurement.

HEDIS Results and Quantitative Analysis

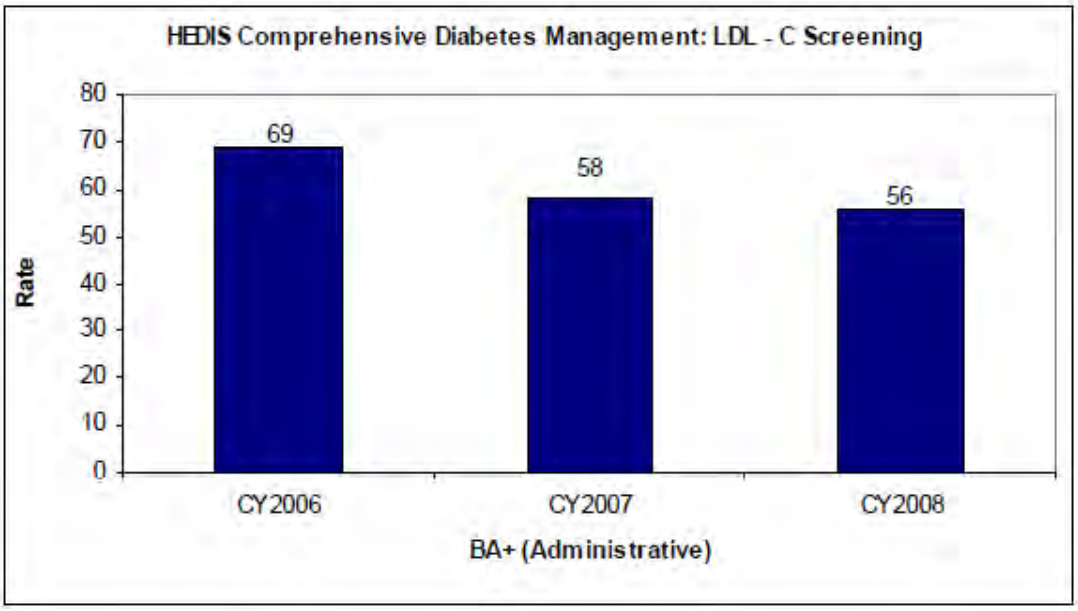
In 2008, the HEDIS results for experience year 2007 were evaluated for key measures related to the Healthy Companion program. Results were evaluated in light of interventions and actions taken to improve these outcomes. Results for each of these measures are discussed throughout the following pages.



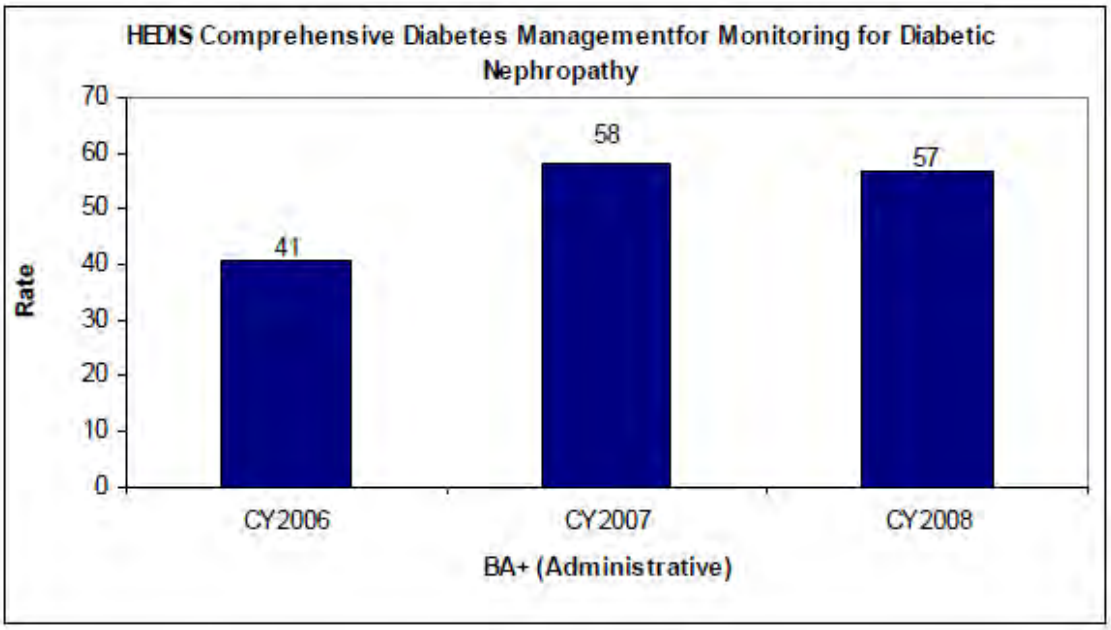
The result for comprehensive diabetes management, requiring hemoglobin A1C testing shows that HEDIS 2008 result for Blue-Advantage Plus is not significantly changed from HEDIS 2006.



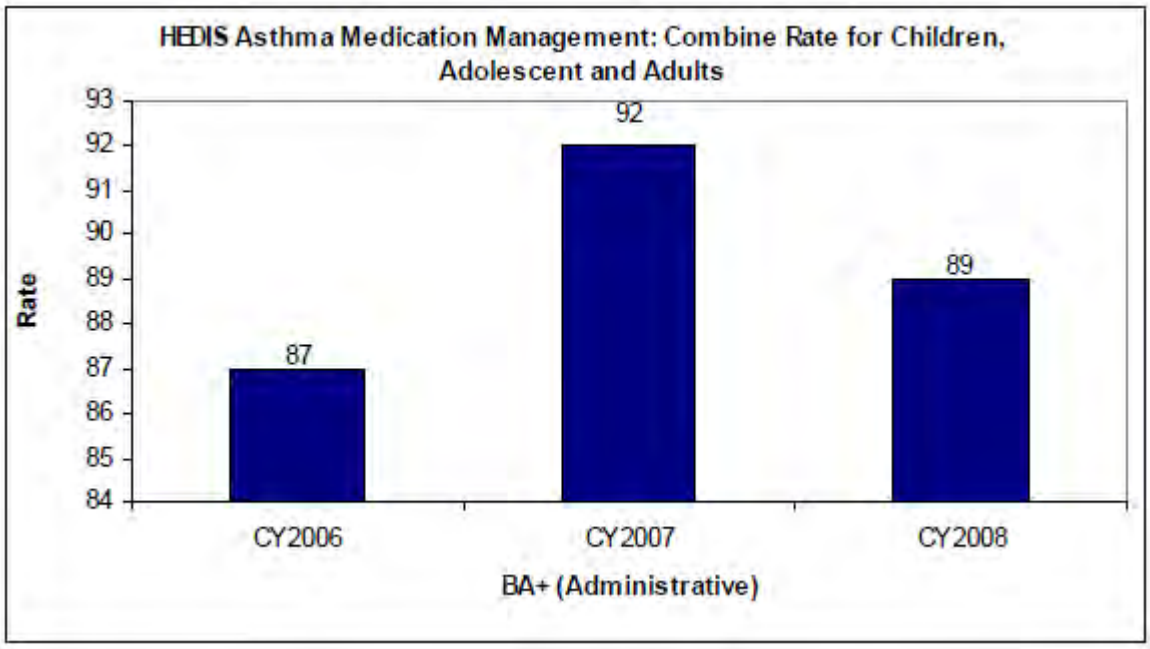
The HEDIS 2008 result for comprehensive diabetes management, requiring annual dilated eye exam, remained the same as for HEDIS 2007.



The HEDIS 2008 result for comprehensive diabetes management, requiring annual LDL-C screening, remained virtually the same as for HEDIS 2007.



The HEDIS 2008 result for comprehensive diabetes management, requiring annual albuminuria screening for nephropathy, showed a statistically significant increase when compared to HEDIS 2006.



The HEDIS 2008 result for asthma medication management was lower than HEDIS 2007 but higher than HEDIS 2006.

HEDIS Results – Qualitative Analysis
Qualitative analysis of the HEDIS results revealed several issues which were likely to have had a significant impact on some measures.

During 2007, BCBSKC implemented TriZetto's Care Advance Enterprise (CAE) system and from 2007-2008, as members were transitioned from vendored programs to our in-house program, the CAE platform was the electronic tool used to identify and stratify members for targeted interventions by the disease management campaigns.

The February 2007 launch of Care Advance campaigns was marred by inaccurate campaign data presented by the Care Advance Enterprise platform. This affected both mailed campaigns to low-risk and high-risk members, as well lists of targeted members for outbound disease management nurse contacts. As a result, we were unable to administer many of the planned clinical campaigns due to malfunctions in the rules engine and other processes in the CAE system. Thus, as members were transitioned to the in-house program, our ability to identify members who needed reminders for overdue services decreased. This issue continued into 2008 and it is reasonable to expect that results in HEDIS 2009 will also be affected. By the end of 2008, cross-divisional management teams determined that the Trizetto Care Advance campaign functions did not meet our business needs, and could not be remedied. Thus, a top priority for 2009 was to identify replacement solutions and implement a new process to produce campaigns and identify targeted members.

2008 Accomplishments
a. Completed ninth year of interventions for respiratory disease management program with improvement in clinical, utilization and functional status outcomes for asthma and COPD;

b. The Healthy Companion program achieved the member satisfaction goal in 2008, by surpassing 80 percent overall satisfaction;

c. Promoted appropriate influenza vaccinations to members in Healthy Companion program. This was accomplished by distributing coupons for obtaining the vaccination at selected sites for those over age nine in the DSM programs. Those under nine years of age were sent letters encouraging them to go to their PCPs for the vaccination.

d. Implementation of member inquiry/complaint tracking process; and added ability to report stratification levels.

e. 100 percent of members who completed a survey after engagement with a Healthy Companion nurse reported satisfaction with the program.

Behavioral Health Care Management including Case Management

AMBULATORY CARE – MENTAL HEALTH

In 2004, New Directions began the Personal Transition Service (PTS) Program, which provides one in-home intervention from a licensed behavioral health practitioner within 72 hours of discharge from the hospital. New Directions has identified and contracted with local clinicians that provide in-home therapy. The in-home service they provide is a one-time follow up post-hospitalization visit. While visits typically take place in the member's home, an office visit option is offered.

Each member receiving inpatient care management is screened for referral to a licensed PTS Clinician by the assigned New Directions Care Coordinator. Based on the results of the screening, a PTS appointment is scheduled within 7 days of discharge. During the individual session, the PTS clinician:

1. Reviews medications prescribed and medication adherence.
2. Ascertains that follow-up visits have been scheduled.
3. Develops an individualized safety plan.
4. Coordinates with New Directions staff if an urgent appointment is needed.

In 2008, 299 BA+ members were discharged from inpatient care, not including those that stepped down to sub-acute or residential care.

- 80% of members had a scheduled appointment within seven days of an acute care discharge
- 44% of members attended an appointment within seven days of discharge (HEDIS-like data)
- 17% of Members attended a PTS appointment post discharge

In the 1Q of 2009, 88 BA+ members were discharged from inpatient care, not including those that stepped down to sub-acute or residential care.

- 72% of members had a scheduled appointment within seven days of an acute care discharge
- 53% of members attended an appointment within seven days of discharge (HEDIS-like data)
- 19% of members attended a PTS appointment post discharge

The New Directions Care Management Team tracks and trends the post discharge care received by members. Many members discharge to C-STAR programs and/or out-of-network services

because they receive interventions from DFS, DMH, or the legal system. New Directions continues to analyze barriers to ambulatory follow-up.

FAMILY EVALUATION/THERAPY FOR ADOLESCENT/CHILD MEMBERS—MENTAL HEALTH

New Directions offers BA+ members the Parents and Children Together (PACT) program, which contributes to improved mental health status by providing intensive, in-home care and case management. A small group of affiliate clinicians that also do in-home therapy have been credentialed to address geographical gaps in the PACT program. Goals of this program include intervention with the family system, sustained medication adherence as needed, appropriate monitoring of symptoms and to enhance motivation for treatment and self-care among individuals at risk for relapse.

- In 2008, 126 BA+ Members benefited from in-home services.
- New Directions contracted with two facilities in 2008 to offer up to 72 hours of respite care services for children and adolescents during times of crisis. During respite, in-home therapy is introduced and the crisis averted.

CO-CASE MANAGEMENT

In a collaborative effort between BCBSKC and New Directions, BA+ members with co-existing medical *and* behavioral health conditions are referred to co-case management services.

BCBSKC medical case management and New Directions prevention and care management staff are available to each other on a daily basis via teleconference to identify, discuss and collaborate medical and behavioral health care for members. Members are assigned a level of acuity (Level I – FYI/Notification; Level II – Referral/Consultation; Level III – Coordination) and peer reviews are conducted quarterly.

- 18 BA+ members were identified for Co-Case Management in CY2008
- 9 members were assigned to Level I status
- 6 members were assigned to Level II
- 3 members were assigned to Level III
- 31 BA+ members were identified for Co-Case Management in 1Q & 2Q 2009
- 18 members were assigned to Level I status
- 8 members were assigned to Level II
- 5 members were assigned to Level III

MEDICATION OVERDOSE PROGRAM

The Medication Overdose Prevention Program was designed to decrease the potential for recurrent prescribed medication overdoses among members hospitalized for psychiatric and/or substance abuse treatment. NDBH Prevention Coordinators and Care Managers attempt to obtain the name and phone number of all of the prescribing physicians for members hospitalized with an overdose attempt. Known prescribers are contacted prior to a member‘s discharge. With the member‘s consent, a Personal Transition Services (PTS) follow-up appointment (in-home clinician visit) is scheduled prior to discharge from the hospital. The appointment is within 7 days of discharge. Key elements of a PTS appointment include a review of medications, appointments with outpatient providers and an individualized safety plan that addresses weapons in the home or access to sharps or medications. If a member declines a PTS appointment, an

appointment with a PTS clinician may be scheduled in the clinician's office or an appointment with an in-network Provider may be scheduled within 7 days.

- In 2008 and the 1Q & 2Q of 2009, 100% of prescribers were notified of their patient's prescription medication overdose.
- No Member was readmitted due to a second prescription overdose within 30 days of a previous attempt in 2008 or the 1Q & 2Q of 2009.
- 26% of members with a prescription medication overdose received a PTS visit post discharge in 2008. In the 1Q & 2Q of 2009, 57% of members with a prescription overdose received a PTS visit.

URGENT/EMERGENT APPOINTMENT ACCESSIBILITY

New Directions monitors urgent and emergent appointment accessibility to ensure timely clinical intervention and improved member safety. Licensed staff refers and assist members calling the Access Center to an appropriate professional resource for all emergent life threatening, emergent non-life threatening and urgent calls. The clinician then follows up to ensure the member was able to access care.

- In 2008 and the 1Q 2009, 100% of audited callers were offered an appointment with a provider within 24 hours of the call.
- Also in 2008 and the 1Q 2009, 100% of audited callers were directed to care within 6 hours of a non-life threatening emergent calls and immediate care for life threatening emergent calls.

Clinical Practice Guidelines

Clinical Guidelines apply to all managed care network physicians of applicable specialty. These are approved biennially by the Care Connections Advisory Committee (CCAC), and revised for approval as needed based upon updated clinical information from network practitioners and national organizations:

a. AAP – American Academy of Pediatrics
b. AAFP – American Academy of Family Physicians
c. AHRQ – Agency for Healthcare Research and Quality.
d. ACOG – American College of Obstetrics and Gynecology
e. ADA – American Diabetes Association
f. NHLBI – National Heart, Lung and Blood Institute
g. USPHSTF –United States Preventive Services Task Force

HMO physician compliance with clinical guidelines is assessed annually for a minimum of three distinct guidelines including one behavioral health guideline. Results are reported to the Quality Council with analysis and recommendations.

Credentialing and Re-Credentialing

The BCBSKC Corporate Credentials Committee policies ensure that network providers are qualified to provide health services to members. The BCBSKC Credentialing policies and procedures meet the following objectives:

a. To ensure that Medicaid members who enroll will have their care rendered by appropriately qualified credentialed providers.
b. To ensure that each provider application has equal consideration for eligibility to participate in the BA+ network in accordance with applicable laws and accreditation standards.
c. To ensure that adequate information pertaining to education, training, licensure, experience, malpractice and other relevant information is reviewed by the appropriate individuals and departments within BCBSKC prior to approval or denial by the Credentials Committee.

All M.D.s, D.O.s, D.P.M.s, D.C.s, D.D.S.s and other licensed independent practitioners who provide covered health care services to members and are or will be listed in the BCBSKC provider directories shall undergo the credentialing and recredentialing process according to the criteria outlined in the Professional Provider Credentialing Policy.

Institutional providers, (i.e. Hospitals, Home Health Agencies, Skilled Nursing Facilities, and Ambulatory Care Centers) are credentialed and recredentialed in accordance with the Institutional Credentialing Policy.

URAC awarded BCBSKC-BA+, a Certificate of Full Accreditation for compliance with Health Provider Credentialing Standards, version 3.0 effective March 1, 2007 through March 1, 2010.

Medical Record Review
Annually Blue Cross and Blue Shield of Kansas City audits the medical record documentation practices of participating HMO and PPO physicians utilizing an internally developed set of criteria. The purpose of the review is to assess compliance and identify areas for improvement and implement network-wide interventions.

184 patient files were randomly chosen from the list of Blue-Care and Blue-Advantage Plus members selected for the HEDIS medical record review (approximately 2000). The audit was performed March through May of 2009 against six of the 25 medical record documentation criteria. Criteria selection was based upon areas that consistently performed below the 80% goal and presented the greatest opportunities for improvement. In addition to the six MRDR criteria, data was also collected regarding documentation of foot exams for diabetic patients and what type of medical record system the office used – electronic, paper, or a combination of both.

Goal: 80%

The results are as follows:

Criteria	2009	2008	2007	Statistical Change '09 to '08
# Medical Records	184 (varied)	148	134	
Problem List	15.6% (28/180)	78.4%	86.57%	Yes ⇩
Adult Immunizations	64.1% (118/184)	51.5%	42.75%	Yes ⇧
Depression Screening	10.3% (19/184)	26.4%	18.69%	Yes ⇩
BMI recorded in chart	72.7% (143/184)	NA	NA	NA
Continuity/Coordination of care between PCP and specialist for diabetes and CAD	64.7% (88/136)	NA	NA	NA
Documentation of diabetic foot exam	56.3% (49/87)	NA	NA	NA
EMR system	23.4% (43/184)	NA	NA	NA
Hybrid medical record system – EMR and paper	4.9% (9/184)	NA	NA	NA

Analysis
Out of five medical record documentation criteria assessed none met the 80% goal. A statistical change was present with three of the criteria:

- Documentation of Adult Immunizations improved
- Problem List and Depression Screening had a statistical drop in results

The remaining two criteria were not audited in 2007 or 2008.

Overall performance is mixed. The most dramatic change is the Problem List. This is a key piece of documentation as it outlines the dates of chronic illnesses and serves as a reference, especially when the patient is seen by a physician that is not the PCP. Conversely, BMI and Continuity and Coordination of Care fared higher than expected.

Documentation of diabetic foot exams was requested by the Manager of Care Management. This is one standard of care for diabetes members that cannot be tracked via claims data.

Barrier Analysis
The challenge is to accurately identify and remove barriers to assist the physician to demonstrate improvement of non-compliant criteria and successfully maintain and sustain compliant medical record documentation.

- There are no interventions planned in 2009 to address medical record documentation issues with physicians.
- A different vendor was hired to perform the custom chart review in 2009. Unlike in 2008, the nurses were trained on the criteria prior to extraction.

Recommendations

1. Submit to the Peer Review Committee for review and recommendation of further action.
2. Publish an article in BlueSpeak regarding medical record documentation practices.
3. Consider providing feedback to physician offices on individual Medical Record Document Review results

Subcontractor Monitoring

BA+ can delegate the authority to perform health plan functions on its behalf; however, it cannot and does not delegate the responsibility for insuring that the functions are performed appropriately. To ensure that the quality of care and services provided on behalf of BA+ is maintained, functions will be delegated to only those entities meeting or exceeding BA+ standards. In addition, the State Programs Department has a comprehensive compliance program, including requirements for documentation submission. Compliance with contract Requirements is taken very seriously at BA+. Analysis of compliance is completed at least annually and more frequently if required.

The Delegated Oversight Committee Chair, responsible for pre-delegation assessment of potential subcontractors, will notify the BA+ Plan Administrator of the desire to subcontract with a new entity. The BA+ Plan Administrator will notify the State of Missouri MO HealthNet Division, providing all requested information. The BA+ Plan Administrator will notify the Delegated Oversight Committee Chair of the decision of the State upon receipt of notification. An implementation plan will be developed, including consideration for transition of care and notification to the members.

BCBSKC and the subcontracting entities have signed agreements before providing services to BA+ members. All agreements provide a description of the services to be fulfilled by the entity. Included in the services that need to be provided to members are State and Federal requirements, and delegation requirements. BCBSKC may choose to delegate specific responsibilities to the entity at BCBSKC‘s discretion. If delegation is agreed upon, the responsibilities delegated are overseen and audited through the Delegated Oversight Committee at BCBSKC – managed through the Quality Management Department. Delegation agreements are reviewed annually for compliance of expected outcomes.

New Directions Behavioral Health, L.L.C.

Type of Service: Behavioral Health – Provide all covered mental health services to all BA+ members, with the exception of the COA4 members (coverage of these members is covered by the State of Missouri MO HealthNet Division).

Delegation Assignment: Claims, Utilization Management, Member Grievances and Appeals, Provider Complaints, Case Management, Credentialing and Quality Management, Care Coordination

Oversight Meetings: 12/11/2008 and 6/16/2009

Doral Dental
Type of Service: Dental Services – Provide all covered dental care services to all BA+ members having dental benefits.
Delegation Assignment: Claims, Utilization Management
Oversight Meetings: 12/2/2008, 3/24/2009, 4/24/2009, 5/22/2009, and 6/25/2009
Corrective Action: Doral Dental has been on a corrective action plan for not meeting the average speed to answer goal (no greater than 30 seconds) and the abandonment rate goal (no greater than 5%). BA+ is monitoring and working closely with Doral Dental to resolve this issue.

Doral Dental has implemented the following corrective action plans:

- Recruiting efforts were implemented to fill eight open customer serve positions
- Changed call center management and VP and replaced with experienced Call Center management experience.
- Three temporary employees started working for Doral Dental on 12/10/2008.
- The HR Department started monitoring staff and they will ensure temporary employees are assisting Doral to meet requirements.
- Additional training and quality monitoring will be provided.
- Adjusting staffing models as call volume is analyzed.
- Revising IVR to enhance capabilities and evaluating of scripts.

Doral Dental must meet the average speed to answer goal and the abandonment rate goal for six consecutive months in order for the corrective action to be removed. The goal for speed to answer should be no greater than 30 seconds and the abandonment rate goal should be no greater than 5%.

Medical Transportation Management
Type of Service: Medical Transportation – Provide non-emergent transportation services to BA+ members having transportation benefits.
Delegation Assignment: N/A
Oversight Meetings: 7/29/2008, 9/5/2008, 11/11/2008, 1/6/2009, 2/4/2009, 3/27/2009, and 6/24/2009
Corrective Action: During FY 2009, MTM was placed on corrective action for not meeting the abandonment rate (no greater than 5%) and speed to answer (no greater than 30 seconds) goals. BA+ is working closely with MTM to resolve this corrective action. MTM has implemented the following corrective action plans to meet the abandonment rate and speed to answer goals:

- MTM increased the number of CSRs who maintained the BA+ queue.
- MTM placed a higher focus on managing Mondays by making staff adjustments. This is required since they receive up to 20-25% of all calls on Mondays.
- MTM will implement ~~–P~~ipkens" workforce management tool in mid-August. This tool will collect and analyze call center data, aiding in Blue-Advantage Plus – Annual Appraisal of the QI Program – Program Year SFY2009 64 scheduling, schedule adherence and other various staffing needs in the call center environment.
- A higher discipline regarding CSRs' time management has been maintained. It is critical to adhere to set schedules including time spent in the available and talk time mode.

MTM must meet the average speed to answer goal and the abandonment rate goal for six consecutive months in order for the corrective action to be removed. The goal for speed to answer should be no greater than 30 seconds and the abandonment rate goal should be no greater than 5%.

The subcontractor contracts are managed within the Health Care Services Department of BCBSKC for BA+.

Children's Mercy Family Health Partners

Program Review
The purpose of the Quality Improvement Program is to provide a framework for the continuous improvement of the health care provided to Children's Mercy Family Health Partners (CMFHP) members through assuring the provision of appropriate, affordable and accessible care. This is accomplished by identifying, evaluating and monitoring the quality of health care services provided to or proposed for plan members. All CMFHP providers are required to collaborate with the Quality Assurance and Performance Improvement activities. One component of the program is to assess and improve the satisfaction of members through the development, administration and evaluation of surveys.

Survey Development
Purpose and Objectives

Children's Mercy Family Health Partners purpose for completing the Medicaid Child Satisfaction Survey is to provide an assessment of member satisfaction with the health care services provided during the last six months. All of CMFHP Missouri enrolled children in the Title 19 and Title 21 programs and meeting the enrollment criteria, as designated by the survey requirements, are the eligible population. A random sample is completed from the identified population. Based on this assessment, CMFHP will evaluate the outcomes and identify areas for improvement.

The objectives of the Medicaid Child Satisfaction Survey include:
1. to meet the contractual requirements to the State of Missouri;
2. to capture accurate and complete information about consumer-reported experiences with health care;
3. to measure how well CMFHP is meeting the members' expectations and goals;
4. to determine which areas of service have the greatest effect on members' overall satisfaction; and
5. to identify areas of opportunity for improvement, which could aid CMFHP in increasing the quality of care provided to its members.

Survey Audience(s)

CMFHP will utilize the survey and outcomes to inform the following entities of member satisfaction:

1. State of Missouri; MO Net Division;
2. State of Missouri; Department of Health and Senior Services;
3. CMFHP CEO, Directors and Board of Directors;
4. CMFHP Administrative Oversight Committee;
5. CMFHP Subcontractors;
6. CMFHP employees;
7. CMFHP members; and
8. CMFHP providers.

Survey Instrument

CMFHP utilized the existing and contract designated CAHPS 2009 Medicaid Child Survey. The CAHPS 2009 Medicaid Child Survey is developed and registered by the U.S. Agency for Healthcare Research and Quality. The survey is a standardized industry survey. The following statement regarding survey development is from the website for the Agency for Healthcare Research and Quality.

The development of the CAHPS Health Plan Survey began in 1995, when AHRQ awarded the first set of grants to Harvard, RTI, and RAND. In 1997, the Consortium released CAHPS 1.0 for public use.

Since that time, the Consortium has clarified and updated the survey instrument to reflect

- Field tests results;
- Feedback from industry experts;
- Reports from sponsors, vendors, and other users; and
- Evidence from cognitive testing and focus groups.

The CAHPS Consortium recently released the latest version of the instrument: the CAHPS Health Plan Survey 4.0. The development of this update to the Health Plan Survey has been part of the "Ambulatory CAHPS (A-CAHPS) Initiative," which arose as a result of extensive research conducted with users in the first year of the CAHPS II contract.

Key Steps in the Process

Interviews with Stakeholders: In the first year of the CAHPS II contract, the Consortium members interviewed a variety of stakeholders about their experiences with the Health Plan Survey to learn what worked well, what needed improvement, and what they wanted to see in future surveys for the ambulatory care setting. Feedback from these interviews was pivotal in the early planning stages of the 4.0 version of this survey. Additionally, the RAND CAHPS Team conducted research with health plans around the country in 2003 to elicit their perspectives on the instrument. To learn more about this research, go to https://www.cahps.ahrq.gov/content/resources/QI/RES_QI_Supplemental.asp.

Creation of a A_CAHPS Advisory Group: To support the development and implementation of the updated CAHPS Health Plan Survey and the new Clinician & Group Survey, the Consortium established a new Advisory Group comprised of key stakeholders: accrediting bodies, major provider and health plan associations, purchasers, and consumer representatives.

Members of A_CAHPS Advisory Group: Through the Advisory Group, these stakeholders have opportunities to learn about and participate in the development process and provide input into the products. The Advisory Group has had two in-person meetings (on December 1, 2004 and on June 15, 2005) and one meeting via conference call (on March 2, 2006).

Ongoing Outreach to Sponsors, Users, and Consumer Organizations: The CAHPS Consortium takes advantage of various opportunities to inform interested parties about the updates to the Health Plan Survey and elicit comments and questions to advance its development. These outreach vehicles include meetings, Webcasts, newsletter articles, and requests for public comment through the *Federal Register*. As part of this effort, the Consortium has shared each draft questionnaire of the Health Plan Survey 4.0 with various stakeholders and, asking for their input on domains, topics within domains, item content, and response scales. This feedback has helped to ensure that the survey results for each level of the health care system reflect functions that are truly under their control.

Cognitive Testing: In order to determine whether the questionnaire items are understandable and meaningful to respondents, the CAHPS Consortium and the National Committee for Quality Assurance (NCQA) submitted the draft of the Health Plan Survey 4.0 to multiple rounds of cognitive testing starting in December 2004. This testing helped survey developers choose the most accurate and accessible language in English as well as Spanish for each question included in the survey.

Field Testing: Once the Consortium had incorporated findings from cognitive testing into the draft instrument, they moved on to the field testing stage. Working closely again with NCQA, they submitted the instrument to field tests at 6 geographically diverse sites in the spring of 2005 and spent the following months analyzing the field test data and revising the instrument accordingly.

Submission of the Instrument to the CPM and AQA: In January of 2006, the Consortium submitted a draft of the CAHPS Health Plan Survey 4.0H to NCQA‘s Committee for Performance Measurement (CPM) for review. After examining the instrument, the sampling and data collection protocols, and field test data, the CPM granted official approval for the core questionnaire and the HEDIS supplemental set to be released for public comment. The Ambulatory Care Quality Alliance also accepted the instrument in January.

Final Steps: The CPM‘s approval of the Health Plan Survey 4.0H draft allowed for its inclusion in the HEDIS 2007 public comment period, which took place in February and

March of 2006. NCQA and the Consortium adjusted the instrument one last time based on feedback from this month-long period.

AHRQ released the Health Plan Survey 4.0 in November 2006, along with guidance on how to customize and administer it. In 2009, NCQA accepted the 4.0H version of the child questionnaire.

Contributors to the Health Plan Survey‘s Development: Organizations contributing to the development of the CAHPS Health Plan Survey include the following:

- American Institutes for Research (AIR)
- Harvard Medical School
- RAND
- Research Triangle Institute (RTI)
- Westat
- Centers for Medicare & Medicaid Services (CMS)
- National Committee for Quality Assurance (NCQA)
- Foundation for Accountability (FACCT)
- Child and Adolescent Health Measurement Initiative (CAHMI)

Survey Administration
Implementation of the Survey
The CAHPS Medicaid Child survey was formatted, reproduced and distributed by The Myers Group. The sample frame was approved by the NCQA/HEDIS auditors and then sent to The Myers Group for administration. Creation and oversight of the file production was completed by the IT Analyst.

CMFHP‘s administrative agent, The Myers Group, has been associated with CAHPS administration for CMFHP for ten years. CMFHP has confidence in the administrative agent‘s processes of administration. CMFHP and The Myers Group coordinated initial dates of delivery and processing during the contract period. Both entities participated in teleconferences to review the processes and administration. An interim report teleconference was conducted in May 2009. CMFHP has a strong collaborative relationship with the assigned account representatives. CMFHP utilizes the on-line –Client Services” tracking portal to monitor receipt of surveys throughout the survey process. In addition, CMFHP maintains a tracking log of survey returns.

CMFHP accepted the NCQA definition of a completed Child CAHPS 4.0 survey for the MOHN Child CAHPS 4.0 survey. The NCQA definition of a completed survey are 1) the member answers one or more survey questions and 2) the member responses indicate the member meets the eligible population criteria.

CMFHP‘s CAHPS survey sample size was established with the goal of achieving 411 valid and complete surveys. This target goal for complete and valid surveys was based on the average number of complete and valid surveys obtained by health plans in previous years. Most plans should obtain between 385 and 412 responses to achieve 95% confidence level and +/- 5% margin of error.

According to the CAHPS protocols, CMFHP must achieve a minimum of 411 completed surveys, or 100 responses for each CAHPS survey question to report CAHPS survey results for that question. If the number of responses to any question is less than 100, CAHPS results calculated using that question receive a measure result of Not Applicable (N/A). The CMFHP MOHN CAHPS 4.0 survey target number of completed survey responses was 411. The completed number of surveys for the MOHN Child Population was 374. The question frequencies for the composite attribute and rating questions revealed at least 100 valid responses for the MOHN Child General Population in all but seven of the eighty-two (82) survey questions. Four of six custom questions had at least 100 valid responses.

CMFHP's contracted vendor, The Myers Group, performs response/non-response bias analysis in order to validate that the responses received accurately reflect the demographic and eligibility characteristics of the sample population.

CMFHP administered the survey through The Myers Group and did not encounter any problems with the survey process.

CMFHP's prior experience in contracting with The Myers Group included an overview of its administrative processes to ensure data quality. The Myers Group has provided the following description of these processes.

The Myers Group
Data Collection Processes and Quality Assurance Process for Received Data

Database Development
The standard mixed methodology is used for the Medicaid Child and CAHPS Medicaid Child with Chronic Illness CAHPS enrollee data collections, following the NCQA's basic tasks and time frames. The Myers Group pursues contact with potential respondents until the selected data collection protocol is completed.

With respect to the CAHPS surveys, The Myers Group obtains confirmation from the client that a certified auditor has validated the data sample frame prior to sampling. Using the enrollment file to be supplied by the client, The Myers Group develops the sampling methodology for the surveys consistent with NCQA protocol.
Raw data from multiple sources and formats are incorporated by The Myers Group to form an accurate and cohesive file and/or sample in preparation for the mailing process.
The Myer Group's data services include:

- Complete list maintenance
- Merge multiple lists and purging duplicates
- Post net bar-coding, carrier route and zip+4 appending
- Data conversions from CD-ROM, diskette, or tape
- Address updating to meet USPS regulations including National Change of Address (NCOA) & Address Change Service (ACS)
- Endorsements (Address Service Requested, etc)
- Print labels and lists

In order to achieve the target response rates, The Myers Group Project Manager (PM) first works with the client to devise the sample file (i.e. the eligible population from which to draw the sample) for each of the surveys to be conducted. NCQA sampling procedures are strictly followed. At the beginning of the project, the client receives a worksheet containing instructions from the PM. These instructions guide the process of compiling the data for the membership file. After receiving the membership file, the PM conducts an extensive verification process before and after the sample frame is drawn. The Myers Group uses a unique three- tiered approach to "de-duplicate" the sample file to ensure only one sample member per household is selected to receive a survey. The addresses and telephone numbers of each sample member are verified and/or updated using the National Changes of Address (NCOA) and CASS registries, and the most accurate, up-to-date external database sources. The Myers Group understands the sample frame is one of the most critical components of a successful survey project and, therefore, we take steps beyond NCQA's requirements to verify audit membership files.

- All elements of the file are verified by the PM and a database audit worksheet is completed by PM.
- The database is then forwarded to The Myer Group's Information Technology department (IT). IT cleans the database and a raw data statistics program is run, followed by two audits.
- Raw Data Statistics are reviewed to ensure the data population statistics appear correct.
- Twenty-five random members are compared from "cleaned" raw data and original raw data. The PM completes a Job Control Worksheet (JCW) and the database is run through the National Change of Address (NCOA) software program. The PM pulls the sample from the JCW and a Sample Data Statistics program is run on the database.
- The PM reviews the Sample Data Statistics to ensure the sample complies with standards and includes the correct information required by the client. The PM verifies the sample against the Job Control Worksheet to ensure all data areas requested by the client have been pulled. The PM approves the sample and our Management Information Systems (MIS) group runs a ZIP Code update program. Next MIS generates unique ID numbers for the sample members. The updated sample is pulled into the SMS for Mail Merge processing and output to Neo-post. The Myers Group provides all means necessary to collect the responses by return mail, conduct data entry, and ensure data retention.

Member Confidentiality

The Myers Group maintains confidentiality of randomly sampled members. Neither NCQA nor HMOs have access to the names of members selected for the survey.

Confidentiality of the sampling frame members is accomplished in the following manner:

- For each member, personal-identifying data is separated from member response data within the SMS
- Mechanisms are in place for preventing access of these files by inappropriate individuals
- Automated system safeguards – password and access levels – are established
- Confidential materials are kept in locked filing cabinets
- Employee confidentiality agreements for all staff with access to sensitive data are required
- The electronic and hard copy materials related to conducting the survey project is maintained in a secure location with limited access

Mail Survey Data Collection
The Myers Group provides all postage/return postage resources, complying with all applicable regulations of the United States Postal Service. We have the capability to process several classes of mail, including first class, first class presort, and standard presort. Among the outgoing mail services offered by The Myers Group are:

- Personalized letters with addressing
- Laser addressing for personalized mailings
- Address imaging and label affixing
- Inserting and folding
- Sealing, metering, stamping, and sorting

The Myers Group's 4,550 square-foot mail facility utilizes equipment that is specifically designed for the mail fulfillment industry, such as the MailCrafters 9800 High-Speed Mail Inserter that has the ability to collate, insert, and seal approximately 9,500 envelopes per hour. TMG uses the Neopost AS223P Addressing Machine to print names, addresses, and postal bar-codes on approximately 5,000 postcards or envelopes per hour. This addressing machine has the ability to customize settings to handle a variety of paper sizes and thicknesses. For projects for which we are unable to use our bulk mail permit, the Neopost IJ45 Postage Meter can automatically feed and meter approximately 9,000 envelopes per hour. TMG also maintains an MBM 352 Vacuum Folding Machine to fold approximately 30,000 sheets per hour.

The Myers Group complies with all United States Postal Service requirements and has first-class and standard class bulk mailing permits. TMG maintains a strong relationship with the local USPS mail centers and follows all guidelines strictly. Through compliance with strict internal audits and adherence to the USPS regulations, TMG is able to maximize efficiency and ensure that all mailings are processed accurately and in a timely manner.

The Myers Group's efficiencies and industry standard equipment have allowed TMG to process over 2 million outgoing mail pieces.

Phone Survey Data Collection
The Myers Group offers a state of the art Computer-Assisted Telephone Interview (CATI) network that provides timely and efficient data collection. Our telephone interviewing technical and service capabilities include:

- 73 fully automated CATI stations
- Inbound and Outbound line support
- A staff to supervisor ratio of 9:1
- TouchStar programming interface
- Virtual Network Computing (VNC) monitoring software and remote monitoring cards
- Phone Rider ISA2 adapter proactive dialer system and Lucent VINA T1s
- Spanish questionnaire programming and Spanish interviewers on staff
- Executive interviewing capabilities

In order to assure quality and accuracy is maintained throughout the telephone interviewing process, the following measures are employed:

- Ten to twenty percent of all calls are validated (based on client specifications)
- VNC visual monitoring software and an auditory monitoring system are used to monitor interviewers as they conduct calls. If desired, this allows clients to hear surveys through remote monitoring.
- Trained and experienced interviewers use the TouchStar Technologies to conduct CATI surveys. TouchStar provides full telephone interviewing automation. Features of the system include:
- Sample and call management to ensure that every member within a sample has the opportunity to participate in the survey
- Auto dialing and proactive dialing provides greater efficiency and productivity
- Multi-lingual interviewing allows interviews with all sectors of a target sample
- Sample, quota, callback, disposition, and productivity reporting allows the Project Managers to monitor a project very closely
- Direct data and label exporting to SMS speeds results back to the analytics department

CATI Software Program

All CATI surveys are conducted by TMG interviewers using TouchStar software. TouchStar gives TMG full telephone interviewing automation and is linked to our SMS for recording of the interview disposition and proper tracking of member survey status. It allows for detailed sample and call management to ensure that every person in a sample will have the opportunity to participate in the survey. Both inbound and outbound calling permits potential respondents to call in at their convenience. The inbound calls may be received at any call station, thus reducing the number of missed calls. The TouchStar software enhanced in 2009 allows all respondents to call one CAHPS number that fields both English and Spanish. This gives all callers the option to speak to a Spanish interviewer. Calls that come in after hours and on weekends are sent to voice mail. These calls will be returned within 24 hours after receipt or on Monday if left over the weekend. If questions cannot be answered during the initial call, the caller will receive the answer within 24 hours. If a respondent calls in during business hours and expresses the desire to respond via telephone, the respondent will be triaged to a CATI interviewer. A contact log will be kept to document and track questions asked and answers provided to members calling the help line. This is done through the QA Log. This is the application completed by the interviewer detailing the call. Call Center Staff are trained in NCQA CAHPS standards and are given a list of frequently asked questions. In addition, our systems show the health plan‘s toll-free customer service telephone number, which TMG requests from the plan at the beginning of the survey design process to have on record for those members with questions outside the scope of the CAHPS survey. Questions regarding the CAHPS survey, its purpose, how the member was selected, etc. are all answered based on these frequently asked questions and within the NCQA CAHPS guidelines and specifications. If a member contacts our help line about issues with their health care, benefits, etc. TMG Call Center Staff are instructed to direct the member to call the health plans‘ toll-free customer support number and provide that number to them if needed. TMG operates a toll-free help line which allows members to ask questions, conduct the survey, or schedule an appointment for a later time. Automated and predictive dialing of the CATI means greater efficiency and productivity of operators. Sample, quota, callback, disposition, and productivity reporting allows each Project Manager to monitor a project very closely. The

TouchStar software, combined with on-site management and fulfillment of the phone stations, enable TMG to conduct as many as 350,000 phone interviews a year.

Interviewer Monitoring and Supervision
The Myers Group performs regular, simultaneous visual and audio, unobtrusive electronic monitoring of interviewers and maintains a ratio of monitors to interviewers to ensure that each interviewer is monitored at least once during the shift. A summary report of the monitoring results can be provided on a regular basis. The Myers Group maintains a supervisor to interviewer ratio of at least 1:10. One method we use to monitor our interviewers is via silent monitoring equipment that allows us to both listen in and observe their keystroke entries unobtrusively. We use this equipment to provide ongoing coaching and learning. We also employ a checklist to rate each interviewer on all applicable points. The checklist allows room for comments so the supervisor who is monitoring can provide specific examples of how the interviewer performed and can improve. We then assign a score to each item on the monitoring form. Interviewers receive incentives based on these quality scores.

Any _problems' encountered with an interviewer's technique are recorded in a tracking mechanism. The Myers Group's can easily see if patterns of poor interviewing technique are developing. This permits us to manage improvement even though different supervisors monitor any given individual over time. In addition to in-depth monitoring, we conduct "Intro" monitoring that focuses on the first few moments of the survey in which the interviewer introduces him or herself and establishes rapport with the respondent. We have learned that it is in these first few moments that an interviewer gains cooperation from the potential respondent or not.

The Myers Group's telephone system allows the company to digitally record these introductions and play them back for the interviewer. By hearing themselves, an interviewer can learn the finer points of how energy, charm, enthusiasm, clarity of speech, pace, etc. impact their ability to gain cooperation. At the end of each month, our interviewers receive a report card that summarizes their performance in the areas of Productivity, Quality (monitoring), Attendance, and Behavior.

The Myers Group provides numerous incentives for our top performers and constantly reviews our pool of interviewers to cull out underachievers. Upon request, The Myers Group can provide excerpts from our telephone-monitoring manual that demonstrate procedures used to ensure quality interviews are conducted through our call center.

Survey Processing
Incoming mail and survey returns are processed and coordinated by TMG's full-service, on-site survey processing center. Incoming mail is opened, sorted, and entered into the Survey Management System (SMS) based on the mail type (returned surveys, bad addresses, change of addresses, and final dispositions). Once surveys are entered into the SMS to indicate they have been received, they are ready for the scanning process. The Survey Processing Center utilizes Cardiff's Teleform Enterprise Version 9 scanning software to process returned surveys. This "smart software" has Optical Character Recognition (OCR) as well as Optical Mark Recognition (OMR) capability allowing for greater flexibility in reading different types of marks such as hand print, machine print, optical marks, barcodes, and signatures. The software also has the ability to

use customizable scripting, project level decision rules and controls based on type of project, several built-in quality checks to check for duplicate surveys, multiple marks, range limits, length limits, and field confidence settings. This is extremely efficient and ensures that only error-free data is captured. In the event that a member has denoted their personal thoughts via a question(s) that allow for open-ended member responses, those comments are recorded verbatim or "word for word" on behalf of the health plan. TMG does not interpret member comments unless the health plan requests TMCG develop bucket categories into which comments are divided.

TMG also employs four high-speed Panasonic duplex scanners (KV-S2055 and KV-S3065). These scanners allow for greater efficiency and accuracy in the data capture process by providing TMG with high levels of power and flexibility. They are rated to scan 65 pages per minute and capable of binary or color imaging up to 600 DPI. These scanners are duplex enabled and allow TMG to capture images and data from both sides of the survey in one pass. They also allow scanning of a variety of paper sizes – standard and custom. This provides for greater data accuracy as there is no need to "break up" the scanning process by scanning one side and then the other or slicing of the survey to accommodate a standard pre-set paper size.

Final Analysis/Reporting
At the conclusion of the data collection period, data cleaning and editing routines are performed. The Myers Group also assesses the integrity of collected data and follows-up with survey respondents, if necessary. A final data file containing all received and validated member responses, and other required data elements associated with the administration of the survey, is created. Data from each survey methodology employed, i.e. phone and mail, is combined into a single project file. A Final Disposition Assignment Program (FDAP) is run on the data. Once the scrub and load database processes are complete, The Myers Group audits the data by verify scripting (i.e. are required data elements present for analysis and coding?). Upon verification of the data, the database is sent to the Analytics department. The Analytics department reviews the member-level file generated from database (i.e. check header info, approved format, complete data set, etc.).

Reporting Detailed Results
The Myers Group, at this point, is ready to prepare a report with detailed results of all the survey responses and to submit the CAHPS data to NCQA and other outside groups designated by the client. Reports submitted for the CAHPS survey responses will fully comply with NCQA format requirements and will be provided in the timeframe agreed to in the work plan.

Comprehensive Analysis
The Myers Group will perform response/non-response bias analysis in order to validate that the responses received accurately reflect the demographic and eligibility characteristics of the sample population. The Myers Group will also calculate the CAHPS® composite response scores, as described in the NCQA protocol.

After the Analytics department performs an audit on the database, the database is then prepared for analysis and reporting. The database is loaded into SPSS or other data format as may be

required by the client. Once fully loaded into the system, the Analytics department creates tables by applying the data into report templates. For custom jobs and/or custom questions, the Analytics department modifies the reporting templates accordingly. Based on survey results, The Myers Group can produce reports and data files, as defined by the client. The PM receives the survey reports and modifies the reports, as needed. The PM proofreads the final reports and checks spelling, omissions, continuity, etc. and verifies numbers and graphs against the data. With approval from the PM, the final versions of the reports are printed. The PM compiles the reports and sends the report and final data set to the client. The Myers Group will report the results to the client in a manner suitable for public reporting.

CMFHP's final report, pages 2-3 through 3D contain narrative and graphs of the received responses. These pages provide outcomes and statistical comparisons for the demographics of the sample population and responses from the sample population.

CMFHP's final report includes both narrative and graphical display of data. CMFHP received the final report in a PDF file for review July 10, 2009. A teleconference for review of the final report was conducted in July 17, 2009 and July 19, 2009. CMFHP's administrative group has experience with the final report formats and found the report understandable and relevant. CMFHP's review group agreed the report was clearly stated and data was pertinent to assess the target population's satisfaction.

Survey Population

The sample frame for the Child Survey (With Measurement Set) included all CMFHP child enrollees in the Missouri HealthNet Medicaid program and enrolled continuously for six months with no more than one enrollment gap of 45 days. Any one day enrollment gap was considered administrative and did not exclude an enrollee. The source of the sample frame was CMFHP's member files and the sample frame was selected by NCQA CAHPS survey criteria via accredited NCQA software. The CMFHP total eligible population for Medicaid Child Survey in MOHN was 34,700 eligible members. A stratified random sample of children ages 0 to 17 from the Managed Care Organization's (MCO) Medicaid product line membership database is used as the sample. A total of 1,650 child members are randomly selected from the eligible population (General Population). Exclusions included all retroactive enrollees, as allowed by the survey specifications guidelines.

This strategy was utilized by CMFHP as the recommended strategy by the CAHPS Technical Specifications Booklet. The stratified random sample strategy provided representative samples of the population from which it was selected.

The stratified random sample strategy provided that every child member of the MOHN Medicaid child population that met enrollment criteria had an equal chance of being selected.

The MOHN Medicaid Child sample size was determined by the CAHPS Technical Specifications Booklet. Bias in sample selection is eliminated by utilizing only enrollment data and enrollment history. This process and sample size was designed to

guard against bias and minimize sampling error. The selection of eligible populations was conducted by the Information Technology Department with oversight by senior management with twenty years experience in producing member satisfaction survey sample frames based on CAHPS specifications. In addition, the analyst utilized VIPS computer software to produce the sample frames. VIPS is a NCQA accredited software for producing CAHPS sample frames.

The Information Technology Department has quality verification processes in place to ensure eligible populations and survey sample frames were appropriately identified. Samples of these processes include:
1. Review and query to identify outlier dates of birth;
2. Review and query to identify enrollment gaps.
3. Comparison of eligible populations to internal reports.

Sample frames are validated by CMFHP's certified HEDIS auditor. The validated sample frames are submitted to CMFHP's survey vendor, The Myers Group, in the standardized format specified by NCQA. The survey vendor selects the survey sample from the sample frames according to NCQA specifications for sample selection. Member enrollment is received and processed daily into the CMFHP medical information system for enrollee benefits and processing. The Information Technology Analyst utilizes this system in coordination with the VIPS software to identify enrollees.

A data dictionary was not incorporated or provided in the MOHN Medicaid Child Survey

Response Rate
The MOHN Medicaid Child Survey utilized a mixed methodology strategy for locating and contacting the sample population (targeted respondents). The mixed methodology of mail and telephone includes four waves of mail (questionnaire mailings and two reminder post cards) with a telephone follow-up of at least 3 attempts.

No required response rate was specified by the State of Missouri, MOHN or DHSS. CMFHP utilized the information from last year's survey to track results and benchmark outcomes in the same state and population.

CMFHP's strategies for maximizing the response rate included utilization of the second address and phone number screen for locating the target population. CMFHP's strategies for maximizing the response rate also included the Customer Service Department adding information about the member satisfaction surveys to both the ~~–o~~n-hold messaging" and ~~–H~~OT TOPICS". The Customer Service Department utilized both mechanisms to encourage members to complete and return surveys.

CMFHP's contracted The Myers Group as the CAHPS survey administrative agent.

A response rate is only calculated for those members who were eligible and able to respond. According to NCQA protocol, ineligible members include those who are deceased, do not meet the eligible population criteria, have a language barrier, or are

either mentally or physically incapacitated. Non-respondents include those members who have refused to participate in the survey, could not be reached due to a bad address or telephone number, or members that reached a maximum attempt threshold and were unable to be contacted during the survey time period. NCQA also considers surveys that have been returned with less than 80% of the questions answered a non-response.

Children's Mercy Family Health Partners – MOHN‘s total sample size was 1650.

General Population Response Rate
TMG surveyed a random sample of 1,650 eligible general population child members of Children's Mercy Family Health Partners - MOHN population. A total of 374 valid surveys were completed from this random sample, 265 by mail and 109 by phone. A survey is included as a valid completion if the member appropriately responds to Question 1 and answers at least 80% of the survey questions (not including Questions 84, 85, or custom questions). After adjusting for ineligible members, the General Population survey response rate was 23.4%. The overall NCQA target number of complete responses is 411 for the General Population.

The table below shows the total number of members in the general population sample that fell into each of the various disposition categories.

Ineligible surveys are subtracted from the sample size when computing a response rate as shown below.

Deceased (M20/T20) 1
Does not meet eligibility criteria (M19/T19) 35
Language barrier (M22/T22) 16
Mentally/physically incapacitated (M24/T24) 0
Total Ineligible 52

Bad address/phone (M23/T23) 276
Refusal (M32/T32) 74
Maximum attempts made (M33/T33) 874
Total Non-response 1224

Completed surveys/Sample size – Ineligible surveys = Response Rate

Using the final figures from Children's Mercy Family Health Partners‘ MOHN Medicaid Child survey, the numerator and denominator used to compute your response rate are presented below.

265 (Mail) + 109 (Phone) = 3748/
1650 (Sample) – 52 (Ineligible) = 1,598 = 23.4%*

* 2009 Final Report for Children's Mercy Family Health Partners

Analysis and Evaluation

Survey Documentation

The table below shows the total number of members in the sample from 2008 and 2009 that fell into each of the various disposition categories. Depending upon the survey protocol, some of the groupings below may not apply.*

	2008	2009
Deceased (M20/T20)	0	1
Does not meet eligibility criteria (M21/T21)	12	35
Language barrier (M22/T22)	19	16
Mentally/physically incapacitated (M24/T24)	0	0
Total Ineligible	32	52
Bad address/phone (M23/T23)	333	276
Incomplete survey	24	Not reported
Refusal (M32/T32)	51	74
Maximum attempts made (M33/T33)	862	874
Total Non-response	1270	1224
Response rate	21.5%	23.4%

CMFHP conducted the MOHN Child Medicaid CAHPS 4.0 survey in 2009. In 2008, CMFHP conducted the MOHN, Medicaid Child CAHPS 3.0 survey. Benchmarking comparisons of the CMFHP 2009 Child CAHPS results were made to the following data sources:

- 2008 CMFHP MOHN Child Medicaid CAHPS 3.0 survey
- 2008 Quality Compass (Medicaid Child Public Report)
- 2009 TMG Medicaid Child Book of Business
- 2008 National CAHPS Benchmarking Database

The following is an assessment of the survey outcomes for the general child population in the areas of access, quality, and timeliness of care. High scores represent increased satisfaction. High scores are greater than or equal to 80%. (CMFHP 2009 MOHN Medicaid Child CAHPS report, page 4B):

Access to Care

- Getting care, tests, or treatment you thought necessary (85%)

Quality of Care

- Doctors showing respect for what you had to say (94.3%)
- Doctors listening carefully to you (92%)
- Doctors explaining things in an understanding way (89.9%)
- Doctors spending enough time with your child (85.7%)
- Treated with courtesy and respect when talking with Customer Service (93.8%)
- Rating of personal doctor (82.2%)

- Rating of health care (80.2%)
- Rating of health plan (83.5%)

Timeliness of care
- Obtaining needed care right away (90.3%)
- Obtaining care when needed not when needed right away (86.9%)

Strengths-Description of Data Findings
CMFHP's MOHN Child CAHPS 4.0 survey analysis of the general child population identified strengths and opportunities for improvement for to this population.

The following are strengths for CMFHP's MOHN general child population 2009 compared to CMFHP's MOHN Child population 2008 (CMFHP 2009 MOHN Medicaid Child CAHPS report, page 3A):
- Obtaining needed care right away
- Obtaining care when needed not when needed right away
- Doctors listening carefully to you
- Doctors showing respect for what you had to say
- Doctors spend enough time with your child
- Rating of health care
- Rating of personal doctor
- Rating of Specialist
- Rating of the health plan

The following are strengths for CMFHP's MOHN general child population 2009 compared to Quality Compass, Medicaid, 2008 (CMFHP 2009 MOHN Medicaid Child CAHPS report, page 4B):
- Doctors showing respect for what you had to say
- Doctors listening carefully to you
- Doctors explaining things in an understanding way
- Doctors spending enough time with your child
- Rating of personal doctor
- Rating of Specialist
- Rating of health care
- Rating of health plan
- Obtaining needed care right away
- Obtaining care when needed not when needed right away

The following are strengths for CMFHP's MOHN general child population 2009 compared to The Meyers Group Book of Business for Child CAHPS 4.0, Medicaid, 2009 (CMFHP 2009 MOHN Medicaid Child CAHPS report, page 4B):
- Getting care, tests, or treatment you thought necessary
- Ease of getting appointment with a specialist

- Doctors showing respect for what you had to say)
- Doctors listening carefully to you
- Doctors explaining things in an understanding way
- Doctors spending enough time with your child
- Treated with courtesy and respect when talking with Customer Service
- Getting information from Customer Service
- Health promotion and education
- Coordination of care
- Health provider talked about pros and cons of choice of treatment
- Doctor or provider asked which treatment choice was best for you
- Rating of personal doctor
- Rating of health care
- Rating of health plan
- Obtaining needed care right away
- Obtaining care when needed not when needed right away

The following are strengths for CMFHP's MOHN general child population 2009 compared to The National CAHPS Database, Medicaid, 2009 (CMFHP 2009 MOHN Medicaid Child CAHPS report, page 4C):

- Getting care, tests, or treatment you thought necessary
- Ease of getting appointment with a specialist
- Obtaining needed care right away
- Obtaining care when needed not when needed right away
- Doctors explaining things n an understandable way
- Doctors listening carefully to you
- Doctors explaining things in an understanding way
- Doctors spending enough time with your child
- Treated with courtesy and respect when talking with Customer Service
- Getting information from Customer Service
- Rating of personal doctor
- Rating of health care
- Rating of Specialist
- Rating of health plan

Custom Questions

CMFHP included six NCQA approved custom questions to assist the health plan to assess member satisfaction with the 24-hour nurse line, customer service responsiveness, health plan website knowledge, received communication regarding benefits and health plan loyalty.

CMFHP identified the following strengths from the custom questions:

- Customer Service timeliness of response to requests (91.7%)
- Member loyalty based on recommendation to family and friends (96.6%)
- Members rate communication regarding benefits good to excellent (90.8%)

Weaknesses
CMFHP identified weaknesses from the Child CAHPS survey for the MOHN general child population based on comparison to the benchmarking entities.

The following weakness for CMFHP's MOHN general child population 2009 compared to CMFHP's MOHN population 2008 (CMFHP 2009 MOHN Medicaid Child CAHPS report, page 3A):

- Doctors explaining things in an understandable way

The following weakness for CMFHP's MOHN general child population 2009 compared to NCQA's 2008 CAHPS Booklet-Medicaid Child (CMFHP 2009 MOHN Medicaid Child CAHPS report, page 4B):

- None identified, no statistically significant changes

The following weakness for CMFHP's MOHN general child population 2009 compared to The Meyers Group Book of Business for Child CAHPS 4.0, Medicaid, 2009 (CMFHP 2009 MOHN Medicaid Child CAHPS report, page 4B):

- None identified, no statistically significant differences

The following weakness for on CMFHP's MOHN general child population 2009 compared to The National CAHPS Database, Medicaid, 2009 (CMFHP 2009 MOHN Medicaid Child CAHPS report, page 4C):

- None identified

CMFHP identified the following weaknesses from the custom questions:

- Member access and satisfaction with CMFHP's 24-hour nurse line
- Member knowledge, access and satisfaction with health plan website

Opportunities
The opportunities for improvement of the survey implementation and analysis include:

- Monitor for increases in the number of bad addresses and incorrect phone numbers
- Monitor for increases in the number of members meeting the in-eligibility criteria
- Monitor for increases in the number of members identified with a language barrier
- Increase promotion of the survey to members to increase complete and valid survey responses
- Over-sample the population to increase the complete and valid survey responses

CMFHP's opportunities related to access, quality of care and timeliness of care include:

- Increase member satisfaction with —doctors explaining things in an understandable way"

CMFHP's opportunities related to nurse advice call center and website education:

- Increase member knowledge of and satisfaction with nurse advice call center
- Increase member knowledge of and access to the health plan website

Recommendations
CMFHP's CAHPS Survey validation and administration

- Continue assurance of plan specific questions that are consistent with the CAHPS questions for all future surveys
- Continue to assess over-sampling options for future surveys to obtain the NCQA recommended sample size and increase the odds of obtaining more than 100 valid and complete responses for all survey questions
- Consider development of internal target satisfaction goals in addition to benchmark data for identification of improvement opportunities and to enhance health plan performance strategies
- Provide provider education regarding explaining things to members in an understandable way

Provider Satisfaction
Children's Mercy Family Health Partners revised our provider satisfaction survey in 2009. We surveyed 231 Primary Care Practices and received 69 responses, which calculated to a return rate of 29.87 percent.

The survey and results are included. Overall, providers expressed a high level of satisfaction with CMFHP in all areas of operation.

CMFHP has implemented a post provider visit survey to determine if we are meeting the needs of our providers. Monthly we randomly select 10% of each provider relations representatives field visits and send an electronic survey to the practice. The results have been very positive and office staff's expectations are being meet during the provider representatives' field visits.

CMFHP continues the pay for performance initiative with our Primary Care Physicians, providing an increased administrative capitation payment for those who qualify. Those PCPs who do better than their peers providing immunizations and lead testing to our members can increase their base administrative capitation payment.

Based on the comments that our provider relations representatives hear during their office visits and complements we've heard when we attend provider functions, the physicians and their staff continue to be very satisfied with CMFHP. This correlates with the information we obtain through our formal survey measurements.

Case Management
Care management is an important component of medical management at Children's Mercy Family Health Partners (CMFHP). The goal of care management is to assist in facilitating healthcare services that are cost-effective, timely, and delivered in the most appropriate environment.

Children's Mercy Family Health Partner's Care Managers are structured into teams for High Risk OB, Special Health Care Needs, Lead Toxicity, Emergency Room Use, and categories for Pediatrics and Adults. The Manager of Clinical Services directs the day-to-day operations of care management, with oversight from the Chief Clinical Officer and the Medical Directors.

CMFHP regularly reviews the way we identify members, the processes for interventions, the documentation of those interventions, and the measurement of outcomes. With the implementation of our care management system, CARE (Case Assessment and Referral Evaluation System), CMFHP implemented new, more comprehensive assessment forms, documentation standards, and audit forms for all care management specialty areas. Since 2005, the Health Services Management team has conducted routine audits of care management staff to ensure compliance with documentation and assessment standards. Current audit standards indicate that staff will meet or exceed an accuracy level of 90%. Over the most recent 4 quarter period, 81% of the Care Management staff consistently met the audit standard with an average score of those staff of 96%. Action plans were implemented for those who didn't meet the standard and all who had action plans were able to resolve the issues in a subsequent audit. In addition, the CMFHP Medical Director conducts weekly case rounds with the care management staff to discuss current status of cases, discuss barriers to care, and identify interventions. This forum provides an ongoing process for care management staff to learn from others and ensure consistency in implementing care plans and establishing goals.

Highlights of the Care Management Initiatives in 2008 - 2009:

Enhancements of the Care Management System (CARE)

Updates to the CARE documentation system (version 2.0) occurred in April 2009 and included enhancements that assisted with integration of other internal health plan systems. Included in this update was the ability to view claims, authorizations and create on line medical necessity referrals for Medical Directors. This integration allowed for a member's information to be located in a single source, allowing all Health Services staff (Precertification Nurses, Utilization Review Nurses, Quality Nurse Reviewers, Health Coaches, and Care Managers) to access information on members to ensure continuity in delivery of services and eliminate duplication within the clinical functions.

In preparation for obtaining NCQA certification and the October 1, 2009 effective date for the new Missouri RFP, planning immediately began for the release of version 2.5 of CARE, focused on enhancing the documentation tools. The release was implemented in October 2009.

Pediatric and Adult Care Management Education to Providers

Efforts were focused this past year on educating participating providers about the services CMFHP offers in our care management programs. Presentations were given to 22 participating provider offices by our OB, Pediatric and Adult Care Managers. Providers were not only educating on the services we offer but how we can assist them in coordinating services for CMFHP members.

OB Program Update on Snugli Prenatal and Postpartum Incentive Program

Due to the low prenatal and postpartum HEDIS rates in 2004 and 2005, CMFHP implemented an intervention targeted to pregnant women 18 years and older. This intervention offered members a Snugli baby carrier as a gift if they obtained early prenatal care, completed routine prenatal appointments and attended their postpartum visits. The incentive program began in August of 2006. The Snugli incentive was initially measured in 2007 to determine if an incentive gift would improve compliance with attending both prenatal and postpartum visits.

Since implementation of the Snugli incentive program, the HEDIS Timeliness of Prenatal Care and the Postpartum Care measures have continued to increase each year. Since 2004, Timeliness of Prenatal Care has increased 14% and the Postpartum Care measure has increased by 29%. CMFHP plans to continue to offer this incentive to pregnant women and will add an additional notification about the incentive to the new member welcome packets in 4th Quarter 2009.

Lead CEU Program Developed for Providers
In 2008, CMFHP developed an educational program for providers and community agencies to educate on lead toxicity and the importance of screening for lead. The Lead Poisoning Prevention program was submitted and approved for one continuing education unit (CEU) for nurses and physicians. The CEU program is offered free of charge to any community agency or provider in the CMFHP network. CMFHP has provided this program to 49 participants in provider offices and the survey results received after the presentation have been very positive. Many providers have indicated they will change their current practice patterns to improve compliance with lead testing based on the information provided in the presentation.

ER Care Management Program
CMFHP's telephonic ER program was expanded over the past year to include additional facilities for education and outreach. The new facilities added to the outreach program include Children's Mercy Hospital and St. Luke's East. These facilities join Truman Medical Center, St. Joseph Health Center and Liberty Hospital in our efforts to educate members who were seen during normal business hours for non-urgent care. Members are educated about the importance of establishing and utilizing their Primary Care Provider and provided benefit information that may be useful in future situations. CMFHP's current ER trends per 1000 members in Missouri for adults from July 1st 2008 through June 30th 2009 was 1404/1000, which is less than a 1% increase over last year's results. Based on past ER trends, as well as regional and national growing ER trends, the ability to maintain relatively constant ER utilization year over year is a success.

Offering of Care Management
As a result of an annual evaluation of the Care Management program, several enhancements and changes were made to the program structure in an attempt to improve both the members identified for care management and overall communication about the program. As a result, new monthly reports were implemented to help identify key diagnoses that require care management assessment. The need for a welcome and discharge letter specific to care management was also identified as an opportunity to improve communication. These letters are now being implemented to notify members and providers of care management services.

<u>Additional Opportunities Identified for 2010:</u>

- Update the care management documentation system (CARE) to ensure NCQA documentation compliance with complex case management standards
- Train care management staff on documentation requirements, including establishment of short and long term goals focused on disease-specific clinical outcomes
- Implement a satisfaction survey for members receiving care management services
- Analyze top diagnoses followed in care management, adopt and distribute clinical practice guidelines to support optimal care outcomes to appropriate providers

- Implement a process to measure provider compliance with clinical practice guidelines
- Continue to work on identification of additional hospitals that will work with us to increase identification of members for the ER telephonic care management program

Our Health Improvement programs focus on providing education and reminders for our members in key areas of prevention and wellness. Most of these programs are tied to HEDIS measures and CAHPS results. Our Health Improvement Committee (HIC) reviews the results from these two sources and develops interventions and education programs for our members.

EPSDT/Immunizations/Lead Screening/Dental Screening
In an effort to increase member awareness of periodic screenings and exams in our pediatric and adolescent population, we have implemented the following reminder mailings:

Birthday Cards (implemented in 2009): to reach out to members and provide education on Immunizations and Well-Child visits, we implemented a Birthday Card reminder system for all members age 1-11. The birthday cards provide a periodicity schedule for Immunizations, Well-Child visits and Lead Screening.

Newborn Cards (implemented in 2009): to emphasize the importance of well-child visits and immunizations in the first 15 months of life, we implemented a Newborn Card reminder system. The cards provide a periodicity schedule for Immunizations, Well-Child visits and Lead Screening.

Teen Newsletter (implemented in 2009): CMFHP understands how difficult it is to communicate with the adolescent population. Therefore, we have developed a newsletter directed specifically to Teens. The newsletter is mailed twice each year in January and July. The topics for the newsletter are focused on wellness, safety, taking responsibility for one‘s health, and the benefits available to them as members.

Mailings/Reminders:
To ensure our members are taking advantage of the benefits available to them, we send reminder cards for many of the recommended health screenings.

On-Hold Recordings/Hot Topic:
We include many topics in our library of on-hold recordings so that our members may receive education while on the phone with us. Some of the topics covered are:

- Cervical Cancer Screenings
- Dental
- Healthy Snacks
- Poison Prevention
- Healthy Kids Day
- Child Abuse
- Children‘s Mental Health
- Food Allergies
- Firework Safety
- Men‘s Safety

- Sun Safety
- Prevention
- Dog Bites
- Immunizations
- Family Health & Fitness
- Lead
- Breast Cancer
- Flu Vaccine
- Diabetes
- Healthy Eating

DATA/TRENDS & ANALYSIS

Since most of the programs have been implemented in the last year, we have not conducted a data review to assess the impact of the overall program. We expect that in the next report we will be able to provide a review and analysis of the HEDIS measures that were targeted by these interventions.

STRENGTHS

We have focused much of our efforts in the areas of screening and testing. These are the core components of prevention and provide the opportunity for early detection of medical issues.

We have also focused our effort on the greatest number of our population. A majority of our members are either children or adolescents. Our publications and reminders target these populations and are developed to reach these two demographics. We are also providing this education while members are still young and developing positive prevention and wellness habits.

WEAKNESSES

We have not yet addressed our adult population in a focused way. The adult population has many more issues related to adherence, prevention and wellness.

A majority of our past efforts have been in print media through reminders and newsletters.

OPPORTUNITIES

Adult Newsletter: In order to provide education to our adult population, CMFHP is in the process of developing a newsletter that focuses on adult health issues. The newsletter will be mailed twice each year and will focus on wellness, cancer screenings and all other recommended screenings and the benefits available to them as members.

Additional media: We are adding many features to our website. We will be adding a Teen Corner to our website which will focus on the same issues as the newsletter. We will also be adding general prevention and wellness topics added to the website for all ages.

Disease Management Program
The Children's Mercy Family Health Partners Disease Management programs, developed by clinical experts, use a unique approach to manage chronic disease. Rather than relying exclusively on phone consultations or patient education materials, our community educators form personal relationships with primary care providers (PCP's) to help them implement comprehensive disease management in their offices, supporting the patient-provider relationship with the goal of improved patient health and reduced costs. We have a Disease Management Committee which includes specialists in chronic diseases as well as community physicians. This committee conducts reviews of our current programs and assists in the development of new programs and initiatives.

The Children's Mercy Family Health Partners Disease Management programs consist of the following highly integrated components:

- Physician office education
- Data analysis and reporting
- Stratified interventions
- Disease-specific Health Coaching
- Environmental assessment
- Provider incentives

By integrating these elements into a comprehensive program, we have demonstrated clinical and fiscal benefits, including an increase in appropriate utilization of health care, increased provider satisfaction and improved patient quality of life.

We use our database to identify members who either have been diagnosed with one of our targeted chronic diseases or who have a condition that is likely to lead to one of those chronic diseases at some time in the future. To do this, we use a combination of claims data, hospital encounters, pharmacy utilization and/or lab tests. By identifying members with a chronic disease early, we can be proactive to promote activities that help maintain good control of their illness and lower acute care utilization.

The Asthma Management Program was implemented in 2001 and twenty seven (27) offices are participating in the program. The Healthy Lifestyle Program (HeLP) program was implemented in 2007 and fourteen (14) offices are participating in the program. We will continue to expand the programs in 2010.

In 2007, we implemented our Health Coaching component to support the provider office intervention. Our Health Coaches contact members identified through referrals from physician offices, care management, utilization review, or self referral by the members. We start the Health Coaching relationship with a phone call or letter to the member with the goal of meeting with the member in person to provide additional education and to encourage increased self-management of his/her chronic disease. We believe strongly in the high touch relationship that only comes through a face-to-face interaction. We have found this approach to be a very powerful influence on making changes in our members' lives.

We continue to develop supporting relationships with organizations that compliment our programs. We have an agreement with the Children's Mercy Hospital and Clinics' PHIT Kids obesity program, the University of Kansas' Healthy Hawks obesity program and the North

Kansas City Hospital's Shapedown program. For each of these programs, we have agreed to financially sponsor our members' participation in the intensive obesity intervention.

We also have an agreement with the YMCA of Greater Kansas City. The YMCA will waive the joining fee for any CMFHP member who joins a YMCA in the Greater Kansas City network. We will continue to seek opportunities to partner with organizations that support of our members in healthy lifestyles initiatives.

In 2009 we started developing a program for our adult members with depression. During a series of meetings with our behavioral health contractor, we developed the inclusion criteria for the program and the stratification for member interventions based on Low, Medium, and High risk. We also began researching the Clinical Practice Guidelines (CPG's) that would be used to educate providers who care for our members dealing with depression.

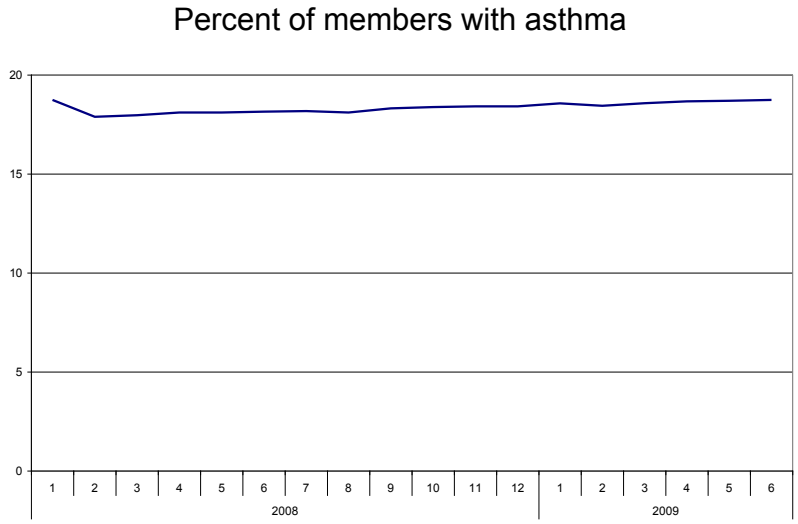
During this same time, we started developing a program for diabetes. Based on our HEDIS results for Comprehensive Diabetes Care, we are developing educational materials for our adult population with diabetes. We developed the inclusion criteria and stratification for member interventions. We are also in the process of developing the CPG's for member education.

DATA TRENDS AND ANALYSIS

ASTHMA MANAGEMENT PROGRAM

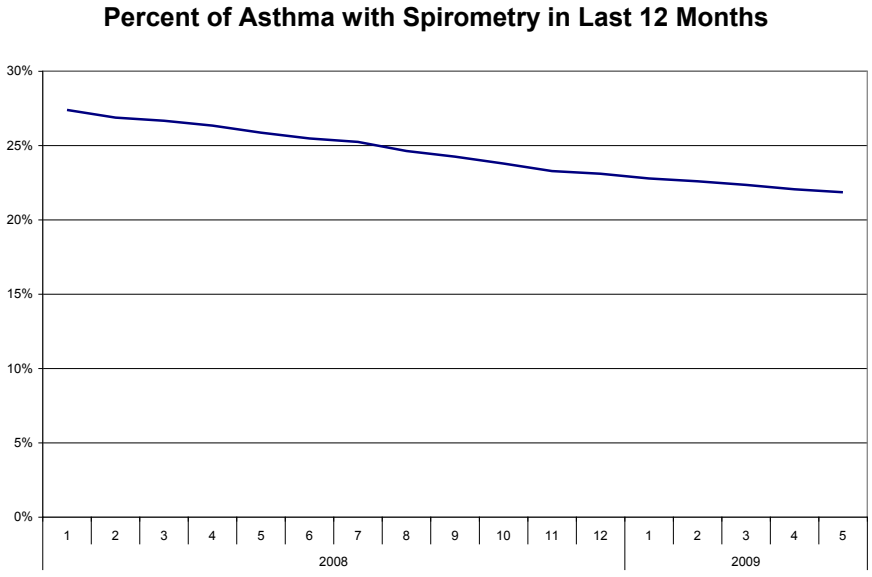
Percent Members with Asthma

According to a 2005 report from the CDC, 8.9% of children and 7.2% of adults have asthma nation wide. When CMFHP started the Asthma Management Program, the diagnosis rate for members was 14%. As we have continued our education in offices, we have seen the rate of asthma climb due to better diagnostic skills in the Primary Care setting. The current rate of diagnosis is just below 20%. We expect those who have been diagnosed to receive more targeted education for improved self-management.



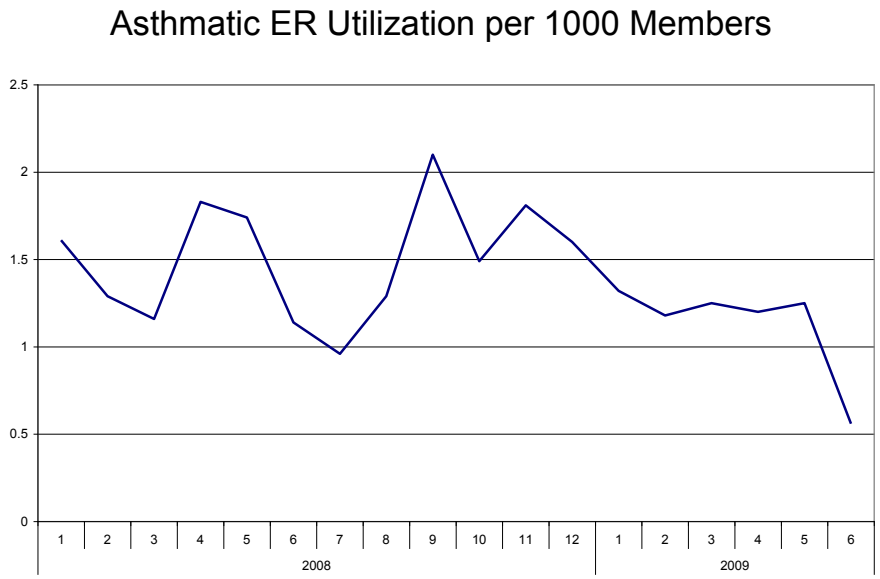
Spirometry

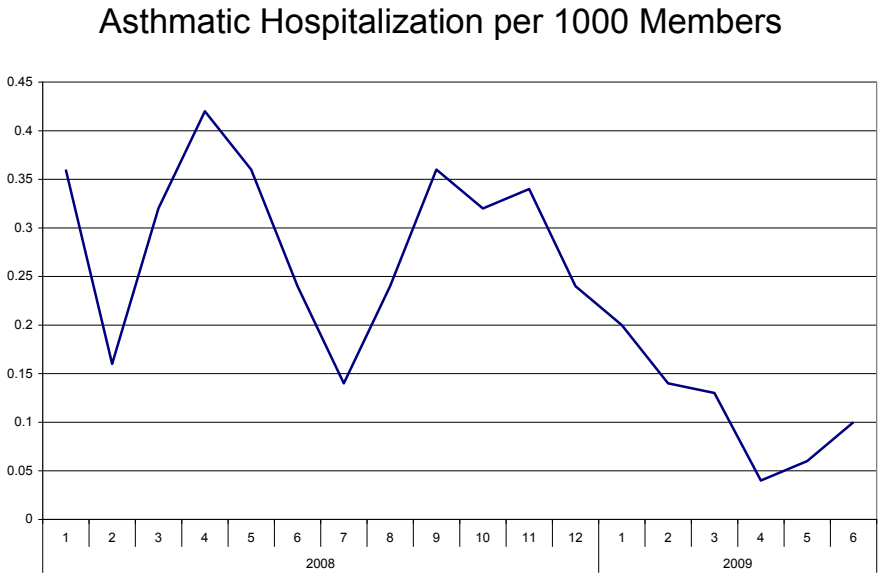
Spirometry is the most common of the Pulmonary Function Tests, measuring lung function, specifically the measurement of the amount and/or speed of air that can be inhaled and exhaled. Spirometry is an important tool used for assessing conditions such as asthma. As demonstrated in the chart below, Spirometry is not being performed on a consistent basis in the primary care provider offices for members with asthma. Spirometry is a key element of our in-office education program. During our time in the Primary Care Provider office, we have a Spirometry machine available for loan to the office for both training purposes and to demonstrate the importance of this test. Often, we find that offices will purchase a Spirometry machine of their own once our education program has been completed.



Emergency Room. Visits and Hospitalizations for Asthma per 1000 Members

Historically, we have found a seasonal variation in both ER utilization and in-patient utilization and this is clearly demonstrated in the following charts. The fall and spring are periods of high utilization for both ER visits and hospitalization. It is the goal of this program to reduce the overall spike in utilization through education directed to both providers and members and a strong education emphasis prior to the spring and fall of each year.





Asthma Costs per Asthmatic per Month (PAPM)

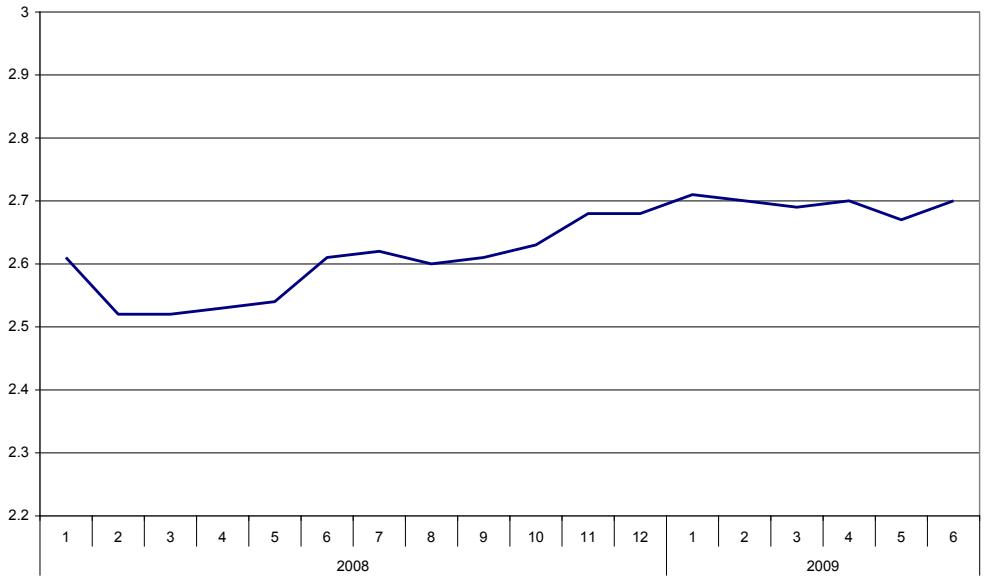
Asthma is a seasonal chronic disease as demonstrated in the chart below. Fall and spring demonstrate in increase in overall cost for members with asthma. As we continue the implementation of the program and asthma is being more accurately diagnosed and treated, we expect outpatient and pharmacy utilization to increase initially, while ER and inpatient utilization decreases. The overall cost for treating members with asthma has decreased over time.

HEALTHY LIFESTYLES PROGRAM

Percent of Members with Obesity by Age Group

The overall percentage of members currently diagnosed with obesity is quite low. It is expected as we continue to implement our Healthy Lifestyles Program (HeLP), we will see an increase in diagnosis of obesity in all age groups. Additionally, we are beginning to discuss this issue with other health plans. Not all plans provide reimbursement for treatment associated with obesity and some plans reject claims that contain codes for obesity. Therefore, many providers will not diagnose obesity to reduce the chance that a patient claim will be rejected.

Percentage of Members Diagnosed with Obesity



STRENGTHS

One of the key strengths of the Disease Management program is the duel pronged approach to education and behavior change. We are engaging the entire staff in the Primary Care Provider's office to address the issue of asthma and obesity. This multiplies the impact of our education efforts through the engagement of educators in every office we are working with. The patient has the potential to be educated by any member of the staff that participated in the training. Additionally, we are engaging the members directly through multiple education products and health coaching. Our goal is to empower both the PCP staff and the patient to work collaboratively to manage their chronic disease or condition.

In our data, we are seeing positive results of our programs. We are experiencing a decrease in overall utilization for our members with asthma in both ED utilization and hospitalizations. We are seeing a decrease in the seasonal spikes in the spring and fall when asthma has the greatest impact on members with asthma.

The diagnosis rate for asthma has stabilized over the number of years we have been presenting in PCP offices. We feel our program has made an impact on the diagnosis rate and ultimately the proper treatment of asthma. Our asthma diagnosis rate is above the rates provided by the CDC; therefore, we are confident that members with asthma are being identified. We are seeing a slight increase in the percentage of diagnosis of obesity. These rates are well below the rates provided by the CDC and demonstrate an opportunity for improvement.

WEAKNESSES

One of the key areas of interest for us is the decreasing rate of Spirometry testing for asthmatics. This test is part of the national guidelines for asthma and is a component of our asthma education modules. When we are in the offices providing education, we provide a spirometer for the office to use during the weeks we are working with the office staff. We demonstrate how to use the spirometer and encourage testing to be done for every asthmatic every year.

The rate of obesity diagnosis remains very low. The Healthy Lifestyles Program has been in place only two years and the continued growth of the education program will have an impact on the diagnosis rate, but there are other areas of concern that need to be addressed.

We have areas that need to be addressed in the area of disease management and we do not currently have programs. These areas are diabetes and depression and both are included in the new contract with the state of Missouri.

OPPORTUNTIES

Spirometry: We continue to see this rate decline and are addressing this issue through our Disease Management Committee to identify barriers and seek interventions to encourage offices to conduct these tests.

Obesity Diagnosis: There are a number of factors that impact the diagnosis rate for obesity. First, obesity has been historically under-diagnosed due to the lack of reimbursement from health plans. This is compounded by the fact that some health plans reject claims that contain codes for obesity. Therefore, many offices have stopped using the diagnosis code for obesity to reduce the number of claims that are rejected. Another factor is the social stigma that comes with a diagnosis of obesity. Some providers are reluctant to use this diagnosis with children. In order for the health plan to identify members with obesity, it is very important for PCP‘s to diagnose obesity. This will continue to be a focus of our education program.

Depression Program: We continue to implement our disease management program for depression with our behavioral health contractor. This will include screening and care management for members who are stratified as Medium and High Risk. We will also develop a newsletter that focuses on wellness issues that support the management of depression.

Diabetes Program: We continue to implement a diabetes disease management program. The diabetes program will be implemented with education and collaboration with other agencies as the primary components. CMFHP will focus its efforts on the development of reminder cards for

members and education materials for members and providers and efforts for collaboration with state and local agencies headed up by the Disease Management Committee.

Home Telemonitoring Program
Oxford HealthCare Partnership

Program Overview
Children's Mercy Family Health Partners (CMFHP) has partnered with Oxford HealthCare to provide telemonitoring services for our members in select clinical situations. The services they provide are most beneficial to those with chronic illnesses which may require ongoing monitoring of vital signs, weight or blood glucose. Members are educated on how to conduct the monitoring based on orders written by their physician. The results of each reading are transmitted through the member's phone line or a pager system (if a phone line isn't available) to a nurse in Springfield, MO. Nurses monitor the results 24 hours a day/7 days a week and, based on pre-established parameters, the member and their physician are notified if the results are outside the expected range for that member. A minimum of at least a monthly home nurse visit is completed on each member and visits can be provided more often if needed.

Criteria
CMFHP members at least 12 years of age who have a chronic illness that requires ongoing monitoring of vital signs, weight or blood glucose and meet the geographical and access criteria for monitor placement. The member and the member's medical physician must agree to the implementation of the Oxford telemonitor device(s).

Implementation Process
The member's physician is initially contacted to discuss the appropriateness of the Oxford telemonitoring system for his/her patient. After physician approval is received, the member is contacted with information about the program and given the opportunity to decline or accept enrollment into the program. After acceptance of the program by both physician and member, a home health nurse sets up the monitoring device in the member's home and educates the member and/or caregiver on how to use the device.

Data Collection Process
Members are identified as potential candidates for this program via referrals from multiple sources: including but not limited to physicians, Care Managers, and claims data review.

Results
Although participation in this program has been minimal, CMFHP has seen significant results from our participating members. Each member was assessed from the implementation date until October 1, 2009 or their term date; whichever occurred first.
The following categories were analyzed to determine the impact:

- Emergency Room Visits (ER)
- Inpatient visits (Inpt)
- Primary Care Physician visits (PCP)
- Total Cost

Most members who participated in this study showed a dramatic change in their utilization of services after the intervention was implemented (see table 1.1).

	Pre-Intervention Data					Post-Intervention Data				
Name	**Date Range**	**#ER**	**#Inpt**	**#PCP**	**Total Costs**	**Date Range**	**#ER**	**#Inpt**	**#PCP**	**Total Costs**
Member 1	1/1/07-7/8/07	3	4	3	57,751.23	7/9/07-5/31/08	0	1	0	4,437.67
Member 2	1/1/07-7/2/08	4	1	6	13,500.92	1/3/08-3/31/09	5	2	4	12,830.33
Member 3	2/1/07-1/3/08	7	5	3	197,905.88	1/4/08-5/8/08	1	1	2	3,921.40
Member 4	12/31/08-6/28/09	0	2	5	82,197.29	6/29/09-10/01/09	0	0	1	114.84
Member 5	10/31/06-8/17/09	2	3	3	18,085.54	8/18/09-10/01/09	0	0	0	0
Member 6	9/1/08-8/10/09	6	0	1	401.72	8/11/09-10/01/09	0	0	0	0
Member 7	7/18/08-8/25/09	6	1	10	18,689.60	8/26/09-10/01/09	0	0	0	0
Member 8	3/19/02-8/17/09	6	0	7	3,839.90	8/18/09-10/01/09	1	0	0	127.6
TOTALS		34	16	38	392,372.08		**7**	**4**	**7**	**21,431.84**

Table 1.1

A comparative analysis was done pre and post intervention.

Results showed:

- 79% decrease in total ER visits
- 75% decrease in total Inpt visits
- 82% decrease in total PCP visits
- 95% decrease in total costs

Behavioral Health Care Management including Case Management

NEW DIRECTIONS BEHAVIORAL HEALTH
ANNUAL APPRAISAL OF CMFHP SERVICES
2008-JUNE 30, 2009

FAMILY SERVICES FOR CHILD/ADOLESCENT MEMBERS

New Directions offers CMFHP members the Parents and Children Together (PACT) program, which contributes to improved mental health status by providing intensive, in-home care and case management. A small group of affiliate clinicians that also do in-home therapy have been

credentialed to address geographical gaps in the PACT program. Goals of this program include intervention with the family system, sustained medication adherence as needed, appropriate monitoring of symptoms and to enhance motivation for treatment and self-care among individuals at risk for relapse.

FINDINGS:

- In 2008, 934 Members benefited from in-home services. In the first two quarters of 2009, 489 Members benefited from these visits.

- New Directions contracted with two facilities in 2008 to offer up to 72 hours of respite care services for children and adolescents during times of crisis. During respite, in-home therapy is introduced and the crisis averted. In 2008, 13 CMFHP Members benefited from respite services. In the 1Q and 2Q of 2009, 33 Members utilized this service.

EVALUATION: In 2009, the number of members to received in-home interventions will meet or exceed the number of members utilizing the service in 2008. In 2009, the Respite Care service utilization has already exceeded the 2008 utilization. Members report being pleased with the Respite Care Providers.

CONCLUSIONS: NDBH will continue to utilize both of these interventions. Year end 2009, consider evaluating the outcomes for community tenure and/or higher level of care utilization.

CO-CASE MANAGEMENT SERVICES

In 2008, a collaborative effort for CMFHP members with co-existing medical and behavioral health conditions began. The identified members were referred to co-case management services for their dual diagnoses.

CMFHP medical case managers and New Directions intensive care managers are available to each other on a daily basis via teleconference to identify, discuss and collaborate on medical and behavioral health care for members.

FINDINGS:

- 2008: 3 CMFHP members were identified for Co-Case Management
- Jan-June 2009: 25 CMFHP members were identified for Co-Case Management

EVALUATION: The number of members referred for co-case management increased during the first two quarters of 2009. There were significant increases in both outpatient and inpatient utilization in 2009 which may partially explain the increase in utilization of this service. There were also more defined procedures for member identification and referral.

CONCLUSIONS: The service has not yet been evaluated for member satisfaction with health condition self management as a result of co-case management services. The holistic approach is a research-based best practice, thus the Program will continue.

MEDICATION OVERDOSE PREVENTION PROGRAM

The Medication Overdose Prevention Program was designed to decrease the potential for recurrent prescribed medication overdoses among members hospitalized for psychiatric and/or substance abuse treatment. Known prescribers are notified by ND staff when the prescriber can be identified. This gives the prescriber the opportunity to implement safety mechanisms when prescribing for the member post discharge. Several procedural changes occurred from 2007-2009 to improve the number of prescribers that staff were able to identify and subsequently notify.

With the member's consent, a Personal Transition Services (PTS) follow-up appointment (in-home clinician visit) is scheduled prior to discharge from the hospital. The appointment is within 7 days of discharge. Key elements of a PTS appointment include a review of medications, appointments with outpatient providers and an individualized safety plan that addresses weapons in the home or access to sharps or medications. If a member declines a PTS appointment, an appointment with a PTS clinician may be scheduled in the clinician's office or an appointment with an in-network Provider may be scheduled within 7 days.

FINDINGS:

CMFHP	Total # IP's with suicide attempts by prescription overdose/ Total # Suicide Attempts	% Inpatients with prescriber contacted after prescription overdose	% Members with prescription overdose who received PTS visits post discharge	% Re-admissions due to second prescription overdose
GOALS	---	**100%**	**≥10%**	**≤ 5%**
2007 Baseline Data	23/53	90% (21/23)	35% (8/23)	13% (3/23)
2008	20/39	90% (18/20)	35% (7/20)	0 (0/20)
Jan-June 2009	17/21	100% (17/17)	35% (6/17)	0 (0/17)

EVALUATION: All goals were met for contact with prescribers, readmissions and PTS visits post discharge.

CONCLUSIONS: Intensive case management services and innovative services such as PTS positively impact outcomes for high risk members. The procedures for members with known prescription overdose will continue through 2009. The monitoring of this program will discontinue if positive results are maintained.

APPOINTMENT ACCESS and AVAILABILITY

New Directions monitors routine, urgent and emergent appointment accessibility to ensure timely clinical intervention and improved member safety. Licensed staff refer and assist members calling the Access Center to an appropriate professional resource for all emergent life threatening, emergent non-life threatening and urgent calls. The clinician then follows up to

ensure the member was able to access care. Audits of staff performance occur on 1Q and 3Q calls.

Members have access to providers for routine appointments within 7 days. Because of the nature of behavioral health illnesses, NDBH set the routine appointment standard at 7 calendar days in order to provide a safe and appropriate amount of time for members to access care for behavioral health issues.

FINDINGS:

- In 2008 100% of audited urgent callers were appropriately offered an appointment with a provider within 24 hours of the call. In 1Q 2009, 92% of urgent callers were offered an appointment with a provider within 24 hours of the call.

- In 2008 and the 1Q 2009, 100% of audited callers were directed to care within 6 hours of a non life threatening emergent calls and immediate care for life threatening emergent calls.

- Routine - Periodic ~~–s~~napshots" of appointments available within 7 calendar days as listed as available on ND *ReferralQuick* scheduling system (2/1/08, 5/30/08, 8/15/08, 10/10/08, 2/9/09, 4/3/09) showed open appointments each week, and look-backs show appointments that were not used.

Medicaid Routine Appt Availability	Psychiatrist	Non-Psychiatrist	Status
1Q 2008	25	166	Goals met
2Q 2008	34	241	Goals met
3Q 2008	29	249	Goals met
4Q 2008	32	182	Goals met
1Q 2009	17	135	Goals met
2Q 2009	24	157	Goals met

EVALUATION: Access goals were met.

CONCLUSIONS: NDBH maintains quick access for members to both outpatient and facility based services. Semi-annual audits of urgent/emergent calls remain an adequate measurement interval based on positive staff performance. Snapshots remain sufficient for routine appointment availability based on performance over time.

FOLLOW-UP AFTER PSYCHIATRIC HOSPITALIZATION

The Ambulatory Follow-Up Program was designed to prevent or detect the incidence, emergence or worsening of behavioral health disorders by facilitating the coordination of behavioral health services among behavioral health providers.

Procedures:

- UM staff work with facilities to begin discharge planning on the first day of an admission.
- New Directions' staff telephone members within 72 hours of discharge to remind the member and family of scheduled follow-up appointments and to assess the member's need for additional services /supports. If the member does not answer the telephone but an option is given to leave a message, a reminder is left for the follow-up appointment: date and time of the appointment and the provider's name. If the member cannot be reached by telephone or answering machine/voice mail, a letter is mailed to the member's home.
- New Directions' provides a Personal Transition Service (PTS) in-home assessment visit from a licensed behavioral health practitioner within 72 hours of discharge from the hospital. Members qualify if they are not already established with an outpatient provider, discharged to partial day or intensive outpatient programs or scheduled for the Parents And Children Together (PACT) in-home family therapy program .

In 2008, a one page flyer was developed for facilities that highlight NDBH resources for discharge planning. The new flyer and all of the prevention program brochures were handed out during each facility meeting. In May 2008, NDBH contracted with a private facility to provide outpatient case management services. The facility added 1 ½ staff to meet the demand. This service will allow members to access services in a more efficient, timely manner. In December, 2008, refresher training on ND's ReferralQuick real-time appointment software system was provided to the New Directions UM and CM staff as a reminder of a resource that is available for discharge planning. During 1Q09: The annual brainstorming meeting was held with ND clinical staff to discuss barriers and opportunities for improving access for ambulatory follow up. The Director of Triage and Referral attended the 2009 session.

FINDINGS:

CMFHP Ambulatory Follow-Up after Psychiatric Hospitalization	Goals	2008	1Q & 2Q 2009	Status
7 day Follow-Up Appointments Scheduled	85%	88%	81%	08-Met goal 09-Goal not met ytd
7 day Follow-Up Appointment Adherence	42.5%	57%	42%	08-Met goal 09- Goal not met ytd

EVALUATION:

	Total	DC to	DC to	DC to	Appt beyond 7 days

	discharges	IOP/PHP	PTS	OP Provider	or not scheduled for various reasons
2008	391	66 (17%)	57 (14.5%)	221 (56.5%)	47 (12%)
1Q09 & 2Q09	274	54 (20%)	53 (19%)	116 (42%)	51 (19%)

Personal Transition Services (PTS) Utilization	2008	Jan-June 2009
PTS Appointments Offered	121	117
PTS Appointments Accepted by the Member	57 (47%)	53 (45%)

- Admissions/Discharges are increasing in 2009 as compared to 2008.
- Appointment adherence nearly met goal in 2009 for the first two quarters.
- PTS appointments offered in 2009 have already nearly reached the total numbered for the entire year of 2008 but fewer members accepted the PTS visit comparatively.
- There was a 7 percentage point increase in appointments not scheduled or scheduled beyond the 7 day standard.

CONCLUSIONS: Enhance interventions to promote community tenure. A quality improvement project began in 3Q09 to develop a user-friendly and current community resource information list to help members maintain community stability. Support Groups generally are very supportive of their members and can promote the idea of outpatient treatment as a necessity for stability. This stability should help prevent extreme exacerbations of behavioral health symptoms. NDBH will consider another workshop on member engagement techniques for ND staff and facility UM staff.

CULTURAL COMPETENCY

Cultural Competency Activities – New Directions Behavioral Health (NDBH) has been involved in the promotion of cultural competency for CMFHP‘s provider networks since 2000 by promoting workshops and presentations for area health care professionals.

In 2007, New Directions collaborated with two other organizations to present a culturally focused 4-hour workshop featuring a nationally recognized cognitive behavioral therapist.

In 2008, New Directions presented several small workshops on cultural competency topics such as suicide awareness across population mixes, bullying and violence in school settings, and a major four hour workshop ―Family Clinical Interventions for Adolescent Suicidality with Special Emphasis on Latinas: A Cultural Competency Perspective.”

In 2009, New Directions began a collaborative initiative with the University of Washington in St. Louis School of Social Work to obtain a grant to study cultural implications in providing evidence based clinical services to members on an outpatient setting. Researchers at University of Washington will analyze the professional services approaches of select providers on the New Directions‘ panel. The grant initiative will include evaluation of present practices, education, observation and feedback components. The actual initiative is expected to begin in early 2010.

In addition, in 2009, New Directions has cosponsored luncheon workshops on challenges military veterans and their families face and a full day workshop on August 7, 2009 on Mindfulness-Based Cognitive Therapy.

Further, New Directions continues to focus on a collaboration with local school district to provide immediate services for students counselors and social workers identify as having behavioral health issues and has facilitated an arrangement for a full service provider (outpatient to inpatient services) to provide on-site and in-home services to the school district. Additionally, a collaborative initiative is underway with a non-profit organization, Kansas City Suicide Awareness and Prevention Programs (KC SAPP) to survey the district students around violence and suicide issues and to provide educational, preventive and timely individual services.

During 2nd and 3rd quarters 2009 the NDBH Clinical Resource Center staff reviewed cultural diversity research articles and materials to bolster the staff's sensitivity to the diverse needs of members. A formal training plan including didactic presentations from internal consultants as well as external programs was scheduled to address the unique multi-cultural and psychosocial needs of the Medicaid population. The use of on-line training modules through "Essential Learning' web programs will address clinical and cultural diversity topics that will allow for demonstrated staff competency through post testing.

Clinical Practice Guidelines

Clinical practice guidelines are an integral component of Children's Mercy Family Health Partners (CMFHP) utilization management and disease management programs. CMFHP distributes clinical practice guidelines to physicians as requested. Milliman Care Guidelines are the primary resource utilized by the Pre-certification, Utilization Review, and Care Management nurses for medical necessity determination of requested services or procedures.

In addition to Milliman Care Guidelines, clinical practice guidelines are developed internally by CMFHP Medical Directors and Health Services management staff, utilizing available nationally recognized resources. All clinical practice guidelines utilized or distributed by CMFHP are reviewed through the Clinical Criteria Committee, with oversight by the Medical Management Committee prior to implementation.

In addition, CMFHP distributes immunization and preventive guidelines annually to all network providers. These guidelines are adopted from nationally recognized sources and represent evidence-based practice standards. CMFHP maintains a policy on the adoption and distribution of clinical practice guidelines.

In 2010, CMFHP will implement the use of Milliman Chronic Care Guidelines, which are nationally recognized clinical practice guidelines specific to high volume disease states that are typically managed in our complex care management program. The Care Managers will use these guidelines in their documentation of assessments, interventions, and goal setting process.

CMFHP will also place adopted clinical practice guidelines on our website. We will increase the number of guidelines distributed to network physicians and establish a process for measuring the application of the guidelines for our high volume physicians. The CMFHP Senior Medical

Director is responsible for leading the effort to review and adopt clinical practice guidelines for the Health Plan.

Credentialing and Re-Credentialing

Children‘s Mercy Family Health Partners completes all credentialing and re-credentialing in house, which includes the oversight of all delegated entities through an annual review according to NCQA Standards. The credentialing and re-credentialing process includes review of the application for completeness and any additional information that may be necessary based on responses to specific questions and primary source verification, as well as Medicare/Medicaid sanctions. Children‘s Mercy Family Health Partners has followed the NCQA guidelines for credentialing/recredentialing practices for several years and expects to attain NCQA accreditation for our health plan in the near future.

Overall in 2009, Children‘s Mercy Family Health Partners credentialed 423 new Missouri providers and completed re-credentialing of 160 Missouri providers. We also completed the annual review of our delegated entities. Of our delegated groups, all were at 100 percent compliance with all standards. Our delegated groups are University Physicians Associated, Bridgeport, Children's Mercy Hospital and Physicians, New Directions, HealthFirst, Freeman PHO and Citizen‘s Memorial.

Children‘s Mercy Family Health Partners continues to successfully credential and re-credential providers and facilities as well as complete delegated audits in a timely manner.

Medical Record Review

Program Review

Children‘s Mercy Family Health Partners (CMFHP) maintains a provider network for delivery of coordinated quality medical care to members. CMFHP performed medical record reviews every three years based on the NCQA Credentialing and Re-credentialing schedule.

Since 1997, Children‘s Mercy Family Health Partners has coordinated a comprehensive medical record review of the Primary Care Providers‘ health care delivery to members similar to those described in the Request for Proposal. CMFHP uses analysis of Primary Care Provider Medical Record Reviews as a mechanism to identify areas for improvement opportunities. Medical record review performance indicators are grouped by category and prioritized. Actions are then developed to improve provision of services to members and improve provider documentation of services.

Data and Trends

In the reporting period July 1, 2008 through June 30, 2009, CMFHP identified that pediatric immunization records and problem lists emerged as not meeting thresholds for Medical Record Indicators. Although these indicators did not meet threshold, the outcome was not identified as meeting criteria for corrective action plan but will continue to be monitored. The issues not meeting threshold for Clinical Quality Indicators were lead related activities and testing. Other Clinical Quality Indicators not meeting threshold during the reporting period were mammogram screenings, asthma action plans within the medical record and adult immunization records.

The tables that follow demonstrate the previous tracking and trending of clinical and medical record maintenance indicators for the reporting period and comparisons with previous years.

Primary Care Provider Medical Record Reviews

		FHP	**FHP**	**FHP**	**FHP**	**FHP**	**FHP**	**FHP**	**FHP**
		2008	**2007**	**2006**	**2005**	**2004**	**2003**	**2002**	**2001**
# of Practices/Groups assessed/reviewed		23	44	46	36	17	24	64	*
# of PCPs assessed/reviewed		80	71	148	42	36	69	185	40
# of Member Records assessed/reviewed		484	1083	1642	801	489	689	1841	408
CLINICAL INDICATORS	**Target**								
Are risk factors for disease identified?	90%	100%	100%	100%	100%	100%	98%	90%	99%
Is family and personal (past medical history) documented?	90%	100%	100%	100%	99%	99%	97%	91%	99%
Is there identification of smoking?	90%	100%	100%	100%	99%	96%	98%	97%	83%
Has smoking cessation been discussed?	75%	100%	100%	99%	94%	87%	70%	81%	16%
Has the effects of passive smoking been discussed?	75%	100%	100%	99%	94%	87%	81%	83%	15%
Is there identification of alcohol use?	75%	100%	100%	100%	97%	95%	97%	97%	75%
Is there identification of illegal drug use?	75%	100%	100%	100%	94%	93%	97%	95%	73%
Has anticipatory guidance been discussed and/or given?	90%	99%	100%	100%	98%	100%	96%	83%	72%
Education regarding sexual activity?	60%	99%	100%	99%	94%	82%	95%	82%	77%
Age specific adult immunization record?	60%	28%	17%	24%	71%	68%	26%	24%	52%
Documentation of early diagnostic screens?	90%	99%	99%	100%	99%	100%	98%	86%	99%
Pap Smear (start when sexually active)	70%	79%	67%	73%	89%	80%	84%	76%	75%
Mammogram(start at age 40)	75%	53%	67%	75%	75%	57%	69%	63%	75%
Lead Questionnaire included in EPSDT screening?	100%	50%	78%	68%	78%	74%	65%	50%	46%

Blood Lead level for any positive response on the lead questionnaire?	100%	100%	100%	98%	92%	97%	81%	74%	74%
Blood level 12 months?	100%	61%	98%	78%	82%	82%	60%	56%	66%
Blood level 24 months?	100%	58%	100%	86%	77%	84%	53%	47%	67%
Blood levels for all children aged 12 – 72 months	100%	43%	59%	56%	56%	63%	52%	35%	89%
Dental referral documented?	57%	100%	100%	96%	95%	89%	92%	83%	52%
Documentation of a dental screen/exam?	57%	87%	86%	84%	88%	88%	88%	83%	79%
Documented height?	85%	98%	98%	99%	99%	97%	90%	87%	87%
Documented weight?	85%	100%	100%	99%	100%	100%	99%	100%	99%
Documented B/P? (start age 3)	85%	98%	99%	96%	98%	97%	96%	96%	95%

Clinical Quality Indicators (cont)	Target	FHP 2008	FHP 2007	FHP 2006	FHP 2005	FHP 2004	FHP 2003	FHP 2002	FHP 2001
Documented history regarding exercise?	50%	100%	100%	100%	100%	94%	95%	86%	84%
Documented history regarding diet intake?	75%	100%	100%	100%	100%	96%	95%	87%	76%
Documented hearing test/screen? (1mo-20 years & at risk)	80%	93%	95%	92%	91%	91%	90%	81%	75%
Has an Asthma Action Plan been Initiated?	80%	97%	100%	99%	96%	84%	86%	55%	56%
Is there an Asthma Action Plan in the record?	80%	45%	97%	91%	95%	62%	62%	32%	44%
Has the member had an HbA1c once every 6 months?	50%	88%	92%	94%	100%	69%	86%	86%	*
Has the member had a foot exam with every office visit?	75%	64%	41%	73%	86%	60%	36%	50%	*
Has the member had an annual dilated eye exam?	75%	44%	54%	76%	100%	53%	36%	54%	*
Has the member had a yearly LDL?	50%	68%	95%	94%	100%	69%	64%	83%	*
Documented vision screens?(3-21 years screen-1-36 mos & at risk)	80%	92%	95%	90%	91%	90%	89%	79%	79%

Medical Record Maintenance Indicators	Target	FHP 2008	FHP 2007	FHP 2006	FHP 2005	FHP 2004	FHP 2003	FHP 2002	FHP 2001
Are age appropriate EPSDTs documented?	80%	89%	91%	90%	90%	88%	88%	79%	88%
Is there an age specific pediatric immunization record?	90%	87%	90%	87%	97%	97%	89%	79%	79%
Presenting problems from previous office visits addressed in visits?	95%	100%	100%	100%	100%	100%	100%	98%	100%
Are unresolved problems from previous office visits addressed in visits?	95%	100%	100%	100%	100%	100%	100%	99%	99%
Is there documentation of an action/treatment?	95%	100%	100%	100%	100%	100%	100%	99%	99%
Does record indicate follow up dates to treatment?	95%	100%	100%	99%	100%	100%	100%	99%	99%
Do all pages contain patient ID?	95%	100%	100%	100%	100%	100%	100%	96%	99%
Is documenting person signing, initialing progress/treatment notes?	95%	100%	100%	100%	100%	100%	100%	100%	100%
Are all entries dated?	95%	100%	100%	100%	100%	100%	100%	100%	99%
Is the record legible?	95%	100%	100%	100%	100%	97%	100%	100%	100%
Is there a problem list?(Member seen 3 times or more)	95%	80%	87%	82%	100%	81%	70%	72%	96%
Are allergies and adverse reactions to medication prominently displayed?	95%	99%	100%	100%	98%	85%	97%	98%	99%
Is there a referral/correspondence note related to state(s) of health?	95%	100%	100%	100%	100%	100%	100%	99%	99%
Is education related to medication documented?	95%	100%	100%	100%	100%	100%	93%	99%	92%
Are diagnostic test results initialed or in plan of care?	95%	100%	100%	100%	100%	99%	99%	99%	97%
Is follow up for hospitalization requested by the provider?	95%	100%	100%	100%	100%	98%	99%	98%	93%
Is urgent/ER service									

follow up requested by the provider?	95%	100%	100%	100%	100%	97%	100%	97%	99%
Does the DOS & ICD9 code match documentation in medical record?	100%	99%	100%	97%	*	*	*	*	*
Does the DOS & CPT code match documentation in medical record?	100%	100%	100%	99%	*	*	*	*	*

* Indicator not applicable

Analysis

CMFHP's provider medical record review for clinical indicators met twenty-five of thirty-three indicator thresholds, which is 76%. Eight of the thirty -three clinical indicator thresholds were not met or 24%. The following clinical indicators did not meet threshold: Mammogram screening; Lead questionnaire included in EPSDT screening; Blood lead level at 12 months; Blood lead level at 24 months; Blood lead levels for all children aged 12-72 months not previously tested; asthma action plan initiated; member with diagnosis of diabetes had a foot exam with every office visit; and member with diagnosis of diabetes had an annual dilated eye exam.

Four of the eight clinical indicators not met are related to provider assessment and initiation of blood lead screening at appropriate member age. CMFHP has a Care-Management Program targeted at member and provider education, identification, screening, and treatment for children identified with elevated lead levels. CMFHP incorporated mammogram screening reminder mailings into its outreach activities biannually. CMFHP has an Asthma Disease Management Program that provides education to providers regarding asthma action plans. Providers not meeting threshold were given education in the closing of the review and referred to the asthma educators. CMFHP continues ongoing education to providers regarding documentation of adult immunizations.

CMFHP's provider medical record maintenance review met sixteen of nineteen indicator thresholds or 84%. Three of nineteen medical record maintenance indicators were not met or 16%. The following indicators did not meet threshold: Is there an age specific pediatric immunization record; Is there a problem list; and Does the date of service and ICD9 code match documentation in the medical record. These indicators did not meet threshold but were not at such an unsatisfactorily level to require the initiation of a corrective action plan.

Children's Mercy Family Health Partners completed provider medical record reviews in 2008. In 2009, CMFHP initiated the process of reviewing NCQA Standards for accreditation and identified the standards for medical record review every three years changed. CMFHP identified that NCQA recommends that medical record reviews be coordinated across the health plan's record review processes to decrease the provider burden and enhance an internal coordinated process.

Children's Mercy Family Health Partners current process to monitor provider medical record documentation, clinical practice guidelines, disease management monitors and Healthcare Effectiveness Data and Information Set (HEDIS) medical record reviews is not a coordinated process across departments.

Strengths
To address ongoing quality improvement activities, support the success of previous findings and continue to maintain and improve documentation standards in member records, CMFHP continued provider education in this reporting period through the Medical Record Review Education and Provider Newsletters. Provider Newsletters were sent in October 2008, February 2009, May 2009 and July 2009.

CMFHP has established medical record documentation standards, clinical practice guidelines, disease management monitors and HEDIS quality indicators that are known to the provider network.

Weaknesses
CMFHP does not have a coordinated medical record review process to include medical record documentation standards, clinical practice guidelines, disease management monitors and HEDIS medical record reviews.

Opportunities
CMFHP identifies an opportunity to develop a new medical record review process to include medical record documentation standards, clinical practice guidelines, disease management monitors and quality indicators requirements for quality reporting to meet contract obligations. This new process will enhance coordination with providers by decreasing repeated reviews

CMFHP identifies the ongoing opportunity for member and provider education regarding the dangers of lead exposure, lead screening and lead poison prevention and treatment for elevated lead levels.

CMFHP identifies the ongoing opportunity for member and provider education regarding mammogram screening, asthma action plans and diabetes care.

Subcontractor Monitoring
Bridgeport Dental Services
CMFHP subcontracts dental services to Bridgeport Dental. As part of our ongoing relationship with Bridgeport, we work with the entity to ensure dental access for CMFHP members and to resolve issues that may arise in the areas of access, quality or member benefits.

Quarterly meetings between Bridgeport staff and CMFHP staff are held. Topics discussed and reports presented at these meetings include: utilization reports, provider recruitment updates, outreach activities update, fraud and abuse reports, grievance and appeals reports, and other relevant topics that may be appropriate. Further, performance projects and measures concerning Bridgeport are discussed quarterly and documented in CMFHP minutes. Areas that are always

considered for performance projects and measures are community outreach activities as well as access for members to general dentists.

Bridgeport continued provider recruitment efforts, member education and outreach throughout FY 2009 in all counties of the Western Region. Bridgeport works collaboratively with CMFHP in meeting with providers and community advocates. CMFHP had been receiving complaints about dental access issues from providers and advocates in the expansion county areas. To address this concern, in 2009 CMFHP invited Bridgeport to present at CMFHP's joint provider and community advocate meeting in Bolivar, Missouri. Bridgeport did an excellent job of explaining its program and the processes in place to ensure member access to dental services. This program was well received by the audience and it will be presenting at future provider and community advocate meetings.

CMFHP collaborated with Bridgeport to develop a Performance Improvement Project (PIP). This project focused on children in Jackson and Clay counties, ages 2 through 20, who have not had a dental visit in the last 12 months. Over 15,000 postcards were mailed in June 2008. Results showed an annualized increase of 33%.

The postcards will be sent to all un-serviced members in all counties in February 2010. Additional information regarding dental benefits and education will be included on our website and member newsletter. A statewide PIP is also being developed to improve dental services among MO HealthNet participants. The goal is to improve each plan's screening rates by 3%. Interventions will be implemented in 4Q09.

During Fiscal Year 2009, CMFHP regularly monitored the encounter submissions and acceptance rates for Bridgeport. CMFHP works to ensure that encounters submitted are ultimately accepted. Over the year, progress has been made to increase encounter acceptance rate upon the first submission. Bridgeport's monthly accepted rate has consistently been around 96%.

Bridgeport is proactive in identifying and bringing issues to CMFHP's attention and has shown true integration with CMFHP and our Quality Management program to ensure that our members receive the best dental services possible in a timely manner.

New Directions Behavioral Health

CMFHP understands that coordinating behavioral health services with the rest of a member's health needs is essential to provide effective care. Since February 1, 2007, CMFHP has contracted with New Directions Behavioral Health (NDBH) to deliver behavioral health services to CMFHP members. Representatives from CMFHP and NDBH meet on a quarterly basis to review operational issues, monitor quality and utilization, and develop protocols to integrate medical and behavioral health services. NDBH provides comprehensive reports to the quarterly oversight meetings which included information about appointment availability, utilization trends, grievance trends analysis, and ambulatory follow-up after hospitalization.

In addition to the quarterly oversight meetings, the clinical management team for NDBH attends case rounds with CMFHP Care Managers quarterly to discuss cases where behavioral health

issues were involved. This collaboration could occur on a daily basis, if needed, to coordinate care for specific members needing both medical and behavioral health services urgently.

A project initiated by NDBH in 2007, the RE-Aim Project continues to reach into the community to educate a range of NDBH providers and advocates that may be interacting with CMFHP members. FY 2009 interventions included meetings with many area behavioral health advocates and providers, with the goal of increasing education about the types of services and benefits provided by NDBH.

NDBH began or continued several other initiatives during FY 2009, including a medication overdose prevention program; collaboration with primary care physicians to encourage the use of the NDBH help line; and the development of mailings and educational pamphlets on bullying, respite service, and stop-violence programs.

CMFHP's Chief Clinical Officer and Director of Provider Relations maintained oversight of all of delegated activities, such as utilization management and credentialing. NDBH maintained URAC certification as a Utilization Review organization. NDBH also maintained NCQA accreditation for its credentialing processes. The Chief Clinical Officer performed an annual case management audit of NDBH records. The results of this audit were reported to the CMFHP Health Services Review Committee and the Medical Management Committee.

During FY 2009, CMFHP regularly monitored the encounter submissions and acceptance rates for NDBH. CMFHP works to ensure that encounters submitted are ultimately accepted. Over the year, progress has been made to increase our encounter acceptance rate upon the first submission. New Directions' average accepted rate for FY 2009 is approximately 91%.

MTM Transportation Services

CMFHP recognizes the importance to members of having available and manageable non emergent medical transportation. Beginning July 1, 2008 CMFHP contracted with Medical Transportation Management (MTM) to provide these services.

Representatives from CMFHP and MTM met on a quarterly basis in FY 2009 to review operational issues, monitor quality and utilization, and develop protocols to provide high quality transportation services to CMFHP members.

The following enhancements/changes were made to the transportation program in FY 2009:

- Developed a key fob with MTM's phone number that will allow members to have access to the transportation number on their key rings.
- MTM presented to the CMFHP Community Advisory Council in an effort to spread the word about the transportation benefit.
- Continued monthly action plan meetings, as well as quarterly oversight meetings to discuss and resolve issues, quality and utilization. An action log is maintained to track issues and follow up.
- A denial process was developed to mail member letters when transportation was denied, allowing the opportunity for an appeal.

- A section of the member newsletter now includes a column titled "Benefit from your Benefit" that includes information about the transportation benefit and how to call for a ride or gas reimbursement.
- An educational flyer was sent to all transportation vendors about car seat safety and the state requirements for childhood car safety seats

During FY 2009, CMFHP regularly monitored the encounter submissions and acceptance rates for MTM. CMFHP works to ensure that encounters submitted are ultimately accepted. Over the year, progress has been made to increase our encounter acceptance rate upon the first submission. MTM's average accepted rate for July 1, 2008 to June 30, 2009 is approximately 96%.

Sentinel Events
Children's Mercy Family Health Partners has functionally defined sentinel event(s) as a case(s) of an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase, "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.

Data/Trends
There were unexpected deaths and injuries, but upon medical review, none appeared to be outside the standard of care.

Analysis
Sentinel events, a patient safety indicator, will continue to be reviewed and analyzed as they occur during 2009-2010.

Strengths
CMFHP has a consistent process for identifying, reporting and evaluating quality of care cases.

Weaknesses
CMFHP did not identify any weaknesses in the process during this timeframe.

Opportunities
CMFHP has the opportunity to continue to monitor identified quality of care cases and processes to evaluate those cases.

Harmony Health Plan of Missouri

Provider Satisfaction
Harmony/WellCare continued to focus resources on improving the provider telephonic satisfaction survey, implemented in all WellCare markets in early 2007. This telephonic survey is activated when a provider calls our Provider Service Center. Prior to being connected to a customer service agent, the provider is prompted to choose if they would like to participate in an anonymous survey following their call. Once the provider selects the yes or no prompt their call

is routed to the customer service agent as normal. If the provider chose to participate in the survey, upon termination of their call with our customer service agent, the provider would receive an almost immediate call-back which is the automated survey consisting of approximately five questions.

While this survey has been successful in many of our other markets, we have found the response from our Missouri providers to be fairly low. Of the sixty-five (65) responses received during the July 1, 2008 – June 30, 2009 survey period, 75.38% providers were satisfied with Harmony. We will continue to promote the telephonic survey as it is useful at capturing respondents who may not normally agree to complete a paper survey. We will consider re-implementing the paper survey in our Missouri market and may explore web-based solutions as well for the upcoming year.

Case Management

The Case Management department assists members in the coordination of care, education, transition of care, and overall member advocacy. Case Management identifies appropriate members with specific disease states and/or needs to ensure compliance with all state and federal regulations and contracts.

I. *Scope and Methodology*

Program Objectives: Timely coordination of quality healthcare services to meet an individual's specific healthcare needs in a cost effective manner to promote positive member outcomes. The Case Management program assists members to meet their specific goals through the care planning, monitoring, and coordination of care processes. The Case Management (CM) process is as follows: member identification, member mini-screening for CM criteria (trigger list, i.e. Asthma, Diabetes, Lead, High Risk OB, Complex Member Conditions or Co-morbidities.), comprehensive assessment conducted by RN Case Manager, Care Plan development/education, ongoing monitoring of member, re-assessment of member, satisfaction level with the program, and case closure. Case management occurs across a continuum of care, is individually focused, and member centric.

Specific objectives for the Case Management program are as follows:

- Ensure transition of care for members with complex conditions
- Identify opportunities for improvement in the case management process and implement as needed
- Consult with appropriate specialized healthcare personnel when needed such as medical directors, pharmacists, social workers, behavioral health professionals, health coaches, etc.
- Work collaboratively with disease management, behavioral health, utilization management to ensure smooth transition and service delivery to the member

Project – Children with Special Health Care Needs (CSHCN)

Children with Special Health Care Needs (CSHCN) is defined as children who have serious medical or chronic conditions, or who are identified with special health care needs. An individual is considered a child under Twenty-One (21) years of age according to the EPSDT guidelines identified in the contract.

Case Management will identify Children with Special Health Care Needs from a variety of internal and external referral sources. The Member Engagement Team or Case Manager will screen the member for Case Management service using the CSHCN Screener©. The CSHCN Screener© was developed through the Child and Adolescent Health Measurements Initiative (CAHMI). It identifies a child with special health care needs. Additional question have been added to the CSHCN Screener© to identify need for Case Management services. If member screens positive for Case Management services, member will be assigned to a Case Manager. The Case Manager will outreach to the parent(s)/member and complete the following:

- Medical Case Management Comprehensive Assessment
- Develop the Care Plan with parent/member involvement according to policy
- Member CM Introduction Letter and CM Care Plan will be sent to member
- CM contact PCP via mail, fax, or phone to notify of member‘s enrollment in the CM Program
- CM initiates intervention with continued coordination and education with parent(s)/member, PCP, and community programs
- CM will ensure that the EPSDT guidelines are being followed: Well Child Check-Ups, Lead Level testing (per Department of Health guidelines), and Immunizations
- Members are discharged from case management according to well established criteria and provided with information about re-entry into the program as well as contact information to maintain continuity if needed

Project – ER Diversion Program

Objective/Purpose – Case Management staff provide members who frequently utilize the Emergency Department with education and guidance in an effort to decrease exacerbations of disease and assist in establishing a medical home.

Implementation/Improvements – An algorithm was developed to better identify members who would benefit from CM intervention.

Project – Lead Case Management Program

Objective/Purpose – Provide case management and education to the parents/children with elevated blood lead levels.

WellCare Lead Case Management along with providers follow the Centers for Medicare and Medicaid Services (CMS) guidelines and CDC Guidelines: Screening Young Children for Lead Poisoning and Managing Elevated Blood Lead Levels Among Young Children in our program operations.

WellCare Lead Case Managers work closely with the Division of Medical Services, the local public health agencies and the Primary Care Physician (PCP) to provide lead screening case management for those children with elevated blood lead levels. The Case Manager refers all confirmed cases to the Local Public Health Agency (LPHA) for an environmental investigation which is the financial responsibility of the Division of Medical Services.

II. *Additional Plans for 2009* – Case Management is in the process of maximizing improvements of the member identification process for the ER Diversion Program. Case Management will continue to monitor all programs for opportunities of improvement.

III. *Analysis of Lead Case Management Data*

HARMONY HEALTH PLAN OF MISSOURI
Lead Case Management Totals

	Jul 08	Aug 08	Sept 08	Oct 08	Nov 08	Dec 08	Jan 09	Feb 09	Mar 09	Apr 09	May 09	Jun 09
Starting Census	8	14	12	15	15	21	25	29	31	31	32	34
Referred	6	1	3	0	6	6	6	3	1	2	6	3
Opened	6	1	3	0	6	6	6	3	1	2	4	3
Closed	0	3	0	0	0	2	2	1	1	1	2	2
Ending Census	14	12	15	15	21	25	29	31	31	32	34	35

IV. *Analysis of ER Diversion Program within Case Management*

MISSOURI ER DIVERSION REPORT SUMMARY						
	Total number of member on Report	Total number of members with >4 visits	Number of Members Outreached	Number of members to receive an ER Outreach Letter	Number of Letters sent to Providers	Number of members opened to Case Management
July-08	2263	9	9	9	9	0
September-08	2997	22	22	22	22	0
November-08	2892	24	24	24	24	1 (BH)
December-08	2820	15	13	12	12	1 (DM)
January-09	2862	11	7	7	7	0
February-09	2960	12	9	9	9	0
March-09	3113	10	10	10	10	0
April-09	3144	20	18	18	18	0
May-09	3208	12	0	0	0	0
June-09	3391	9	9	9	9	1 (8 members followed by Health Coach for 2 months)

V. *Analysis of Children with Special Healthcare Needs within Case Management*

Harmony Health Plan of Missouri

Children with Special Health Care Needs Enrollment Report

	Jul 09	Aug 09	Sept 09	Oct 09	Nov 09	Dec 09	Jan 09	Feb 09	Mar 09	Apr 09	May 09	Jun 09
Starting Census	9	16	14	20	20	22	23	37	41	18	56	46
Referrals	72	32	7	5	7	49	57	68	54	128	74	52
Opened Cases	7	3	7	4	7	4	22	23	3	43	24	9
Closed Cases	8	5	1	4	5	3	8	19	26	5	34	26
Ending Census	16	14	20	20	22	23	37	41	18	56	46	29

VI. *Analysis of Complex Case Management*

Results:

- Number of members enrolled in Case Management in 2008-09 **770**

Recommendations

- Staff Education: Continue to provide staff with tools needed to develop case management skills and qualify for CCM examination.
- Continued Improvement of Member Engagement: Process improvement for front line member engagement (call center).
- Compliance: Continue to improve the Internal Audit Processes and Monitoring, External Audit Preparations, analysis of satisfaction with Case Management, and member health outcomes i.e. SF-8, HEDIS.

Disease Management Program

WellCare provides disease management (DM) services to appropriate members. Disease managers are registered nurses with clinical experience in specific diseases. Disease management is a population based strategy that involves consistent care across the continuum for members at risk in certain disease states. Elements of the program include education of the member about the particular disease and self-management, monitoring of the member for adherence to the treatment plan, and the consistent use by the treatment team and the disease manager of validated, recognized evidence based clinical practice guidelines. The disease manager serves as an important link between the member, the healthcare team, the payer and the community. Disease management occurs across a continuum of care, is population based, but focused on the individual, and is member centric.

Purpose

The purpose of the disease management program is to provide coordination and education services to an identified population with a particular disease state and possible co-morbid conditions, decrease the fragmentation of the healthcare system for these members, and do so with compassion and excellence.

Goals

The goals of the DM 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 education, monitoring and coordination services to members utilizing evidence based guidelines
- Identify barriers to care and wellness and eliminate them
- Ensure access to quality care
- 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

Objectives

The DM program will meet its goals through the application of the following objectives:

- Identification of members at risk
- Stratification of risk for each member with interventional strategies designed for each level of stratification
- Assessment and planned interventional strategies
- Appropriate referrals to appropriate healthcare professional services such as behavioral health, pharmacy, and other specialized practitioners when needed
- Provide education and assistance to members
- Monitor and adjust care plans as needed to optimize the outcome for the member and meet goals established by the DM and the member/family
- Monitor contractual arrangements and resource allocation to ensure that appropriate services are available to meet members‘ health needs
- Tracking and monitoring of member complaints
- Identify opportunities for improvement in the process and implement as needed
- Maintain cultural sensitivity
- Ensure that overall services provided to the member are medically necessary, appropriate, and consistent with the member diagnosis and level of care required
- Consult with appropriate specialized healthcare personnel when needed such as medical directors, pharmacists, social workers, behavioral health professionals, health coaches, etc.
- Ensure the privacy of the member and members‘ protected health information

Disease Management Process

The disease manager performs the primary role functions of assessment, planning, invention including education, and advocacy, which are achieved through collaboration with the member and treatment team. Below are listed the key functions of the disease manager:

- Identification of the member at risk
- Risk stratification of each member within each disease state
- Assessment and development of member directed goals through care planning
- Implementation of care plans within interventional strategy guidelines depending on the risk level of the member, including education of the member and adherence monitoring
- Monitoring of the member throughout all transitions of care
- Education of the member
- Documentation of all interactions and plan of care
- Optimizing outcome and goal attainment

Member Identification
WellCare utilizes various methods for identification of those members at the highest risk for poor outcomes and increased utilization of services. Strategies for member identification include the following:

- Utilization management referral
- Intake coordinator referral
- Physician referral
- Member self-referral
- Discharge planner referral
- Disease management program referral
- 24/7 nurse line referral
- Behavioral case management/concurrent review referral
- Data mining through proprietary claims algorithms

WellCare's case management program is an "opt out" program. This ensures that members who qualify receive services without having to seek out the program.

Disease Management Information Systems
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.

Disease Management Program Structure
The following process is applied to members who are referred to case management or disease management:

- Member is identified through a variety of mechanisms
- Member is contacted by a case coordinator (para-professional in healthcare) and screens the member utilizing the following tools:
    - Patient Health Questionnaire (PHQ-9)—screening tool used to determine whether a member is depressed. On the basis of the findings, the member may be warm transferred to a case manager, a disease manager and/or behavioral health professional for a more comprehensive assessment
    - CAGE/CAGE-AID—The CAGE (alcohol) and CAGE-AID (drug) are four questions that have been shown to effectively identify members who may have an issue with substance abuse; if screened positive, the member is referred to a behavioral health professional
    - SF-8—a standardized tool to establish a baseline regarding the member's perception of health and/or wellness. This screening tool is used by the case

manager at discharge as well to determine the change in member‘s perception of health status

- Members that meet the disease management criteria are assigned to a registered nurse and a comprehensive assessment is performed. The member can opt out of the program anytime during this entire process. The assessment:
    - Identifies a member‘s health status and condition specific issues including co-morbid conditions
    - Includes the historical medical and psychosocial information
    - Identifies needs, barriers, and cultural diversity information
- Risk stratification tool applied, member interventional strategy schedule is set up
- For lower risk members, wellness coaches may be assigned
- Development of the plan of care with the member; identify goals and interventions in accordance with nationally recognized standards of care and evidence based guideline use
- Monitor the member throughout the process of education; monitoring for adherence including pharmacy monitoring
- Members are contacted on a regular basis depending on acuity and needs
- Monitoring of all activities and report generation as needed from common electronic medical record platform
- Members are discharged from disease management according to well established criteria and provided information about re-entry into the program and contact information to maintain continuity if needed

Disease States

- Asthma
- COPD
- Diabetes
- CHF
- Obesity—pediatric
- Hypertension (HTN)
- HIV/AIDS
- Major Depression
- Bi-Polar
- Psychotic Disorders
- Substance Abuse
- Smoking Cessation

Stratification Levels

- Level 1: member is relatively stable with the disease process. Services are often psychosocial in nature; member is stable in self-care and understands their disease process; may benefit from reinforcement education
- Level 2: member may be newly diagnosed or newly discharged. They may have some co-morbid disease states and need some extra assistance or they may not be managing their disease well and could benefit from extra education and adherence monitoring
- Level 3: member requires more intensive disease management and education. These are the members who are either not adherent, not managing their disease well or unstable because of co-morbid conditions. Individuals in this category may become too high risk for DM and require movement to case management.

Behavioral Health Care Management including Case Management

Missouri Medicaid Outpatient Follow-up - Jul 08 - Jun 09
Claims as of 09/09

Follow-up Type	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09	Apr-09	May-09	Jun-09
7 Day Follow-ups			1	3	1		3	2	1	1		1
30 Day Follow-ups	2	5	3	3	2	4	3	4	4	10	4	

The Care Management team focused on improving the HEDIS 7 and 30 Day Follow-Up Post Hospitalization for Mental Illness rate. The strategy included continued focus on discharge planning and ensuring members have appropriate follow-up scheduled prior to discharge. An effort was made to increase utilization of the Hospital-to-Home program. The Senior Clinical Coordinator reached out to the hospital and member via telephone to offer the program. Through the time period of July 2008 – June 2009, 68 members were authorized the service. The final 2009 HEDIS 7-Day rate was 24.7% (18 of 73). Through the month of June 2009, the preliminary 2010 HEDIS 7-Day rate was 39.6% (19 of 48). This is an increase of 60.3%. The final 2009 HEDIS 30-Day rate was 39.7% (29 of 73). Through the month of June 2009, the preliminary 2010 HEDIS 30-Day rate was 58.3%. This represents an increase of 46.9%. Recommendations: Continue efforts to increase the follow-up rates by educating the providers, conduct site-visits to facilities, and establish a collaborative relationship with providers to ensure members get the services needed.

Access and Availability

An Access and availability audit was conducted by the quality improvement department second quarter 2009 to assess HBH network compliance with member access standards. A random sample of 173 Providers was generated using a statistically valid sample size calculator which gave a Confidence Level of 95% and a Confidence Interval of 5% for the Missouri Access & Availability Audit. The results of those providers who responded were as follows:

	Question	Met standard	Total Applicable Providers Contacted	% Compliance
1.	First available appointment for a member discharging from the hospital.	44	98	44.9%
2.	First available MD appointment for a member who has run out of medication and needs to be seen urgently.	2	13	15.4%
3.	First available appointment for a member who is decompensating and needs to be seen right away.	88	97	90.7%
4.	First available appointment for individual therapy.	82	98	83.7%

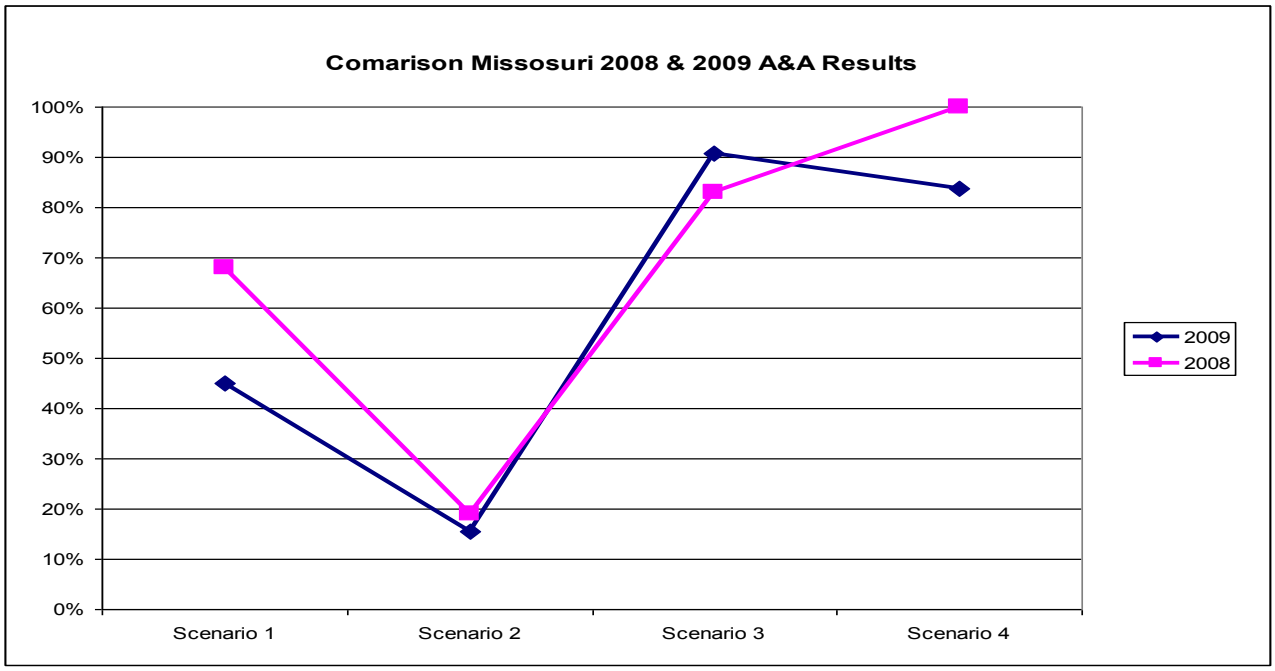
Barriers:
Significant opportunity for improvement exists in the hospital follow-up and urgent appointment categories. It should be noted that the auditor did not ask for the office manager, but for the person who schedules appointments. The individuals who answered the questions were the individuals HBH members speak with when they call for appointments. The name of the individual who answered the scenarios was included on each result report and the mailing address was verified.

In addition, there were a large number of non-responders which indicates a need for education of HBH provider office staff. The reasons for non-response included:

Number of Providers	Non-Response Explanation
70	Did not answer telephone, voicemail message left, or letter sent requesting response
5	Did not offer Outpatient Mental Health Services

Provider Relations was notified of issues encountered during the audit such as telephone numbers and/or addresses requiring updating as they occurred.

The graph below compares the percentage of compliance scores of 2008 and 2009.



While the 2008 scores were significantly higher in every scenario except the emergent need category, the sample for 2008 was a convenience sample while the sample for 2009 was a true random sample. In 2008 if the call was not answered, the auditor moved on to the next name on the list.

In 2009, at least three attempts were made for each provider and voicemails were left. After the third attempt at contact, a letter was sent requesting the provider office call the auditor to respond to the survey.

Corrective action plans were requested from providers who did not meet standards detailing plans to ensure compliance with access standards in the future.

Recommendations: Conduct a follow-up survey of providers who did not meet requirements will in the 4th quarter of 2009. If providers are still not meeting standards conduct one-on one discussions with providers to determine root cause and potential interventions.

Clinical Practice Guidelines

To meet this requirement Harmony provided a listing of their clinical practice guidelines and clinical coverage guidelines.

Credentialing and Re-Credentialing

The Credentialing and Peer Review Committee is the Missouri principal physician committee that reviews and makes recommendations on credentialing, re-credentialing, and peer review activity. Policy & Procedures are brought to the committee annually for review and approval. For the period July 2008 – June 2009 the Missouri Credentialing and Peer Review Committee met

ten times. The Committee was chaired by the Medical Director and membership included the Director of Credentialing or designee, and two participating practitioners. The Credentialing Committee reports to the Quality Improvement Committee. The Quality Improvement Committee reports to the Board of Directors.

Scope and Methodology
During the period of July 2008 – June 2009 Corporate Credentialing provided credentialing services to Harmony Health Plan of Illinois, Inc., - Missouri for the Medicare and Medicaid lines of business. Credentialing services included initial credentialing, re-credentialing, delegation of credentialing and oversight, disciplinary action monitoring, maintenance/compliance of credentialing documentation and full administrative support for the Credentialing and Peer Review Committee functions, agendas, reports, minutes, etc. Thirty Five credentialing policies and procedures were maintained current to incorporate state contract, regulatory and/or accreditation requirements. File processing volume, productivity and turn-around-times were measured monthly.

Policies and Procedures
Annual review and approval of Credentialing Policies and Procedures occurred at the February 2009 meeting of the Credentialing Committee. Thirty five policies and procedures were reviewed and approved.

Initial Credentialing
During the period of July 2008 – June 2009 the target service level turn-around-time for new application processing was set at 93% of files to be completed within 23 business days. (Industry standard is 100% within 180 calendar days). Monitoring was performed on a monthly basis.
In the period of July 2008 – June 2009 214 new applicants were presented to Credentialing Committee on behalf of Harmony Health Plan of Illinois, Inc. – Missouri.

Jul_08	Aug	Sep	Oct	Nov	Dec	Jan_09	Feb	Mar	Apr	May	Jun	Total
0	63	28	14	17	19	6	12	8	22	0	25	214

Results – Eighty four percent (84%) or 180 files were processed within 23 business days, and sixteen percent (16%) 34 exceeded the 23-day processing timeframe however all files were completed within 180 days. A total of four files did not meet ~~–c~~lean" file criteria and were presented for in depth peer review. Internal quality review of credentialing files and database indicated 98% accuracy, with 2% minor keying errors identified such as transposed letters in street names or numbers in addresses.
Re-credentialing
Re-credentialing of the Missouri network was not due in 2008. The re-credentialing process for Missouri began in 2009. A total of 146 re-credentialing applications were presented to Credentialing Committee.

Jul_08	Aug	Sep	Oct	Nov	Dec	Jan_09	Feb	Mar	Apr	May	June	Total
0	0	0	0	0	0	1	36	31	16	0	62	146

Results
Total of 146 applications were presented to the Credentialing Committee. All re-applicants were re-credentialed for a three-year period. Re-credentialing timeliness monitoring indicates re-credentialing is at 100%

Credentialing Delegation Oversight
In the July 2008 – June 2009 time period Credentialing performed delegation oversight audits relative to eight credentialing delegations; (2) IPA's/ PHO's and six (6) ancillary services providers (Vision, Dental, Hearing, Transportation and Pharmacy).

Results
Due to four audits done in July 2008 and annual audit done in June 2009 one month early, a total of twelve audits were performed in the July 2008 – June 2009 period. A total of six Corrective Action Plans (CAP) were issued. Two of which were completed and four are expected to be completed in last quarter of 2009.

Peer Review – Peer Review consisted of items:

1. Submitted by the Quality Improvement Department.
2. Files that exceeded "clean file" criteria/thresholds for both initial and re-credentialing which required committee review.

Results - In the period of July 2008 – June 2009 no providers were submitted by the Quality Improvement Department for Peer Review related to potential Quality of Care or Conduct issues. Four files were submitted for peer review. All four files presented were new applicants. All four providers were recommended for approval.

Licensure and Sanction Monitoring
Licensure Sanctions and Medicare and Medicaid Sanction monitoring is performed at the time of initial credentialing, at re-credentialing and ongoing on a monthly basis between credentialing cycles.

Results - In the July 2008 – June 2009 period the Credentialing Committee reviewed five (5) licensure issues of practitioners. The issues identified did not result in loss of license. All five (5) reviewed by the Committee were new applicants; zero (0) were reviewed by Committee as part of the re-credentialing process; zero (0) were reviewed by Committee as part of the ongoing monitoring of the State licensure disciplinary actions listings; and zero (0) participating practitioners were identified as having Medicaid or Medicare sanctions. After careful consideration the Credentialing Committee recommended participation for the five referenced practitioners.
Seven (7) practitioners were subject to immediate termination due to failing to renew licenses.

Analysis

- New application processing in Missouri decreased from 454 in the July 2007 through June 2008 period down to 214 in the July 2008 through June 2009 period;
- The volume of re-credentialing files processed increased from 0 in July 2007 through June 2008 up to 146 in the July 2008 through June 2009 period;
- Sanction monitoring revealed no network providers were reviewed for licensure actions and no network providers had Medicaid or Medicare sanctions;
- Seven Missouri provider was subject to termination due to failure to re-license.
- Delegation oversight volume was at twelve for the period of July 2008 – June 2009

Plans for 2009

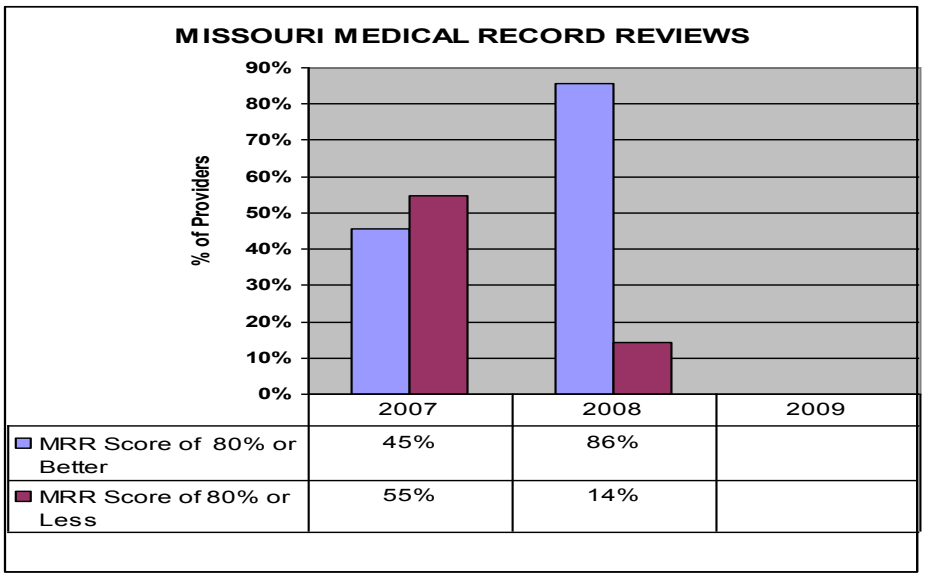
- Continue to provide monthly state specific service level statistics with a target of 93% of new applications processed in 23 business days;
- Ensure compliance with the 3-year re-credentialing cycle;
- Ongoing review, revision and approval of credentialing policies and procedures;
- Continue to support the Credentialing Committee and Peer Review processes.

Medical Record Review

When reviewing medical record for content, an average score of 80 percent or greater is considered to meet documentation standards. Physicians who score 80 percent or greater are reviewed every two years. A corrective action plan will be supplied to physicians who scores less than 80 percent. A re-audit will be conducted within 90 days of notification of the medical record review score and receipt of the corrective action plan. If after 90 days there are not enough records for a valid sample then the re-audit will be conducted six months from the receipt of the corrective action plan. In the event the physician scores less than 80 percent on the re-audit additional disciplinary action will be considered by the Medical Advisory Committee.

When reviewing medical records for quality, the results are compared to previous year's results and the current year's goal to identify the level of performance as well as identify areas of improvement.

As of November 2008 there were two hundred and thirty two PCPs within the Harmony Health Plan of Missouri provider network. Of those two hundred and thirty two PCPS forty five providers were identified as having fifty or more members. Of those forty five providers nine had a review in 2007 and passed with a score of 80 percent or greater so they would not be due for a review until CY2009. A medical record review was performed on seven providers during December 2008. Of those seven PCPs six had a passing score of 80 percent or greater. Eleven PCPs did not qualify for a medical record documentation review as they have not been with Harmony for a full year.



In 2008 six providers or 86 percent passed with a score of 80 percent of greater. The one provider who scored less than 80 percent was placed on a corrective action plan.

For CY2009 the medical record review for documentation compliance will occur in the 4th quarter. In order to obtain more accuracy the Corporate Quality Improvement Department will obtain the list of providers who met the criteria for the record review.

Barriers:

- Not all providers were captured who met the criteria for a medical record documentation review.
- In the past the provider only received one score for the overall review instead of scoring each area (content, continuity of care, pediatric preventive screening (EPSDT) and adult preventive screening) separately.

Recommendations: The Corporate Quality Improvement Department will run the report to identify all providers who meet the criteria for the review. Medical record reviews will be scheduled during the 4th quarter for CY2009. Starting in CY2010 the medical record reviews will be scheduled and completed during the 3rd and 4th quarter. In CY2009 providers will be given a score for each separate area (content, continuity of care, pediatric preventive screening (EPSDT) and adult preventive screening).

Two quality of care issues were identified from July 1, 2008 through June 30, 2009. One case was categorized as post operative infection or wound infection. It was closed as a Level 0 (No impact on the quality, performance or functionality of the patient). The other case is categorized as a readmission within 30 days. Harmony is awaiting medical records for review. Neither case involved the same doctor, clinic or hospital.

Barriers: Not all quality of care issues were identified due to the low number of quality of care issues.

Recommendations: The Quality of Care issues process was revised to increase Harmony‘s identification rate for quality of care issues. There is now a Quality of Care Task Force committee that meets monthly to review the how the process is working and to indentify any areas of deficiency. The Quality of Care Issues Report will be presented at the Medical Advisory/Peer Review Committee and Quality Improvement Committee meetings starting in the 4th quarter of 2009.

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a tool used by HHPI to measure performance on important dimensions of care and service. A hybrid review is completed annually on administrative data and medical records to determine the degree of compliance members have with certain preventative health screenings and the effectiveness of care. The hybrid method requires our organization to look for compliance in both administrative and medical record data and the overall HEDIS® result is reported as a combination of both. The medical records chosen for review consist of a systemic sample of members drawn from the eligible population. The information reported in this section HEDIS® compliance rates depicts only that which was obtained through the review and over read of the medical records.

Effectiveness of Care: Prevention

Medical records reviewed to determine effectiveness of care for prevention and screening measures that are measured by hybrid method include Cervical Cancer Screen, Childhood Immunization Status and Lead Screening in Children.

- Cervical Cancer Screening. Four hundred and eleven records were reviewed to determine if members had received a Papanicolaou test (PAP) during 2008 or 2009. There were 21 records found to have documentation of this screening service resulting in a medical record review compliance rate of 5.11%
- Childhood Immunization Status (CIS). Two hundred and thirty eight records were reviewed to determine if members received appropriate immunizations during 2008. Due to the various types of immunizations, the results are listed in Table 2.
- Lead Screening in Children. Two hundred and thirty eight records were reviewed to determine if members received at least one lead screenings prior to their second birthday during 2008. There were five records found to have documentation of this screening service resulting in a medical record review compliance rate of 2.10%

Table 2 Childhood Immunization Status Medical Record Review Results

HEDIS® Measure	Number of Medical Records Reviewed	Number of records with Documentation of Immunizations Administration	Percent Medical Record Compliance
CIS: DTP[1]	238	46	19.33%
CIS: IPV [2]	238	48	20.17%
CIS: MMR[3]	238	29	12.18%
CIS: Hib[4]	238	34	14.29%
CIS: HEP[5]	238	47	19.75%
CIS: VZV	238	30	12.61%
CIS: Pneumococcal Conjugate:	238	56	23.53%
CIS: Combo 2[6]	238	51	21.43%
CIS: Combo 3[7]	238	53	22.27%

Effectiveness of Care Cardiovascular Conditions

Controlling High Blood Pressure is the only HEDIS® measure in the category Effectiveness of Care Cardiovascular Conditions that is measured by the hybrid rate. During 2008 there were thirty-two records reviewed to determine if a members blood pressure was adequately controlled (<140/90). There were sixteen records found to have documentation of adequate control of blood pressure resulting in a medical record review compliance rate of 53.33%.

Access-Availability of Care

Prenatal and Post partum Care

[1] DTP (Diphtheria, Tetanus, Whooping cough)
[2] IPV (Polio)
[3] MMR (Measles, Mumps, Rubella)
[4] Hib (Hepatitis B)
[5] VZV (Chicken Pox)
[6] Combo 2: four DTaP/DT(diphtheria, tetanus, acellular pertussis or diphtheria, tetanus) three IPV, one MMR, two Hib, 3 HEP and one VZV
[7] Combo 3: four DTaP/DT, three IPV, one MMR, 2 Hib, two HEP, one VAV and four pneumococcal conjugate.

The frequency of prenatal and post partum care are the HEDIS® measures in the category Access-Availability of Care that are measured by the hybrid rate. During 2008 there were 411 records reviewed to determine the percentage of deliveries that received prenatal care in the 1st trimester (or within 42 days of enrollment in the organization). There were 190 medical records found to have documentation of first trimester prenatal care resulting in a medical record review compliance rate of 46.23%. There were 411 records reviewed to determine the percentage of deliveries that had a post partum visit between 21 and 56 days after delivery. There were 84 medical records found to have documentation of post partum care resulting in a medical record review compliance rate of 20.44%.

Use of Services

Medical records reviewed to determine use of services by hybrid method include Frequency of Ongoing Prenatal Care, Well Child Visits in the first 15 months, Well child visits 3-6 years old and Adolescent Well Care Visits.

- Frequency of Ongoing Prenatal Care. Four hundred and eleven records were reviewed to determine the number of deliveries that had the expected number of prenatal visits.
    - <21%: Sixty one or 14.84% records were found to have less than 21% of the expected number of prenatal visits.
    - 21-40%: Eleven records were found to have 21-40% of the expected number of prenatal visits resulting in a medical record review compliance rate of 5.35%.
    - 41-60%: Seventeen records were found to have 41-60% of the expected number of prenatal visits resulting in a medical record review compliance rate of 4.14%.
    - 61-80%: Twenty nine records were found to have 61-80% of the expected prenatal visits resulting in a medical record review compliance rate of 7.06%.
    - 81+%: Eighty seven records were found to have 81% or more of the expected prenatal visits resulting in a medical record review compliance rate of 21.17%.
- Well Child Visits in the First 15 Months. Four hundred and eleven records were reviewed to determine the number of Well Child Visits that were completed in the first 15 months of life.
    - Zero Visits: Twenty-six records were found to have zero visits resulting in a medical record review compliance rate of 0.00%
    - One Visit: Eleven records were found to have one visit resulting in a medical record review compliance rate of 0.00 %
    - Two Visits: Thirty-one records were found to have two visits resulting in a medical record review compliance rate of 0.26%.
    - Three Visits: Forty-two records were found to have three visits resulting in a medical record compliance rate of 1.82%
    - Four Visits: Sixty-five records were found to have four visits resulting in a medical record review compliance rate of 6.25%.
    - Five Visits: Eighty-six records were found to have five visits resulting in a medical record review compliance rate of 2.60%.
    - Six Visits: One hundred and twenty-four records were found to have six visits resulting in a medical record review compliance rate of 11.46%.
- Well Child Visits 3 to 6 Years Old. Four hundred and eleven records were reviewed to determine if members received an annual visit during 2008. Eleven records were found

to have documentation of at least one visits resulting in a medical record review compliance rate of 2.68%.

- Adolescent WellCare Visits. Four hundred and eleven records were reviewed to determine if members received an annual visit during 2008. Of those 411 records eighteen or 4.38% had a medical record review that resulted in at least one compliant visit.

*Barriers***:** Providers still lack knowledge of what documentation is required in the medical record for measures associated with:

- Cervical Cancer Screening
- Childhood Immunization
- Lead Screening in Children
- Controlling High Blood Pressure
- Prenatal and Post partum Care
- Frequency of Ongoing Prenatal Care
- Well Child Visits in the First 15 Months
- Well Child Visits 3 to 6 Years Old
- Adolescent WellCare Visits

Recommendations: Will need to continue education of providers on accurate documentation standards. Will develop and distribute a tool to providers that describes each hybrid HEDIS measure, the documentation required for each measure as well as the CPT and ICD-9 codes for billing each service. This new tool will be given to providers starting in the 4th quarter in 2009 and then with each quarterly non-compliant member list thereafter.

Subcontractor Monitoring

A. *Overview of Subcontractor:*

a. Bridgeport Dental Services, LLC
b. Contract Effective Date January 1, 2007

B. Description of Delegated Services/ products/activities:

a. Dental Vendor for Medicaid
b. Delegated Services
    i. Utilization Management
    ii. Claims Credentialing
    iii. Network Development
    iv. Provider Appeals
    v. Customer Service
c. Annual Utilization Management audit performed 5/7/09 and scored 100%.
d. Annual Claims audit performed 5/7/09 and scored 100%.
e. Annual Credentialing audit performed 5/7/09 and scored 98%. Entity was placed on a Corrective Action Plan.
f. Annual Network Development audit performed 5/7/09 and scored 100%.
g. Annual Member/Provider Appeals audit performed 5/6/09 and scored 100%.

h. Annual Customer Service (Member and Provider) audit performed 5/7/09 and scored 100%

C. Description of Delegation Oversight Process:

a. Delegation Oversight coordinates and oversees all delegated activities ensuring that delegated agencies adhere to contractual, regulatory, and accreditation requirements. The Delegation Oversight Committee ensures compliance with regulatory, contractual, and accreditation standards by maintaining appropriate policies and procedures; monitoring potential delegation activities; completing pre-delegation audits; executing delegation implementation; completing annual delegation audits; monitoring agencies on corrective action; monitoring vendor reporting and data submission.

b. Delegation Oversight reports to the Quality Improvement Committee. The Senior Director, Corporate Quality Improvement served as the Delegation Manager and chaired the Delegation Oversight Committee meetings. In 2008, the Delegation Oversight Committee was comprised of representatives from Appeals & Grievance, Credentialing, Finance, Information Technology, Inpatient Services, Outpatient Services, Provider Relations, Quality Improvement, Customer Services, Behavioral Health and Medicaid Regulatory Affairs.

D. Oversight Outcomes/Findings:

1. Access/availability
    a. Annual Network Development audit performed 5/7/09 and scored 100%.
    b. Vendor ensures that its network of practitioners is sufficient in numbers and types of practitioners
    c. In creating and maintaining its delivery system of practitioners, the Vendor takes into consideration assessed special and cultural needs and preferences
    d. Vendor establishes standards for the number and geographic distribution of subcontracted providers, measure its performance against these standards, identifies opportunities for improvement and implements interventions to improve its performance
2. Fraud and abuse
    a. The Company maintains reference materials related to the prevention, detection, investigation, and reporting of fraud and abuse on file in the SIU. These materials may be made available to facilities, groups, individual providers, members, and employees through FWA education and training seminars and periodic publications
3. Grievances and appeals
    a. Annual Member/Provider Appeals audit performed 5/6/09 and scored 100%

b. Agency handles Appeals for Member and Provider. Agency is not delegated for Grievances. Directions to contact HHP are in letter to member and in Provider's handbook.
c. Communications, including content, procedure, and timeframe, consistent with the Plan
d. Appropriate language on authorization notices for Appeal rights
e. Appropriate language on remittance advice for Appeal rights
f. Appeal letters consistent with the Plan

4. Performance projects and HEDIS measures
5. Encounter data
    a. Agency has a policy in place to submit Encounter Data on a monthly basis to the Plan which adheres to each state's HIPAA Companion Guidelines
6. Prior authorization denials
    a. Annual Utilization Management audit performed 5/7/09 and scored 100%
    b. Appropriate procedures addressing timeliness of denial notices, and the availability of an appropriate practitioner to discuss any UM denial decision; entity uses plan approved notice template
    c. Timeframes consistent with the delegated requirement
    d. Communications, including content, procedure, and timeframe, consistent with Medicaid per state guidelines
    e. Authorization notices, notification letters, denial letters, content meets appropriate reading level
    f. Written process for member referral to the CMO/HMO for appeals
    g. Evidence of the required turnaround times for service authorizations are met
7. Timely payment
    a. Annual Claims audit performed 5/7/09 and scored 100%
    b. Agency has policies in place to ensure providers submit claims in accordance with all applicable contracts and state laws relating to timely submission
    c. Agency has policies in place to ensure compliance with all applicable contracts and state and federal laws relating to the handling of claims within the Prompt Payment regulatory rules for state.

E. Work plan for next year:

Recommendations/Focus for 2010

- Educate agency on fraud, waste and abuse awareness
- Maintain appropriate policies and procedures
- Monitor potential delegation activities
- Complete pre-delegation audits
- Execute delegation implementation
- Complete annual delegation audits
- Monitor agencies on corrective action
- Monitor vendor reporting and data submission

A. <u>Overview of Subcontractor:</u>

a. CareNet/PCN
b. Contract Effective Date December 16, 2006

B. Description of Delegated Services/ products/activities:

a. Customer Service Vendor for Medicaid
b. Delegated Services
   i. Customer Service
   ii. 24 Hour Nurse Call Line/Medicaid Product/Delegated Customer Service Function

C. Description of Delegation Oversight Process:

a. Delegation Oversight coordinates and oversees all delegated activities ensuring that delegated agencies adhere to contractual, regulatory, and accreditation requirements. The Delegation Oversight Committee ensures compliance with regulatory, contractual, and accreditation standards by maintaining appropriate policies and procedures; monitoring potential delegation activities; completing pre-delegation audits; executing delegation implementation; completing annual delegation audits; monitoring agencies on corrective action; monitoring vendor reporting and data submission.

b. Delegation Oversight reports to the Quality Improvement Committee. The Senior Director, Corporate Quality Improvement served as the Delegation Manager and chaired the Delegation Oversight Committee meetings. In 2008, the Delegation Oversight Committee was comprised of representatives from Appeals & Grievance, Credentialing, Finance, Information Technology, Inpatient Services, Outpatient Services, Provider Relations, Quality Improvement, Customer Services, Behavioral Health and Medicaid Regulatory Affairs.

D. Oversight Outcomes/Findings:

1. Access/availability
   a. Annual Customer Service (Member) audit performed 11/11/08 and scored 100%
   b. Maintains written policies and procedures that have specific guidelines for documenting inbound/outbound calls into system including the date, nature of inquiry, and outcome
   c. Maintains written policies and procedures that address the use of state approved scripts/appropriate when responding to member and provider inquiries as well as guidelines for effective call handling.
   d. Maintains written policies and procedures that have specific guidelines for documenting inbound/outbound calls into system including the date, nature of inquiry, and outcome

2. Fraud and abuse
    a. The Company maintains reference materials related to the prevention, detection, investigation, and reporting of fraud and abuse on file in the SIU. These materials may be made available to facilities, groups, individual providers, members, and employees through FWA education and training seminars and periodic publications

3. Grievances and appeals
    a. Maintains written procedures to assist WellCare in the timely investigation and resolution all member and provider grievances in accordance with state/federal and CMS standards based on the urgency of the situation
    b. Maintains written documentation guidelines for registering a member or providers grievance, inclusive of whether the grievance was received verbally or in writing, a short dated summary of the problem, the name of the grievant, and the date of the grievance

4. Performance projects and HEDIS measures
5. Encounter data
    a. Evaluates Customer Service-related reports and customer satisfaction surveys on a regular basis.
    b. Performs annual substantive evaluation of delegated activities in accordance with applicable accreditation standards
6. Prior authorization denials
    a. Patient and provider satisfaction survey on utilization management process
7. Timely payment

E. Work plan for next year:

Recommendations/Focus for 2010

- Educate agency on fraud, waste and abuse awareness
- Maintain appropriate policies and procedures
- Monitor potential delegation activities
- Complete pre-delegation audits
- Execute delegation implementation
- Complete annual delegation audits
- Monitor agencies on corrective action
- Monitor vendor reporting and data submission

A. <u>Overview of Subcontractor:</u>
    a. Harmony Behavioral Health
    b. Contract Effective Date June 1, 2006

B. <u>Description of Delegated Services/ products/activities:</u>

    a. Behavioral Health Vendor for Medicaid

b. Delegated Services
    i. Utilization Management
    ii. Network Development
    iii. Provider Appeals
    iv. Customer Service
    v. Quality Improvement

c. Annual Utilization Management audit performed 9/9/08 and scored 100%.
d. Annual Network Development audit performed 9/9/08 & 7/7/2009 and scored 100%
e. Annual Provider Appeals audit performed 9/9/08 and scored 100%.
f. Annual Customer Service (Member and Provider) audit performed 9/9/08 & 09/01/2009 and scored 100%
g. Annual Quality Improvement audit performed 9/23/08 & 09/18/2009 and scored 100%

C. Description of Delegation Oversight Process:

a. Delegation Oversight coordinates and oversees all delegated activities ensuring that delegated agencies adhere to contractual, regulatory, and accreditation requirements. The Delegation Oversight Committee ensures compliance with regulatory, contractual, and accreditation standards by maintaining appropriate policies and procedures; monitoring potential delegation activities; completing pre-delegation audits; executing delegation implementation; completing annual delegation audits; monitoring agencies on corrective action; monitoring vendor reporting and data submission.

b. Delegation Oversight reports to the Quality Improvement Committee. The Senior Director, Corporate Quality Improvement served as the Delegation Manager and chaired the Delegation Oversight Committee meetings. In 2008, the Delegation Oversight Committee was comprised of representatives from Appeals & Grievance, Credentialing, Finance, Information Technology, Inpatient Services, Outpatient Services, Provider Relations, Quality Improvement, Customer Services, Behavioral Health and Medicaid Regulatory Affairs.

D. Oversight Outcomes/Findings:

1. Access/availability
    a. Annual Network Development audit performed 9/9/08 & 7/7/2009 and scored 100%.
    b. Vendor ensures that its network of practitioners is sufficient in numbers and types of practitioners
    c. In creating and maintaining its delivery system of practitioners, the Vendor takes into consideration assessed special and cultural needs and preferences
    d. Vendor establishes standards for the number and geographic distribution of subcontracted providers, measure its performance against these

standards, identifies opportunities for improvement and implements interventions to improve its performance

2. Fraud and abuse
    a. The Company maintains reference materials related to the prevention, detection, investigation, and reporting of fraud and abuse on file in the SIU. These materials may be made available to facilities, groups, individual providers, members, and employees through FWA education and training seminars and periodic publications
3. Grievances and appeals
    a. Annual Provider Appeals audit performed 9/9/08 and scored 100%.
    b. Agency handles Appeals for Member and Provider. Agency is not delegated for Grievances. Directions to contact HHP are in letter to member and in Provider's handbook.
    c. Communications, including content, procedure, and timeframe, consistent with the Plan
    d. Appropriate language on authorization notices for Appeal rights
    e. Appropriate language on remittance advice for Appeal rights
    f. Appeal letters consistent with the Plan
4. Performance projects and HEDIS measures
5. Encounter data
    a. Agency has a policy in place to submit Encounter Data on a monthly basis to the Plan which adheres to each state's HIPAA Companion Guidelines
    b. Evaluates Customer Service-related reports and customer satisfaction surveys on a regular basis
6. Prior authorization denials
    a. Annual Utilization Management audit performed 9/9/08 and scored 100%.
    b. Appropriate procedures addressing timeliness of denial notices, and the availability of an appropriate practitioner to discuss any UM denial decision; entity uses plan approved notice template
    c. Timeframes consistent with the delegated requirement
    d. Communications, including content, procedure, and timeframe, consistent with Medicaid per state guidelines
    e. Authorization notices, notification letters, denial letters, content meets appropriate reading level
    f. Written process for member referral to the CMO/HMO for appeals
    g. Evidence of the required turnaround times for service authorizations are met
7. Timely payment
8. Customer Service
    a. Annual Customer Service (Member and Provider) audit performed 9/9/08 & 09/01/2009 and scored 100%
    b. Maintains written policies and procedures that have specific guidelines for documenting inbound/outbound calls into system including the date, nature of inquiry, and outcome

c. Maintains written policies and procedures that address the use of state approved scripts/appropriate when responding to member and provider inquiries as well as guidelines for effective call handling.
d. Maintains written policies and procedures that have specific guidelines for documenting inbound/outbound calls into system including the date, nature of inquiry, and outcome

9. Quality Improvement
    a. Annual Quality Improvement audit performed 9/23/08 & 09/18/2009 and scored 100%
    b. The organization assesses the cultural, ethnic, racial and linguistic needs of its members and adjusts the availability of practitioners within its network, if necessary
    c. The organization demonstrates (identifies) three clinical improvements, one of which is in the behavioral health arena
    d. The organization selects three measures to assess performance and identify clinical improvements that are relevant to and likely to have an impact on its membership.

E. Work plan for next year:

Recommendations/Focus for 2010

- Educate agency on fraud, waste and abuse awareness
- Maintain appropriate policies and procedures
- Monitor potential delegation activities
- Complete pre-delegation audits
- Execute delegation implementation
- Complete annual delegation audits
- Monitor agencies on corrective action
- Monitor vendor reporting and data submission

A. Overview of Subcontractor:
    a. HearX (Hear USA)
    b. Contract Effective Date January 1, 2008

B. Description of Delegated Services/ products/activities:

    a. Hearing Vendor for Medicaid
    b. Delegated Services
        i. Claims
        ii. Credentialing
        iii. Network Development

    c. Claims pre delegation audit performed 07/08/-07/09/2008 and score 100%. Annual Claims audit performed 6/23/09 and scored 99.85%.

d. Credentialing Pre delegation audit performed 07/08/-07/09/2008 and score 98%. Entity was placed on a CAP. CAP completed 11/02/09. Annual Credentialing audit performed 6/23/09 and scored 100%.

e. Network Development pre delegation audit performed 07/08/-07/09/2008 and score 86% - Entity was laced on a CAP. CAP completed 11/04/2009 Annual audit performed on 6/23/09 and scored 85% Entity was placed on a CAP. CAP completed 9/24/09

C. Description of Delegation Oversight Process:

a. Delegation Oversight coordinates and oversees all delegated activities ensuring that delegated agencies adhere to contractual, regulatory, and accreditation requirements. The Delegation Oversight Committee ensures compliance with regulatory, contractual, and accreditation standards by maintaining appropriate policies and procedures; monitoring potential delegation activities; completing pre-delegation audits; executing delegation implementation; completing annual delegation audits; monitoring agencies on corrective action; monitoring vendor reporting and data submission.

b. Delegation Oversight reports to the Quality Improvement Committee. The Senior Director, Corporate Quality Improvement served as the Delegation Manager and chaired the Delegation Oversight Committee meetings. In 2008, the Delegation Oversight Committee was comprised of representatives from Appeals & Grievance, Credentialing, Finance, Information Technology, Inpatient Services, Outpatient Services, Provider Relations, Quality Improvement, Customer Services, Behavioral Health and Medicaid Regulatory Affairs.

D. Oversight Outcomes/Findings:

1. Access/availability
    a. A pre delegation audit was conducted on 07/08/-07/09/2009- included a review of HearUsa‘s Network Development and score 86%. Entity was placed on a CAP. CAP completed 11/04/09
    b. Annual Network Development audit performed 6/23/09 and scored 85% Entity was placed on a CAP. CAP completed 9/24/09
    c. Vendor ensures that its network of practitioners is sufficient in numbers and types of practitioners
    d. In creating and maintaining its delivery system of practitioners, the Vendor takes into consideration assessed special and cultural needs and preferences
    e. Vendor establishes standards for the number and geographic distribution of subcontracted providers, measure its performance against these standards, identifies opportunities for improvement and implements interventions to improve its performance
2. Fraud and abuse

a. The Company maintains reference materials related to the prevention, detection, investigation, and reporting of fraud and abuse on file in the SIU. These materials may be made available to facilities, groups, individual providers, members, and employees through FWA education and training seminars and periodic publications

3. Grievances and appeals
4. Performance projects and HEDIS measures
5. Encounter data
   a. Agency has a policy in place to submit Encounter Data on a monthly basis to the Plan which adheres to each state's HIPAA Companion Guidelines
6. Prior authorization denials
7. Timely payment
   a. Claims pre delegation audit performed 07/08/-07/09/2008 and score 100%. Annual Claims audit performed 6/23/09 and scored 99.85%.
   b. Agency has policies in place to ensure providers submit claims in accordance with all applicable contracts and state laws relating to timely submission
   c. Agency has policies in place to ensure compliance with all applicable contracts and state and federal laws relating to the handling of claims within the Prompt Payment regulatory rules for state.
8. Credentialing
   a. Credentialing Pre delegation audit performed 07/08/-07/09/2008 and score 98%. Entity was placed on a CAP. CAP completed 11/02/09. Annual Credentialing audit performed 6/23/09 and scored 100%.
   b. During this audit the Credentialing program was assessed.
   c. The delegation audit included a review of HearUSA Credentialing Program including Policies, Procedures, Forms and File Review. During the audit there was one deficiency found related to Credentialing.

E. Work plan for next year:

Recommendations/Focus for 2010

- Educate agency on fraud, waste and abuse awareness
- Maintain appropriate policies and procedures
- Monitor potential delegation activities
- Complete pre-delegation audits
- Execute delegation implementation
- Complete annual delegation audits
- Monitor agencies on corrective action
- Monitor vendor reporting and data submission
-

A. <u>Overview of Subcontractor:</u>
   a. Medical Transportation Management (MTM)
   b. Contract Effective Date July 1, 2007

B. Description of Delegated Services/ products/activities:

a. Transportation Vendor for Medicaid
b. Delegated Services
    i. Utilization Management
    ii. Claims
    iii. Credentialing
    iv. Network Development
    v. Customer Service
c. Annual Utilization Management audit for Medicaid performed 5/6/2009 and scored 100%.
d. Annual Claims audit for Medicaid performed 5/6/09 and scored 98%. Entity placed on a CAP.
e. Annual Credentialing audit for Medicaid performed on 5/6/09 and scored 100%.
f. Annual Network Development audit for Medicaid performed 5/6/09 and scored 100%.
g. Annual Customer Service audit for Medicaid performed 5/6/09 and scored 100%.

C. Description of Delegation Oversight Process:

a. Delegation Oversight coordinates and oversees all delegated activities ensuring that delegated agencies adhere to contractual, regulatory, and accreditation requirements. The Delegation Oversight Committee ensures compliance with regulatory, contractual, and accreditation standards by maintaining appropriate policies and procedures; monitoring potential delegation activities; completing pre-delegation audits; executing delegation implementation; completing annual delegation audits; monitoring agencies on corrective action; monitoring vendor reporting and data submission.

b. Delegation Oversight reports to the Quality Improvement Committee. The Senior Director, Corporate Quality Improvement served as the Delegation Manager and chaired the Delegation Oversight Committee meetings. In 2008, the Delegation Oversight Committee was comprised of representatives from Appeals & Grievance, Credentialing, Finance, Information Technology, Inpatient Services, Outpatient Services, Provider Relations, Quality Improvement, Customer Services, Behavioral Health and Medicaid Regulatory Affairs.

D. Oversight Outcomes/Findings:

1. Access/availability
    a. Annual Network Development audit performed 5/6/09 and scored 100%.
    b. Vendor ensures that its network of practitioners is sufficient in numbers and types of practitioners
    c. In creating and maintaining its delivery system of practitioners, the Vendor takes into consideration assessed special and cultural needs and preferences

d. Vendor establishes standards for the number and geographic distribution of subcontracted providers, measure its performance against these standards, identifies opportunities for improvement and implements interventions to improve its performance

2. Fraud and abuse
    a. The Company maintains reference materials related to the prevention, detection, investigation, and reporting of fraud and abuse on file in the SIU. These materials may be made available to facilities, groups, individual providers, members, and employees through FWA education and training seminars and periodic publications
3. Grievances and appeals
4. Performance projects and HEDIS measures
5. Encounter data
    a. Agency has a policy in place to submit Encounter Data on a monthly basis to the Plan which adheres to each state's HIPAA Companion Guidelines
6. Prior authorization denials
    a. Annual Utilization Management audit performed 5/6/09 and scored 100%
    b. Appropriate procedures addressing timeliness of denial notices, and the availability of an appropriate practitioner to discuss any UM denial decision Timely payment
7. Timely Payment
    a. Annual Claims audit performed 5/6/09 and scored 98%
    b. Agency has policies in place to ensure providers submit claims in accordance with all applicable contracts and state laws relating to timely submission
    c. Agency has policies in place to ensure compliance with all applicable contracts and state and federal laws relating to the handling of claims within the Prompt Payment regulatory rules for state.

E. Work plan for next year:

Recommendations/Focus for 2010

- Educate agency on fraud, waste and abuse awareness
- Maintain appropriate policies and procedures
- Monitor potential delegation activities
- Complete pre-delegation audits
- Execute delegation implementation
- Complete annual delegation audits
- Monitor agencies on corrective action
- Monitor vendor reporting and data submission

A. Overview of Subcontractor:
    a. Results - Dallas
    b. Contract Effective Date February 1, 2006

B. Description of Delegated Services/ products/activities:

a. Call Center Vendor for Medicaid
b. Delegated Services
    i. Member and Provider Pharmacy 1.75 calls.

C. Description of Delegation Oversight Process:

a. Delegation Oversight coordinates and oversees all delegated activities ensuring that delegated agencies adhere to contractual, regulatory, and accreditation requirements. The Delegation Oversight Committee ensures compliance with regulatory, contractual, and accreditation standards by maintaining appropriate policies and procedures; monitoring potential delegation activities; completing pre-delegation audits; executing delegation implementation; completing annual delegation audits; monitoring agencies on corrective action; monitoring vendor reporting and data submission.

b. Delegation Oversight reports to the Quality Improvement Committee. The Senior Director, Corporate Quality Improvement served as the Delegation Manager and chaired the Delegation Oversight Committee meetings. In 2008, the Delegation Oversight Committee was comprised of representatives from Appeals & Grievance, Credentialing, Finance, Information Technology, Inpatient Services, Outpatient Services, Provider Relations, Quality Improvement, Customer Services, Behavioral Health and Medicaid Regulatory Affairs.

D. Oversight Outcomes/Findings:

1. Access/availability
    a. Annual Customer Service audit performed 4/7//09 and scored 100%.
    b. Maintains written policies and procedures that have specific guidelines for documenting inbound/outbound calls into system including the date, nature of inquiry, and outcome
    c. Maintains written policies and procedures that address the use of state approved scripts/appropriate when responding to member and provider inquiries as well as guidelines for effective call handling.
    d. Maintains written policies and procedures that have specific guidelines for documenting inbound/outbound calls into system including the date, nature of inquiry, and outcome

2. Fraud and abuse
    a. The Company maintains reference materials related to the prevention, detection, investigation, and reporting of fraud and abuse on file in the SIU. These materials may be made available to facilities, groups, individual providers, members, and employees through FWA education and training seminars and periodic publications

3. Grievances and appeals
    a. Maintains written procedures to assist WellCare in the timely investigation and resolution all member and provider grievances in accordance with state/federal and CMS standards based on the urgency of the situation
    b. Maintains written documentation guidelines for registering a member or providers grievance, inclusive of whether the grievance was received verbally or in writing, a short dated summary of the problem, the name of the grievant, and the date of the grievance

4. Performance projects and HEDIS measures
5. Encounter data
    a. Evaluates Customer Service-related reports and customer satisfaction surveys on a regular basis.
    b. Performs annual substantive evaluation of delegated activities in accordance with applicable accreditation standards
6. Utilization Management
    a. Annual Utilization Management audit performed 6/11/09 and scored 95.65%. Entity placed on a CAP.
7. Timely payment
    a. Entity is not delegated Claims, Credentialing, Network Development, Appeals

E. Work plan for next year:

Recommendations/Focus for 2010

- Educate agency on fraud, waste and abuse awareness
- Maintain appropriate policies and procedures
- Monitor potential delegation activities
- Complete pre-delegation audits
- Execute delegation implementation
- Complete annual delegation audits
- Monitor agencies on corrective action
- Monitor vendor reporting and data submission

A. Overview of Subcontractor:
    a. Results - Lebanon
    b. Contract Effective Date February 1, 2006

B. <u>Description of Delegated Services/ products/activities:</u>

    a. Customer Service Vendor for Medicaid
    b. Delegated Services
        i. Customer Service Member and Provider calls
        ii. Utilization Management – Outpatient

C. Description of Delegation Oversight Process:

a. Delegation Oversight coordinates and oversees all delegated activities ensuring that delegated agencies adhere to contractual, regulatory, and accreditation requirements. The Delegation Oversight Committee ensures compliance with regulatory, contractual, and accreditation standards by maintaining appropriate policies and procedures; monitoring potential delegation activities; completing pre-delegation audits; executing delegation implementation; completing annual delegation audits; monitoring agencies on corrective action; monitoring vendor reporting and data submission.

b. Delegation Oversight reports to the Quality Improvement Committee. The Senior Director, Corporate Quality Improvement served as the Delegation Manager and chaired the Delegation Oversight Committee meetings. In 2008, the Delegation Oversight Committee was comprised of representatives from Appeals & Grievance, Credentialing, Finance, Information Technology, Inpatient Services, Outpatient Services, Provider Relations, Quality Improvement, Customer Services, Behavioral Health and Medicaid Regulatory Affairs.

D. Oversight Outcomes/Findings:

1. Access/availability
    a. Annual Customer Service audit performed 4/9/09 and scored 100%.
    b. Maintains written policies and procedures that have specific guidelines for documenting inbound/outbound calls into system including the date, nature of inquiry, and outcome
    c. Maintains written policies and procedures that address the use of state approved scripts/appropriate when responding to member and provider inquiries as well as guidelines for effective call handling.
    d. Maintains written policies and procedures that have specific guidelines for documenting inbound/outbound calls into system including the date, nature of inquiry, and outcome

2. Fraud and abuse
    a. The Company maintains reference materials related to the prevention, detection, investigation, and reporting of fraud and abuse on file in the SIU. These materials may be made available to facilities, groups, individual providers, members, and employees through FWA education and training seminars and periodic publications

3. Grievances and appeals
    a. Maintains written procedures to assist WellCare in the timely investigation and resolution all member and provider grievances in accordance with state/federal and CMS standards based on the urgency of the situation
    b. Maintains written documentation guidelines for registering a member or providers grievance, inclusive of whether the grievance was received

verbally or in writing, a short dated summary of the problem, the name of the grievant, and the date of the grievance

4. Performance projects and HEDIS measures
5. Encounter data
    a. Evaluates Customer Service-related reports and customer satisfaction surveys on a regular basis.
    b. Performs annual substantive evaluation of delegated activities in accordance with applicable accreditation standards
6. Utilization Management
    a. Annual Utilization Management audit performed 6/11/09 and scored 95.65%. Entity placed on a CAP.
7. Timely payment

a. Entity is not delegated Claims, Credentialing, Network Development, Appeals

E. Work plan for next year:

Recommendations/Focus for 2010

- Educate agency on fraud, waste and abuse awareness
- Maintain appropriate policies and procedures
- Monitor potential delegation activities
- Complete pre-delegation audits
- Execute delegation implementation
- Complete annual delegation audits
- Monitor agencies on corrective action
- Monitor vendor reporting and data submission

A. Overview of Subcontractor:
    a. Teleperformance - Augusta
    b. Contract Effective Date July 30, 2007

B. Description of Delegated Services/ products/activities:

    a. Customer Service Vendor for Medicaid
    b. Delegated Services
        i. Customer Service

C. Description of Delegation Oversight Process:

    a. Delegation Oversight coordinates and oversees all delegated activities ensuring that delegated agencies adhere to contractual, regulatory, and accreditation requirements. The Delegation Oversight Committee ensures compliance with regulatory, contractual, and accreditation standards by maintaining appropriate policies and procedures; monitoring potential delegation activities; completing pre-delegation audits; executing delegation implementation; completing annual

delegation audits; monitoring agencies on corrective action; monitoring vendor reporting and data submission.

b. Delegation Oversight reports to the Quality Improvement Committee. The Senior Director, Corporate Quality Improvement served as the Delegation Manager and chaired the Delegation Oversight Committee meetings. In 2008, the Delegation Oversight Committee was comprised of representatives from Appeals & Grievance, Credentialing, Finance, Information Technology, Inpatient Services, Outpatient Services, Provider Relations, Quality Improvement, Customer Services, Behavioral Health and Medicaid Regulatory Affairs.

D. Oversight Outcomes/Findings:

1. Access/availability
    a. Customer Service (Member and Provider) audit performed 6/23/09 and scored 100%.
    b. Maintains written policies and procedures that have specific guidelines for documenting inbound/outbound calls into system including the date, nature of inquiry, and outcome
    c. Maintains written policies and procedures that address the use of state approved scripts/appropriate when responding to member and provider inquiries as well as guidelines for effective call handling.
    d. Maintains written policies and procedures that have specific guidelines for documenting inbound/outbound calls into system including the date, nature of inquiry, and outcome

2. Fraud and abuse
    a. The Company maintains reference materials related to the prevention, detection, investigation, and reporting of fraud and abuse on file in the SIU. These materials may be made available to facilities, groups, individual providers, members, and employees through FWA education and training seminars and periodic publications

3. Grievances and appeals
    a. Maintains written procedures to assist WellCare in the timely investigation and resolution all member and provider grievances in accordance with state/federal and CMS standards based on the urgency of the situation
    b. Maintains written documentation guidelines for registering a member or providers grievance, inclusive of whether the grievance was received verbally or in writing, a short dated summary of the problem, the name of the grievant, and the date of the grievance

4. Performance projects and HEDIS measures
5. Encounter data

a. Evaluates Customer Service-related reports and customer satisfaction surveys on a regular basis.
b. Performs annual substantive evaluation of delegated activities in accordance with applicable accreditation standards

6. Prior authorization denials
7. Timely payment

E. Work plan for next year:

Recommendations/Focus for 2010

- Educate agency on fraud, waste and abuse awareness
- Maintain appropriate policies and procedures
- Monitor potential delegation activities
- Complete pre-delegation audits
- Execute delegation implementation
- Complete annual delegation audits
- Monitor agencies on corrective action
- Monitor vendor reporting and data submission

A. Overview of Subcontractor:
   a. Walgreens Health Initiatives
   b. Contract Effective Date March 1, 2004

B. <u>Description of Delegated Services/ products/activities:</u>
   a. Pharmacy Processor for Medicaid
   b. Delegated Services
      i. Claims
      ii. Credentialing
      iii. Network Development
   c. Annual Claims audit performed 6/3/09 and scored 96%. Placed on a 30 day CAP. CAP Completed July 14, 2009
   d. Annual Credentialing audit performed on 6/18/09 and scored 92%. Placed on a 90 day CAP
   e. Annual Network Development audit completed on 6/2/09 and scored 96% Placed on a 90 day CAP. CAP completed 10/17/09

C. <u>Description of Delegation Oversight Process:</u>
   a. Delegation Oversight coordinates and oversees all delegated activities ensuring that delegated agencies adhere to contractual, regulatory, and accreditation requirements. The Delegation Oversight Committee ensures compliance with regulatory, contractual, and accreditation standards by maintaining appropriate policies and procedures; monitoring potential delegation activities; completing pre-delegation audits; executing delegation implementation; completing annual delegation audits; monitoring agencies on corrective action; monitoring vendor reporting and data submission.

b. Delegation Oversight reports to the Quality Improvement Committee. The Senior Director, Corporate Quality Improvement served as the Delegation Manager and chaired the Delegation Oversight Committee meetings. In 2008, the Delegation Oversight Committee was comprised of representatives from Appeals & Grievance, Credentialing, Finance, Information Technology, Inpatient Services, Outpatient Services, Provider Relations, Quality Improvement, Customer Services, Behavioral Health and Medicaid Regulatory Affairs.

D. Oversight Outcomes/Findings:

1. Access/availability
    a. Annual Network Development audit completed on 6/2/09 and scored 96% Placed on a 90 day CAP. CAP completed 10/17/09
    b. Vendor ensures that its network of practitioners is sufficient in numbers and types of practitioners
    c. In creating and maintaining its delivery system of practitioners, the Vendor takes into consideration assessed special and cultural needs and preferences
    d. Vendor establishes standards for the number and geographic distribution of subcontracted providers, measure its performance against these standards, identifies opportunities for improvement and implements interventions to improve its performance
2. Fraud and abuse
    a. The Company maintains reference materials related to the prevention, detection, investigation, and reporting of fraud and abuse on file in the SIU. These materials may be made available to facilities, groups, individual providers, members, and employees through FWA education and training seminars and periodic publications
3. Grievances and appeals
4. Performance projects and HEDIS measures
5. Encounter data
    a. Agency has a policy in place to submit Encounter Data on a monthly basis to the Plan which adheres to each state‘s HIPAA Companion Guidelines
6. Prior authorization denials
7. Timely Payment
    a. Annual Claims audit performed 6/3/09 and scored 96%. Placed on a 30 day CAP. CAP Completed July 14, 2009
    b. Agency has policies in place to ensure providers submit claims in accordance with all applicable contracts and state laws relating to timely submission
    c. Agency has policies in place to ensure compliance with all applicable contracts and state and federal laws relating to the handling of claims within the Prompt Payment regulatory rules for state.
8. Annual Credentialing audit performed on 6/18/09 and scored 92%. Placed on a 90 day CAP

E. Work plan for next year:

Recommendations/Focus for 2010

- Educate agency on fraud, waste and abuse awareness
- Maintain appropriate policies and procedures
- Monitor potential delegation activities
- Complete pre-delegation audits
- Execute delegation implementation
- Complete annual delegation audits
- Monitor agencies on corrective action
- Monitor vendor reporting and data submission

HealthCare USA

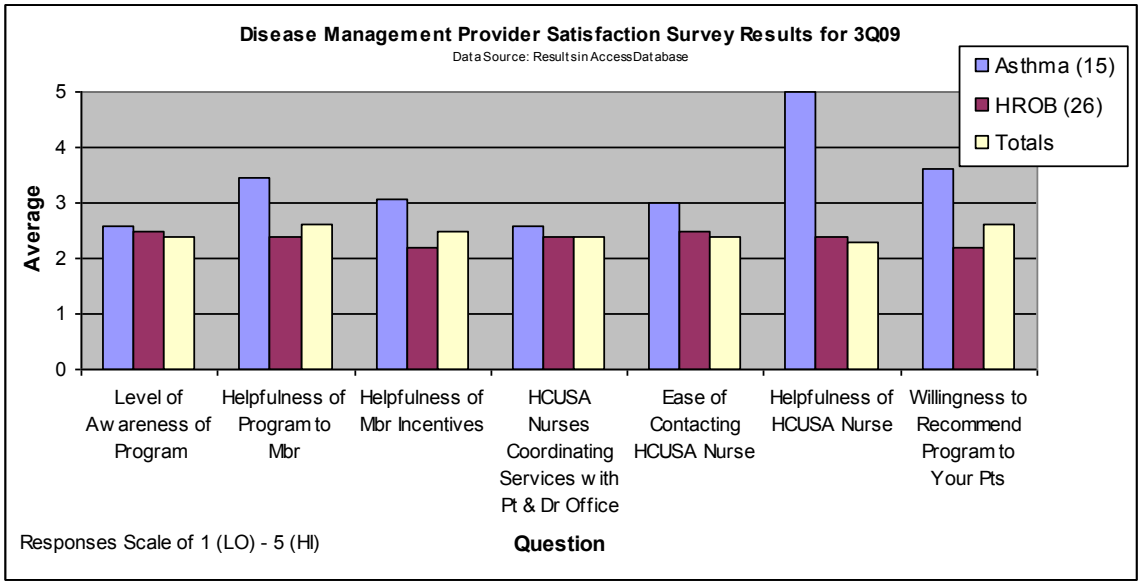
Provider Satisfaction

Prior to 2009, DSS Research was contracted to complete an assessment of provider satisfaction with the Customer Service Organization (CSO). In 2009, the process changed to an internal survey process completed by Coventry for HealthCare USA. The goals of the provider assessment remain the same:

- Measure overall provider satisfaction with the CSO
- Identify reasons for calling the CSO
- Determine overall provider satisfaction with the length of time needed to provide information and resolve issues.
- Examine provider satisfaction with specific elements of customer service

The survey is in process, and results will not be available until after this annual evaluation is completed.

HealthCare USA also monitors provider satisfaction with specific programs, such as disease management. In 2008 provider satisfaction surveys for disease management programs were distributed to providers who made a referral to the programs. Of the few surveys returned, it was clear the providers were not aware of the scope of the programs. Starting in early 2009, the disease management nurses went to high volume provider offices and presented the programs. At the same time, member education materials were expanded to be more comprehensive, more user friendly for the functionally illiterate and to reduce the reading level to the fourth grade, which is the most stringent requirement nation-wide for government programs. The surveys were delivered by Provider Relations Representatives to all high volume provider offices regardless of whether they ever referred a member or not to the Beary Important Breath Asthma Disease Management program or the Beary Important Bundle High Risk OB Disease Management program. Results to date include less than a 5 percent return rate. Surveys were mailed to all providers that were not able to be identified as having returned a survey.



The Asthma Disease Management program was the first program implemented. The results of the program surveys are above. Each question has a 1 to 5 rating scale with 1 being the lowest score and 5 being the highest/best score possible. Results: providers would recommend the program to others, with an average score of 4 out of 5 points possible. Opportunities for improvement were identified in provider's awareness of the program provider's perception of how helpful the program is for their patients, RN coordination of care and services, helpfulness, and the ease of contacting the disease management nurses. These scores may also be lower as a result of provider's lack of awareness of the program as an available resource.

Currently the nurses contact providers/office staff to alert them that their patient has been enrolled in the disease management program. A letter has been developed and recently implemented to includes contact information and program details. The initial letter is sent on enrollment for each member. Routine updates and updates with any changes in status of the member are also communicated to the provider office.

Case Management

Special Needs

MO HealthNet identifies the majority of our members with special health care needs. These currently include children in State custody and those receiving an adoption subsidy, children who qualify through Title V, members who have made an application for SSI and members who have been identified as having mental retardation or developmental delay.

HealthCare USA also identifies members by other sources including, but not limited to the following:

- The member's physician
- Claims data
- Preauthorization nurses
- Concurrent review nurses
- Children requiring hospitalization at Ranken Jordan, a pediatric specialty hospital

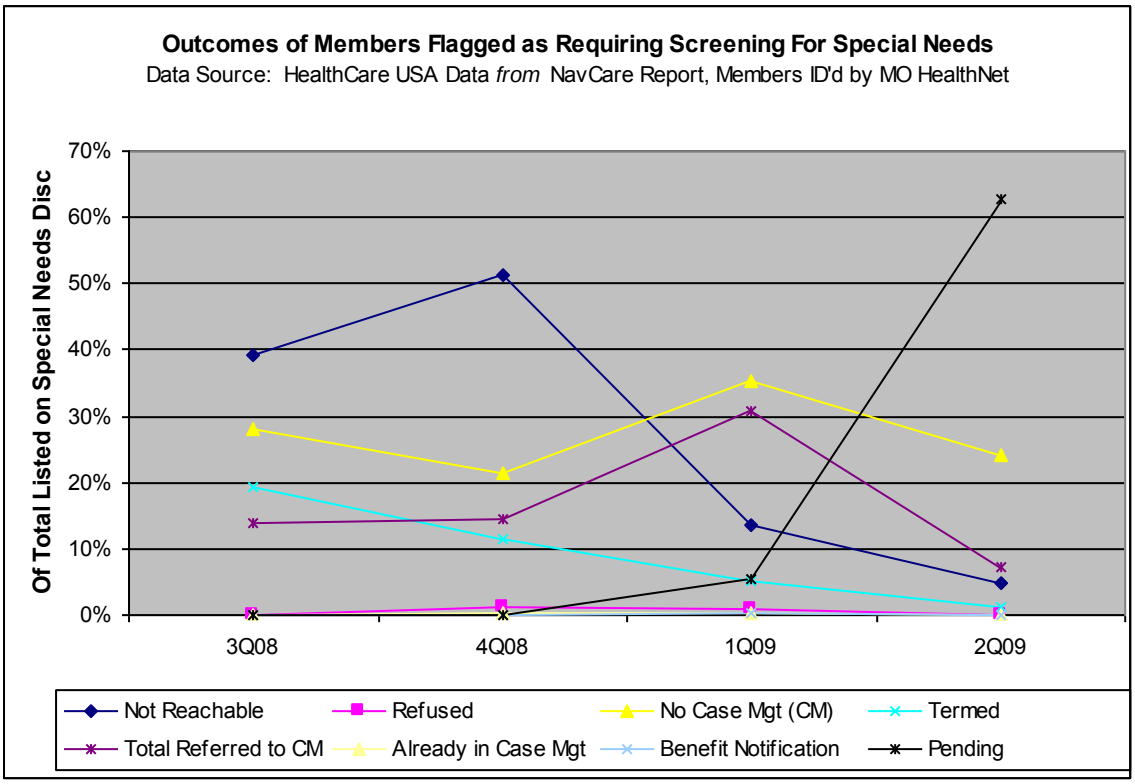
Recognizing that each child and family is unique and deserving of focused attention, our special needs program has evolved into a family-centered, culturally-sensitive approach that is individualized for the child and his/her parents and/or guardians.

Goals

- Facilitate coordination of health care benefits and community resources among members identified as having special health care needs.
- Improve quality of life and well-being.
- Improve adherence to care plan objectives.
- Increase coordination between medical and behavioral health

Through the fall of 2009, the special needs department was comprised of two Licensed Practical Nurses responsible for screening those members identified as having special needs by the State of Missouri, Division of Medical Services during initial enrollment. The special needs coordinators educate the members about their benefits, provide community resources to the member as appropriate and refer them to case management or disease management as appropriate.

In the fall of 2009, the special needs screening and assessment process was changed. The process is now managed by the HealthCare USA social worker, who is an MSW, LCSW. Every member is sent a health risk assessment through SynCare. Follow up to help assure completion of the assessment is also completed by SynCare with both phone and mail follow up and research using a variety of tools and resources. If any needs for case or disease management are identified, the appropriate referrals are made. If any behavioral health needs are identified a referral is made to MHNet. The HealthCare USA social worker follows up on any social needs identified.



Historically, HealthCare USA's special needs department has been successful in contacting, assessing and educating approximately 4,600 members per year of the identified members, despite inaccurate telephone numbers and addresses. In 2009, we started tracking the census by month and to begin to look at the interventions and measure the impact interventions have on outcomes such as hospital readmissions and adherence to preventive care. The top three reasons members are referred to the special needs programs are behavioral health, asthma, and general and complex pediatric health issues.

At least three attempts are made to contact the member and complete the assessment for care management needs. In spite of attempts by phone, mail and through various possible sources, a large number of assessment attempts are unable to be reached. There is usually a larger number that are already enrolled in case management as compared to the number that are not enrolled at the time the special needs disc is received from the state. This number also fluctuates with the number of existing versus new members who are included on any one disc. What appears to be a significant increase in the census in the second quarter of 2009 is really a reflection of an unanticipated, temporary decrease in staffing. As a result of the decrease in staffing, discharges from special needs census were not completed in the computer and census duplications were not able to be removed.

Anywhere from 10 to 30% of members identified as having a special need are referred to case management. Of those referred, the highest percent is referred to case management with MHNet

In 2009, the process for tracking case management changed to reflect the requirements by the State of Missouri, represented in the two charts below. Special needs represents the largest

number of members identified. However, this number includes those who are already enrolled in case and/or disease management and/or behavioral health programs. Members enrolled in lead case management continues to have the highest census followed by members in OB case management and obstetrics follow.

CHART 1 of 2:

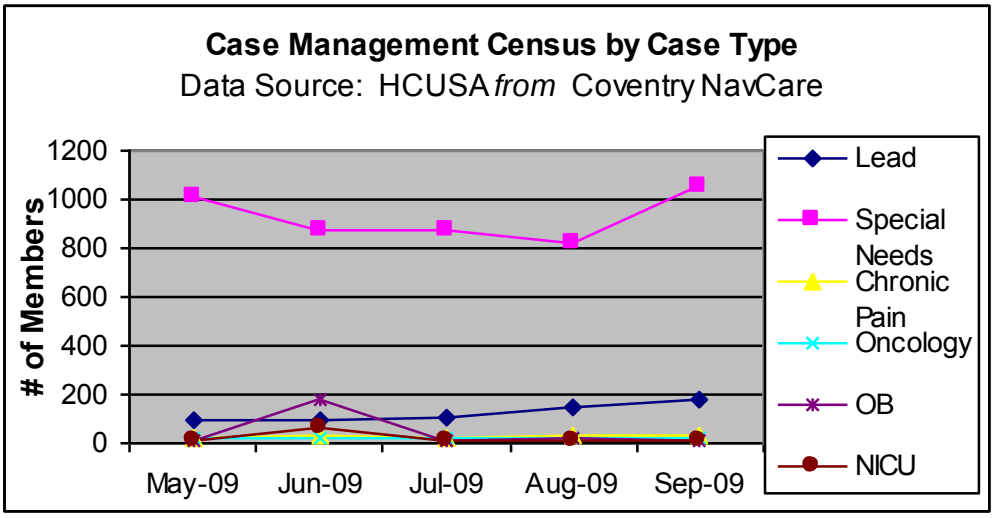
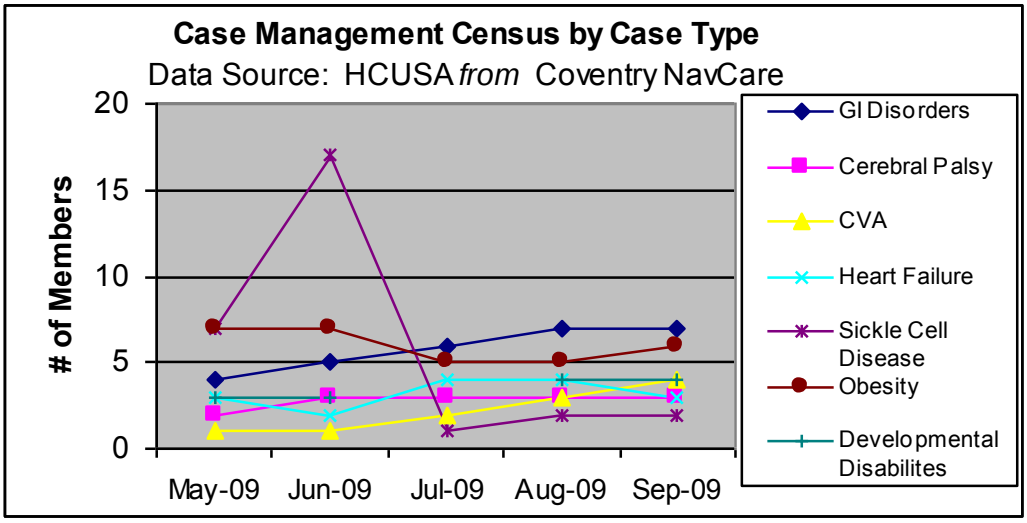


CHART 2 of 2



There was an increase in members identified with sickle cell disease and an overlap of those with asthma and sickle cell disease who are followed by St. Louis Children's Hospital (SLCH) Sickle Cell Disease Clinic (SCD). Members that have both and are followed by SLCLH are referred to a special program being developed in collaboration with SLCH and HealthCare USA disease management.

Preauthorization

One of the most important elements in managed health care is the presence of a process for medical management. The authorization system is a key element in the process for medical

management. There are multiple facets to an effective authorization system. Preauthorization is defined as the review strategy that helps determine appropriate utilization before care is delivered, as compared to concurrent review, which is the review strategy to determine appropriateness as care and services are being delivered. The process also includes obtaining demographic and clinical information from the requesting provider and entering the information into the database. The distinct advantage of preauthorization is that it allows intervention prior to the delivery of patient care and services.

The preauthorization department is supervised by a Missouri licensed Registered Nurse and is comprised of eight (8) Missouri licensed nurses who are responsible for performing medical necessity review as compared to InterQual® criteria or Coventry technical specifications for new medical technology and new uses of existing medical technology for services requested that require preauthorization. Each case is also reviewed to determine if complex case management or disease management intervention is appropriate.

There are nine primary goals of the preauthorization process that include:

1. Member eligibility is verified and benefit coverage is determined.
2. Provider eligibility is verified and verification that services are provided by an appropriate contracted provider.
3. Authorized services are medically necessary and provided at the most appropriate level. Preauthorization coordinators utilize InterQual® standardized criteria, clinical judgment and the Medical Director to assure that all authorized services are medically necessary and appropriate. If a case reviewed by preauthorization staff does not meet InterQual criteria, it is referred to a Medical Director for review.
4. Concurrent review is notified that a member has been admitted as an inpatient. The concurrent review nurse will begin reviewing the member‘s medical record to assure each inpatient day is medically necessary and appropriate for an inpatient level of care as compared to InterQual criteria. Cases not meeting InterQual criteria for level of service and intensity are referred to a Medical Director for review.
5. Cases are identified for which a complex case management or disease management evaluation is appropriate. The preauthorization coordinator can assist in assuring that members with complex and ongoing medical needs are appropriately referred for evaluation of needs for more intense medical management.
6. Discharge planning is begun as soon as possible when preauthorizing elective inpatient admissions. This is the ideal time to identify the discharge plan, anticipated barriers to timely discharge, and any projected services required upon discharge (home care, durable medical equipment, skilled nursing care).
7. The care takes place in the most appropriate setting. A request for inpatient services may be diverted to an ambulatory care setting, or a case may be diverted from a nonparticipating provider to a participating one.
8. Data is captured for financial accruals and utilization reporting. By identifying the number and nature of hospital cases, as well as potential catastrophic cases, the Plan can more accurately predict expenses rather than waiting for claims to come in. This allows management to take action early and to avoid financial surprises. It is also the time to identify those members who have (or can be expected to) incur high-dollar costs. For reinsurance purposes, the costs must be tracked and reported to insure appropriate

reimbursement.
9. Quality of care issues are identified and reported appropriately.

In support of the preauthorization department, two non-clinical personnel fill the roles of preauthorization representatives. The preauthorization Representatives support the preauthorization staff by taking on tasks that do not involve clinical expertise or knowledge. They work under the supervision of the pre-authorization team leader and manager of the department. These staff do not conduct any UM review or activities that require interpretation of clinical information.

The Preauthorization Representatives serve as support for the Health Services Department by faxing information and assisting in department mailings to providers and members. They enter data into the referral system that consists of:

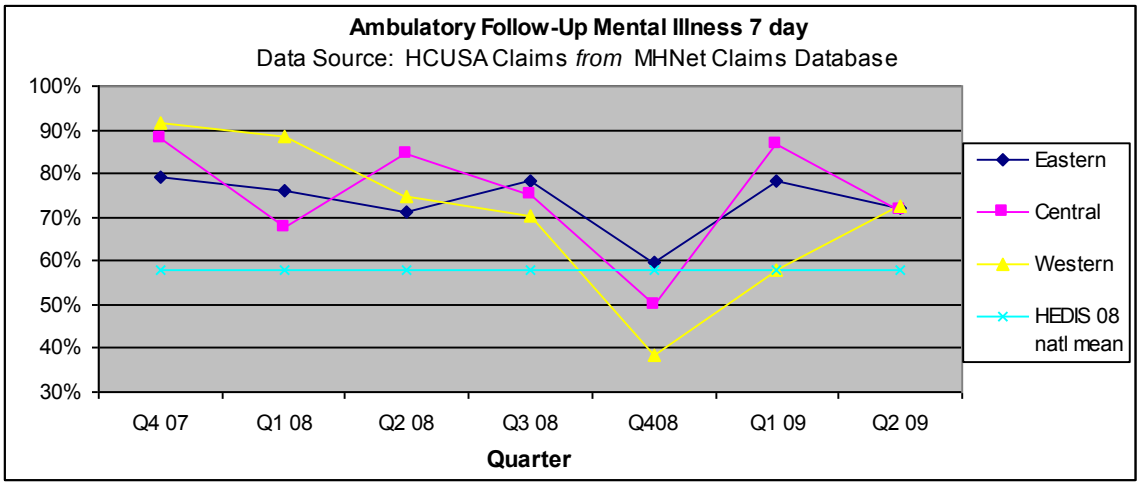
- Demographic information for large hospital groups.
- Newborn authorizations, which consists of statistical data, such as birth weight
- Home health authorization for the mom and baby.
- Global referrals to cover the member prenatal care, as well as home health authorization for selected vendors.

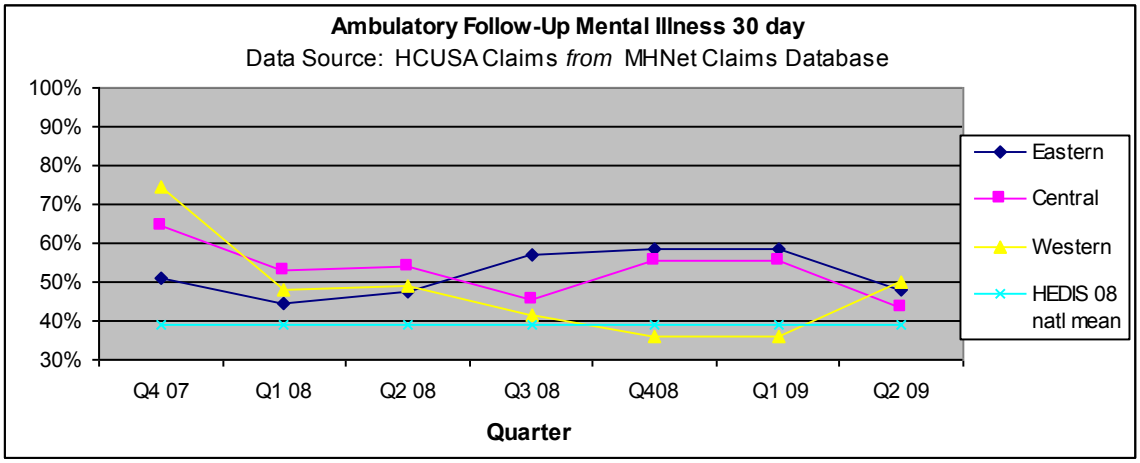
Mental Health

MHNet and Healthcare USA have procedures in place for coordinating care for members with co-morbid conditions. MHNet contacts Healthcare USA complex case managers or disease managers when a member is receiving psychiatric services and is pregnant or has complex medical issues that without proper coordination could result in a negative outcome. MHNet and HealthCare USA have worked to formalize this process over the past year. MHNet currently forwards a census of members on the acute unit for behavioral health treatment to HealthCare USA on a daily basis, noting any applicable co-occurring medical diagnoses. HealthCare USA then evaluates based on member diagnosis for inclusion into the respective case management or disease management programs. Healthcare USA also communicates to MHNet if a members receiving medical treatment is identified as having behavioral health needs.

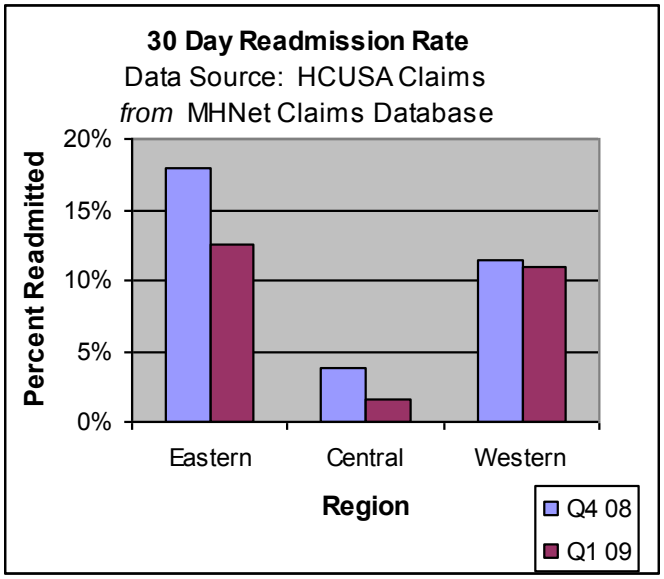
Co-location of one key person for daily on-going coordination between behavioral health issues managed by MHNet, HealthCare USA‘s social worker, and other HealthCare USA health services staff has continued throughout FY 2009.

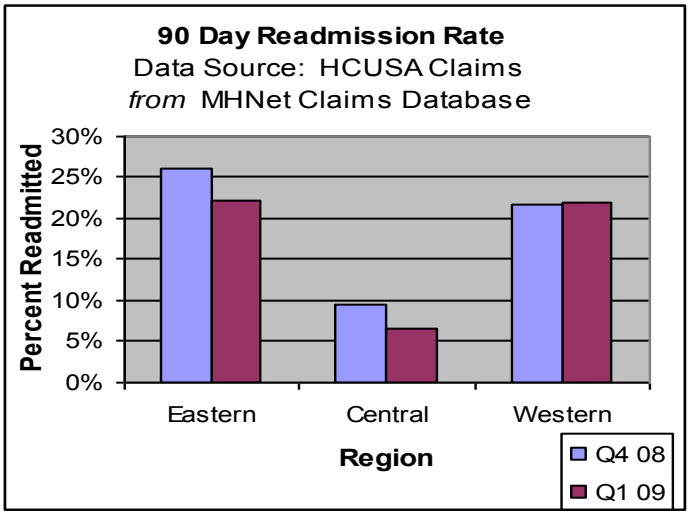
MHNet continued the performance improvement project focused on increasing adherence to follow up visits by 7 days and 30 days post hospital discharge.





Ambulatory follow-up rates for both the 7 day and 30 day timeframe increased in the second quarter of 2009 in the Western region. The current rates exceed the national HEDIS 2008 Medicaid mean across all regions, with the 30 day rates within 2 percentage points of the 75th percentile performance objective (based on NCQA national 75 percentile threshold).





The data for readmissions within 30 and 90 days during the first quarter of 2009 indicates a reduction in readmissions in both timeframes in all regions except the 90 day readmissions in the Western Region, which increased slightly, but not a statistically significant amount. The reduction in readmissions may be a positive reflection on changes such as co-locating and interventions established to improve adherence to ambulatory follow-up. Additional detail about MHNet is included in the Subcontractor Annual Evaluation Report.

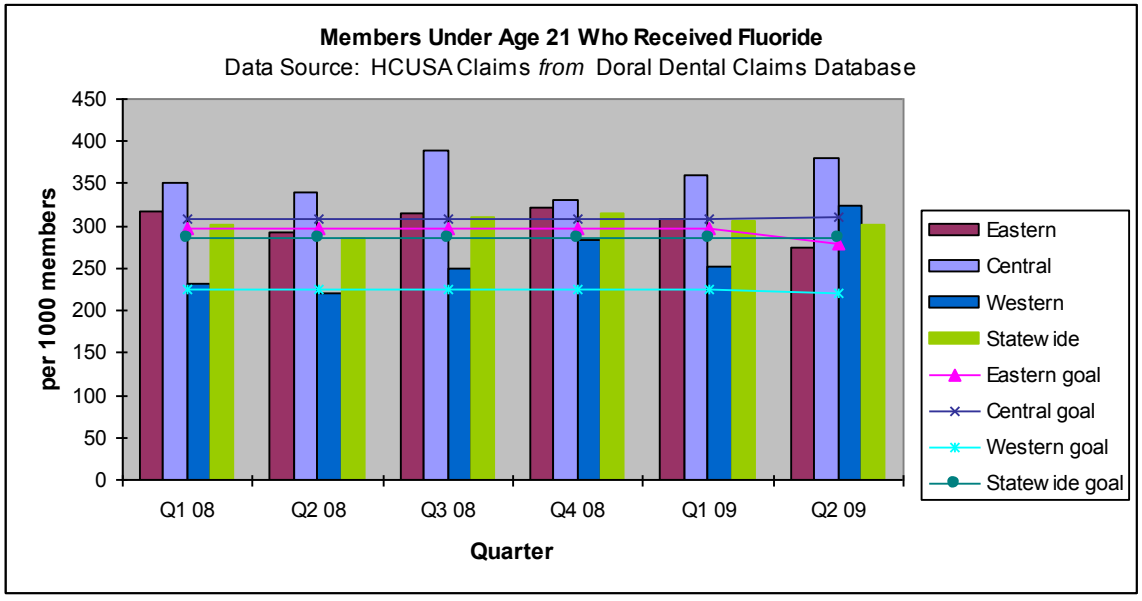
HealthCare USA's social worker continues to work with case management and disease management populations in our health plan to focus on the reducing life stressors of children, adults and their caregivers, to assess high-risk patients and families, support caregivers, provide financial counseling, advocate within the medical system, resolve social and environmental issues, connect families to resource networks, and intervene when anxiety and depression are present.

Dental

HealthCare USA and Doral partnered on numerous activities and community events in FY 2009:

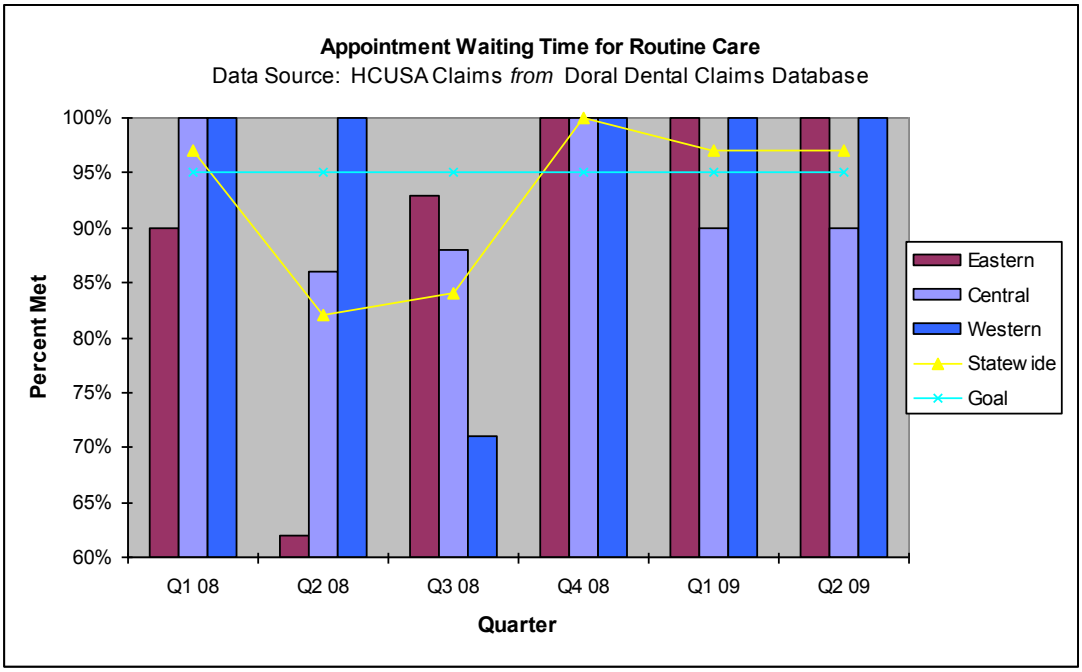
- HealthCare USA sponsored back-to-school health fairs, in which Doral provided dental hygienists that performed dental screenings on more than 1,500 children. Doral also provided toothbrushes, toothpaste, dental hygiene literature and stickers for distribution at the fairs.
- At back-to-school fairs in the Eastern and Western regions HealthCare USA and Doral partnered with Reach Out HealthCare America to provide on-site dental examinations, x-rays and sealants.
- Participation in over 20 additional fairs and outreach events throughout the state of Missouri.
- Participation in the following oral health organizations: Missouri Coalition for Oral Health, Jackson County Oral Health Coalition, Jefferson County Coalition for Oral Health, and Missouri Association of Health Plans (MAHP) member.
- Member Placement Program to assist in securing dental appointments for HealthCare USA members.
- Collaborated on articles for the HealthCare USA member and provider newsletters, informing members and providers of the dental benefits and encouraging members to seek preventative dental care.
- Participated in Peer to Peer Educational Baby Showers to provide education about the importance of dental health and relationship to pre-term labor and delivery and the need to have the baby‘s first dental check up when the first tooth begins to emerge or by no later than one year of age.

Doral continues to participate in QMC meetings and to provide updates on access to dental services and outcomes of interventions to increase the number of children who receive dental care, including fluoride treatments.



The number of fluoride treatments completed in the Eastern region declined in the first and second quarters of 2009 as compared to the prior year while the numbers increased in both the Central and Western regions and overall the number completed across all three regions increased. Additional analysis of the data and drill down may identify something unique in the Eastern region. There was no significant change in access to providers or other environmental changes that explain the decrease. In the Eastern region, access to an appointment during the time that fluoride treatments decreased was well above the other regions where there was an increase in the number who received fluoride treatments.

Additional detail about Doral is included in the Subcontractor Annual Evaluation Report.



Case Management

Case management is a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet an individual's health needs using communications and available resources to promote quality, cost-effective outcomes – Commission for Case Manager Certification (CCMC).

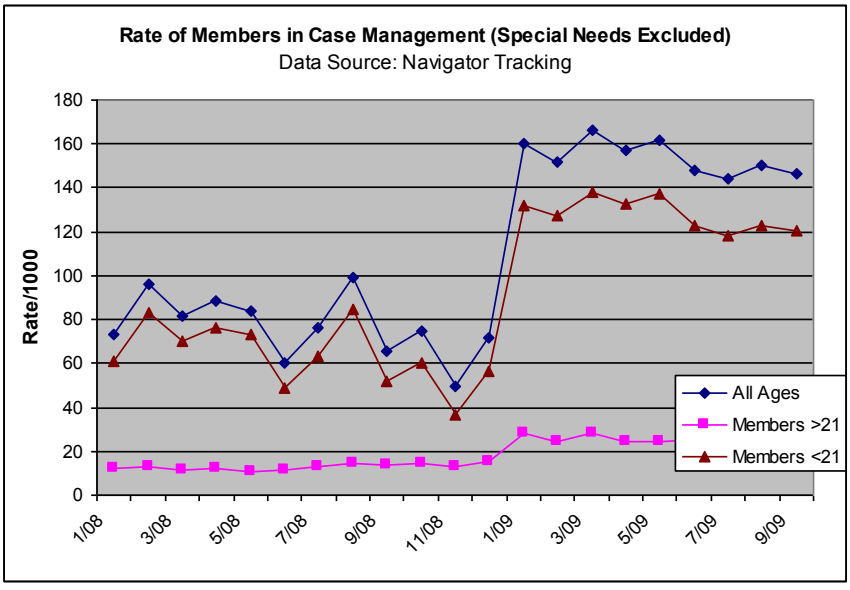
The goal of complex case management is to eliminate barriers to care and services and encourage appropriate use of health care services on a case-by-case basis.

In FY 2009, the case management program continued to be an integral part of HealthCare USA's individualized, member-centered approach to meet our members' medical and psychosocial needs. The case managers are Missouri licensed nurses who serve as member advocates. HealthCare USA has nurse case managers who have appropriate clinical experience and an understanding of the health needs of Missouri's MO HealthNet Managed Care population in all three regions. They coordinate services provided through the health care delivery system and community-based organizations to achieve optimal member outcomes.

HealthCare USA strongly support the concept that quality of care cannot be compromised for the sake of cost reduction. HealthCare USA has both an ethical and legal responsibility for clinical excellence. Our case management program is designed to assure cost-effective, high-quality care and services.

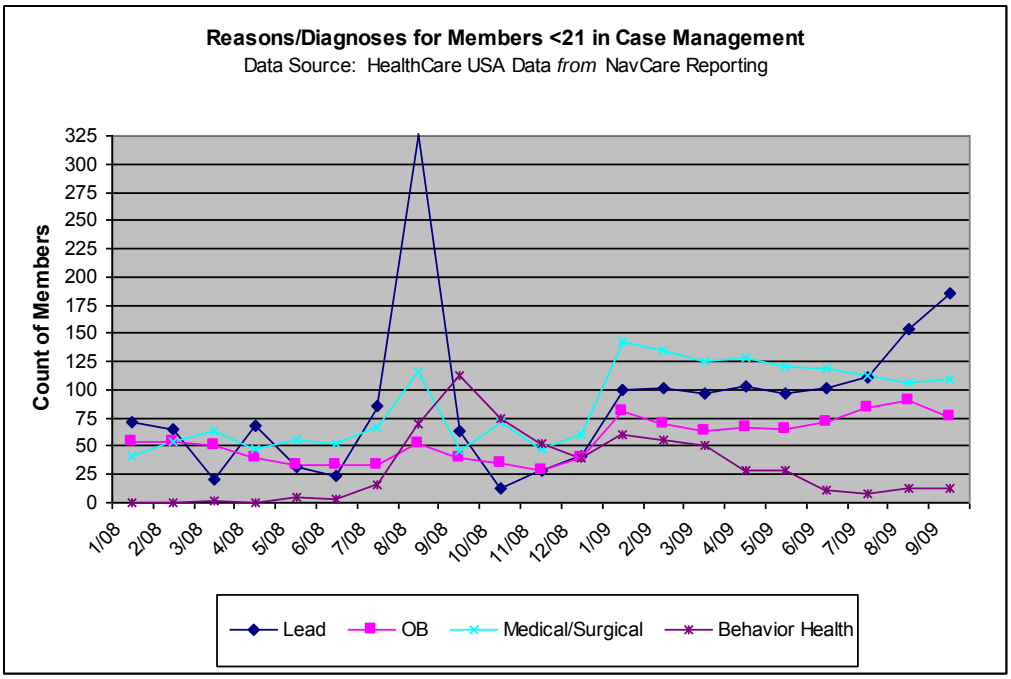
All interventions listed below continue to play an active role in the case management program.

- Identification of members. HealthCare USA uses multiple sources to identify members. Methods include:
  - Self-referrals
  - New member calls
  - Health risk assessments
  - Member surveys
  - In-patient concurrent review
  - Providers
  - HealthCare USA's staff and member advocates.
  - Claims and utilization data analysis to detect trigger diagnoses such as cancer drugs, hospital readmission with in thirty (30) days or less, multiple hospital admissions for same diagnosis, chronic conditions and authorizations for high dollar DME.
- Implementation of a case management database to track and report data.
- Initial telephonic needs assessment that includes a broad range of questions to determine individual situations and risks. Areas assessed are physical and mental health, social and emotional status, capability for self-care, member goals and current treatment plans.
- Individualized treatment plan development based on assessment.
- Collaboration with the PCP to ensure plans of care support the medical plans.
- Consideration of needs for social, educational, therapeutic and other non-medical services such as WIC, Catholic Charities, Nurses for Newborns, counseling and the strengths and needs of the entire family.
- Development of member and provider educational materials.

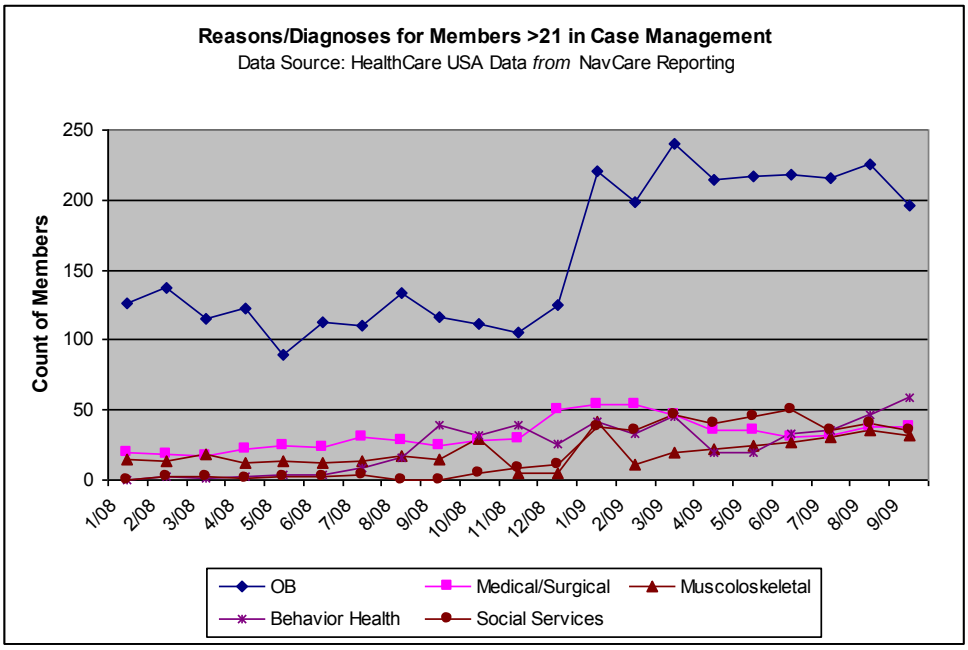


The above graph is the rate per 1000 member months of members in case management, excluding special needs referrals since those identified with special needs and case or disease management needs are referred to those programs and included in the census of the program they are enrolled in.

In January 2009 the report was modified to more accurately reflect the census of those members enrolled in case management. This resulted in the sustained increase in the rate, reflecting those actually enrolled, regardless of whether an intervention was completed in the month or not.



The case management census appears to have increased significantly in January of 2009 as a result of a change in the way the census is tracked. Those enrolled in lead case management did increase in August 2008 because of changes in criteria for lead case management.



Again, increase in all case management counts due to report restructuring in January 2009. In September-October 2008 an MHNet case manager began co-locating at HealthCare USA's main office. This collaboration is reflected in the increase in behavioral health cases at that time.

Disease Management Program

Disease management ~~–is~~ a system of coordinated health care interventions and communications for populations with conditions in which patient self-care efforts are significant" – Disease Management Association of America. The goal of disease management is to prevent exacerbations and/or complications related to specific diagnoses.

HealthCare USA's disease management program focuses the most intense resources on those with the greatest risk for treatment and/or self-management failure. Members are assessed and those who agree to enrollment in a specific disease management program are stratified into one of three acuity levels. When a member ~~–g~~raduates" from a disease management program, they continue to receive well care reminders. If the member subsequently has a hospital readmission or emergency department visits, is referred or self-refers, they can be re-enrolled in the interactive disease management program.

Asthma

The mission of the asthma disease management program is to improve the quality of life and outcomes of care for HealthCare USA members with asthma through education and collaboration with members, providers and community resources. HealthCare USA has actively managed the asthma population since 2005, in a case management model. In 2007, the program was changed to stratify the asthma population to identify those individuals with a lower acuity from those with a higher acuity that are most likely to incur adverse outcomes. The program is designed to provide more intense interventions for those at greatest risk for exacerbations.

The asthma disease management staff are State-licensed registered nurses with past clinical experience in caring for patients with asthma. Their vision is that every HealthCare USA member with asthma will live a normal life without any limitations from asthma.

The HealthCare USA goals for the asthma disease management program are:

- Reduce health care costs associated with asthma by reducing asthma related hospitalizations and ED visits
- Improve quality of care and self-management skills as evidenced by:
  - Improved HEDIS measure for appropriate asthma medications.
  - Improve quality of life and well being as evidenced by member reported improved ability to self-manage and health status as reported on satisfaction survey & HRA.
  - Improve member, provider and staff satisfaction with the asthma Disease Management process and services.
- Set a new all time best standard for asthma outcomes across Coventry

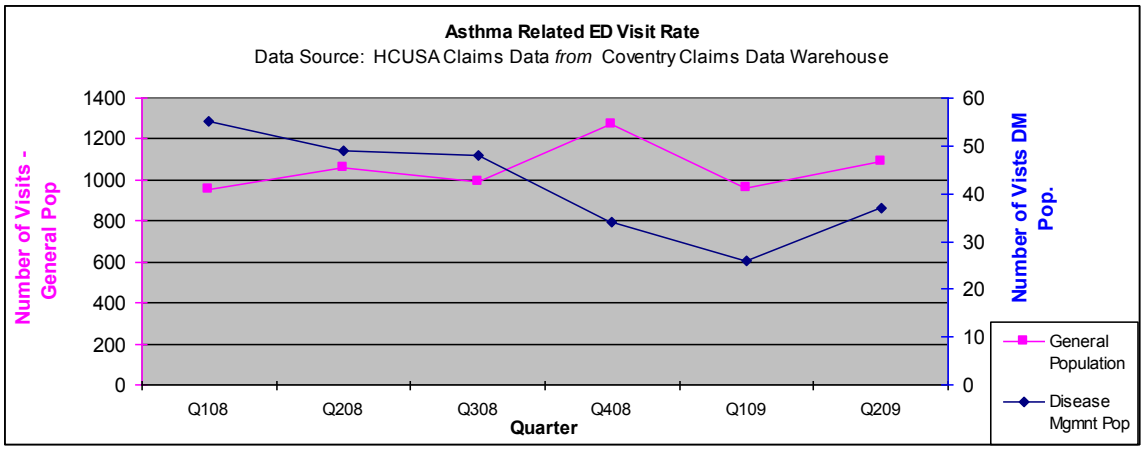
In 2008 HealthCare USA‘s Asthma Disease Management Program was selected as a poster presentation at the National Initiative for Children‘s Healthcare Quality (NICHQ) Annual Best Practices Forum.

The asthma disease managers perform telephonic and face-to-face education and utilize community resources in the management of these members. The National Heart Lung Blood Institute (NHLBI) National Asthma Education and Prevention Program (NAEPP) clinical practice guidelines are referenced for ongoing member and provider education. They manage both the adult and pediatric population, however approximately 98% of the population is pediatric.

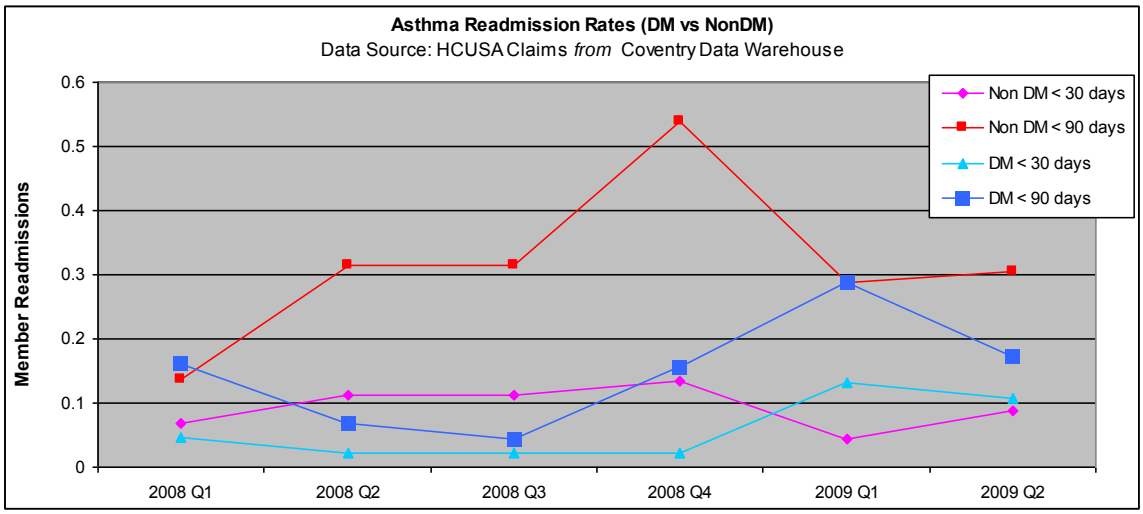
The disease managers utilize multiple resources to assist these members. Some of the resources utilized are:

- Community based programs such as the Asthma and Allergy Foundation, the American Lung Association, the St. Louis Asthma Consortium, the Community Asthma Program, and Health Kids Express.
- School nurses are also an important resource for community collaboration.
- Pharmaceutical company donated spacers and peak flow meters are provided at no cost to providers and other community resources verbalizing a need.
- Partnership with the Human Development Corporation has provided the Community Action Voicemail Service at no cost for our members who do not have access to telephone service.
- Completion of nursing intense member education materials

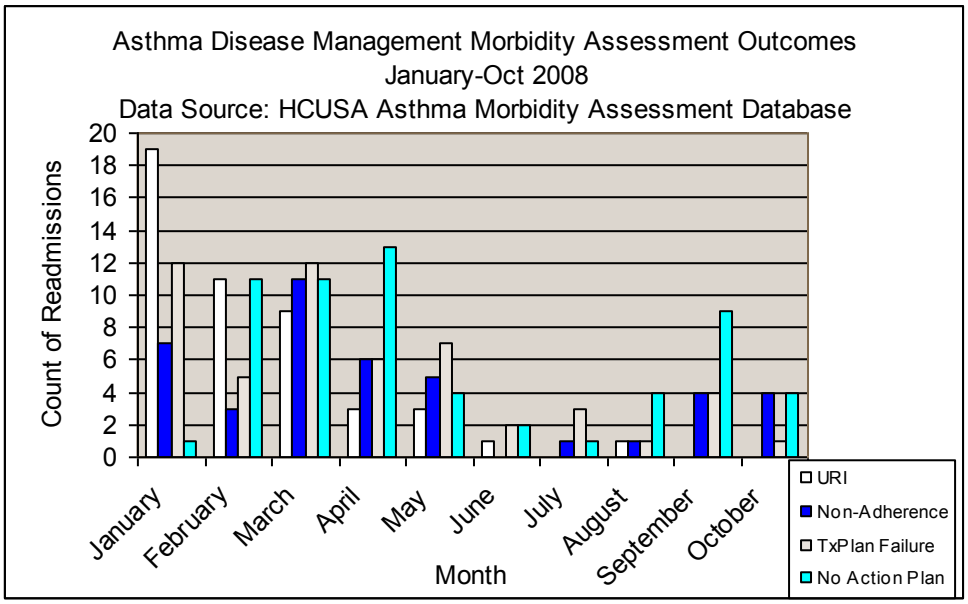
Since the implementation of asthma care activities and initiatives, HealthCare USA has achieved improvements for members in all regions.



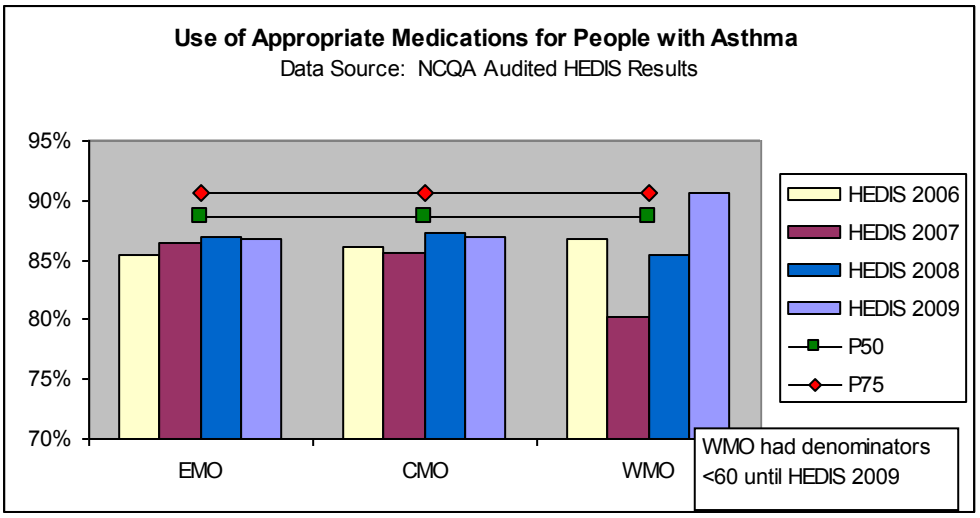
The number of ED visits for those in asthma disease management has trended down since the beginning of 2008, with a slight increased in Q209. The number of ED visits for members in the Asthma Disease Management Program, Beary Important Breath, has continued to trend down and is below the general asthma population.



The number of readmissions for asthma for those not enrolled in disease management and for those enrolled in disease management is less than 30 each thus the variation seen is not statistically significant. In Q309, non disease management readmissions doubled the number of 30 day readmissions and more than doubled the number in 90 days. In disease management, the 30 day rate was essentially unchanged and the 90 day rate was down approximately 25 percent. While we continue to see seasonal variation, the overall readmission rate for those in the asthma program remain below the baseline rate in 2007.

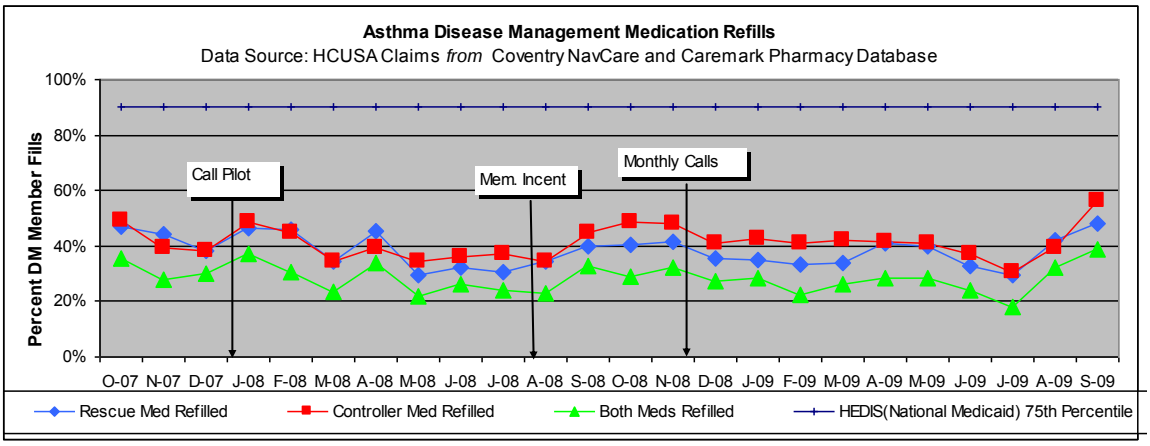


Morbidity assessments are performed on those members enrolled in asthma disease management who are admitted to the hospital. The goal of completing these assessments is to identify any actionable trends in reasons for admission. Upper respiratory infection has been the primary reason/identifiable component for readmission. There has been no trend in those with respiratory infections having evidence of poor asthma control prior to the infection/admission. The morbidity assessment tool was revised in 2009 to try to improve the ability to identify actionable trends. Implementation of the revised tool is too recent to have any valid data for this report.



The HEDIS measure "Use of Appropriate Medications with a Diagnosis of Asthma" is within 95% of the 50th percentile goal in Eastern and Central regions. Western region is now at the 75th percentile for HEDIS 2009. Throughout the year the disease managers call member enrolled in the asthma disease management program who have not filled their asthma medications as a reminder.. The Asthma Around the World incentive also encourages every member with asthma

to fill their prescription(s), see their asthma care provider and secure a rescue person to help them if/when they have an asthma attack.



Asthma disease management program participant adherence to asthma medications (including refills) increased from 17% in June, 2007 to 39% September, 2009. Outbound calls decreased into the third quarter of 2009 as a result of both asthma disease management nurses being on leave and subsequently increased with student interns assisting with calls in August and then both nurses returning from leave.

The asthma disease management program was chosen from over 200 submissions nation-wide as a poster presentation at the 2009 National Initiative for Children's Healthcare Quality 9th Annual Forum.

High Risk OB

The mission of the high risk ob disease management program, Beary Important Bundle is to work in tandem with providers, the community and High Risk OB members to increase the number of healthy moms and full term babies. Since 1995, HealthCare USA has improved care for members with high-risk pregnancies through the multi-disciplinary OB case management program. In 2007, HealthCare USA developed this into a disease management program. While all pregnant members continue to be assessed for any needs and referred to appropriate resources, members with the greatest risk of poor outcomes related to preterm labor and delivery are offered enrollment in the high risk OB disease management program.

The high risk OB disease management staff consists of four (4) state-licensed, experienced obstetrical registered nurses. Their vision is to improve the health of mom's and babies by eliminating preterm labor and delivery and the complications associated with preterm delivery.

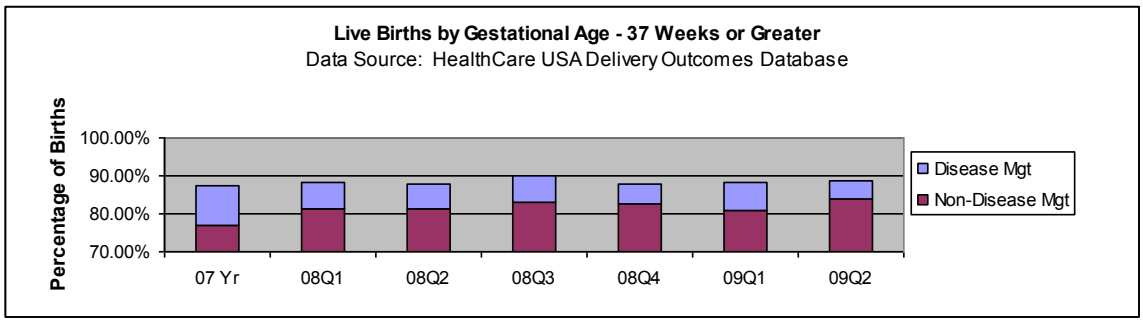
Goals of the high risk OB program:

- Reduce the number of NICU admissions related to pre-term birth
- Reduce NICU length of stay for infants born prematurely
- Improve member, provider and staff satisfaction with OB disease management process and services
- Be the leader in OB disease management services for Coventry

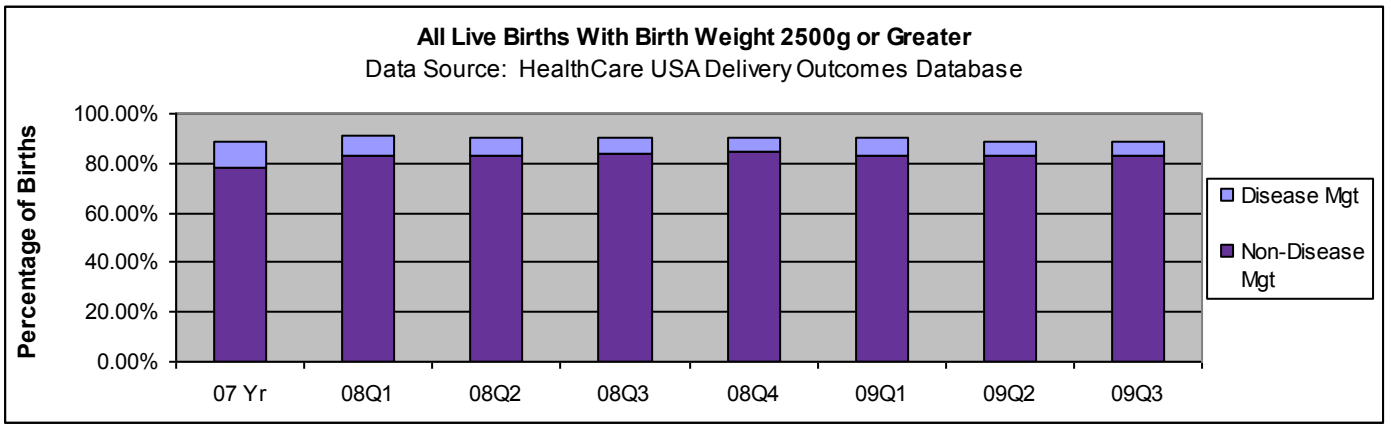
HealthCare USA identifies members for high risk OB disease management based on the following indicators:

- History of preterm delivery of preterm labor
- Gestational diabetes, uncontrolled diabetes
- Incompetent cervix
- Placenta abruption/previa
- ≥22 weeks uncontrolled vomiting
- Hyperemesis due to organic disease
- Sickle-cell/Hb-C disease with crisis
- Poor weight gain
- Thromboembolic disorder
- Vaginal bleeding ≥22 weeks
- Lupus
- Hypertension
- HELLP syndrome
- Multiple gestation
- PIH/pre-eclampsia
- ≥22 weeks ≤37 weeks and admitted to hospital
- Previous neonatal death ≥22 weeks ega
- ≤17 years of age
- Spontaneous premature rupture of membranes
- Oligohydramnios
- Adrenal gland disorders
- Intrauterine growth retardation

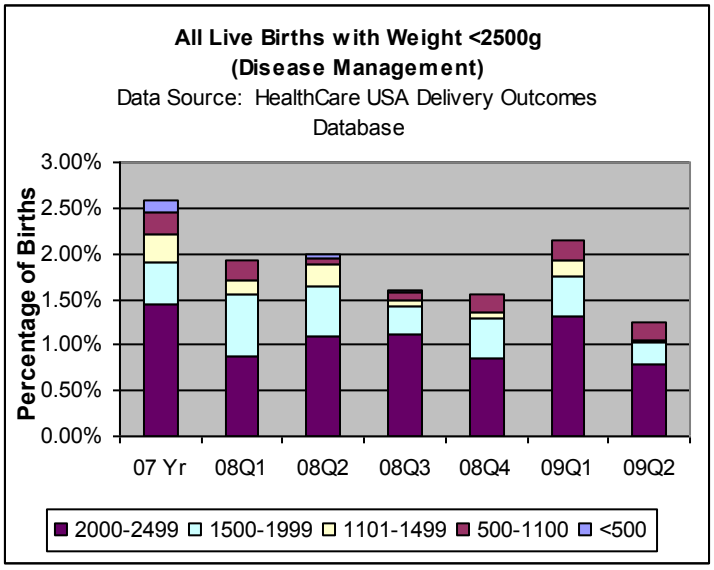
Members are referred to high risk OB disease management through review of data on the state's OB provider completed OB risk assessment form, by provider referrals, UM staff , claims review and in-patient concurrent reviews, review of emergency department logs, nurse call line and other daily reports, case management referral and member self referrals. The staff also review member clinical and authorization history to determine enrollment into the program. Individualized care plans are developed with appropriate interventions and goals. Telephonic education and coordination of services are completed in collaboration with PCPs, OBs, Maternal Fetal Medicine Specialists, HealthCare USA Medical Directors and community resources.



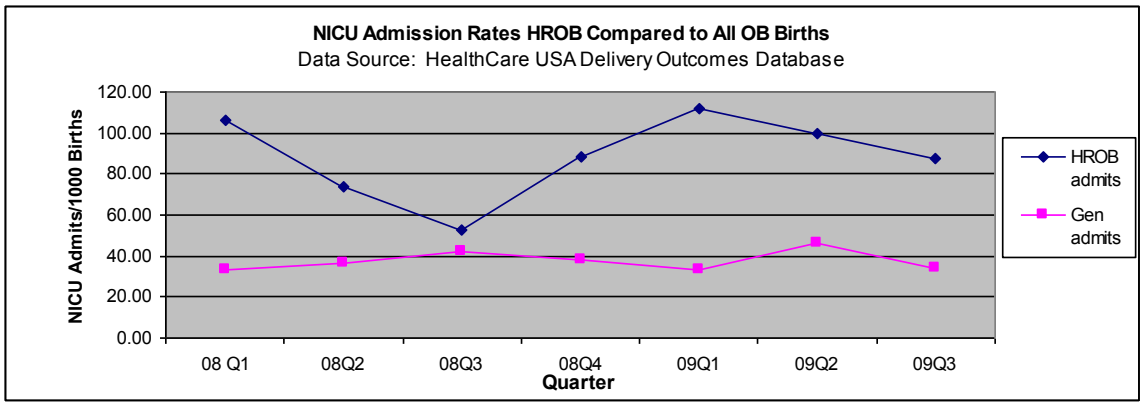
Year over year, the number of live births at or greater than 37 weeks estimated gestational age has been trending up slightly each year from the 2007 baseline of 86% to the 88% of all live births in the second and third quarters of 2009. The third quarter of 2009 was the first quarter since program implementation that all births occurred at 30 weeks or later. The reduction since 2007 of those enrolled in the high risk OB program versus those not enrolled is a reflection of more accurate stratification of the population by those at the greatest risk for a preterm birth and meet program criteria versus trying to provide intense services to all members who are pregnant. All pregnant members are offered case management services and assessed for high risk factors.



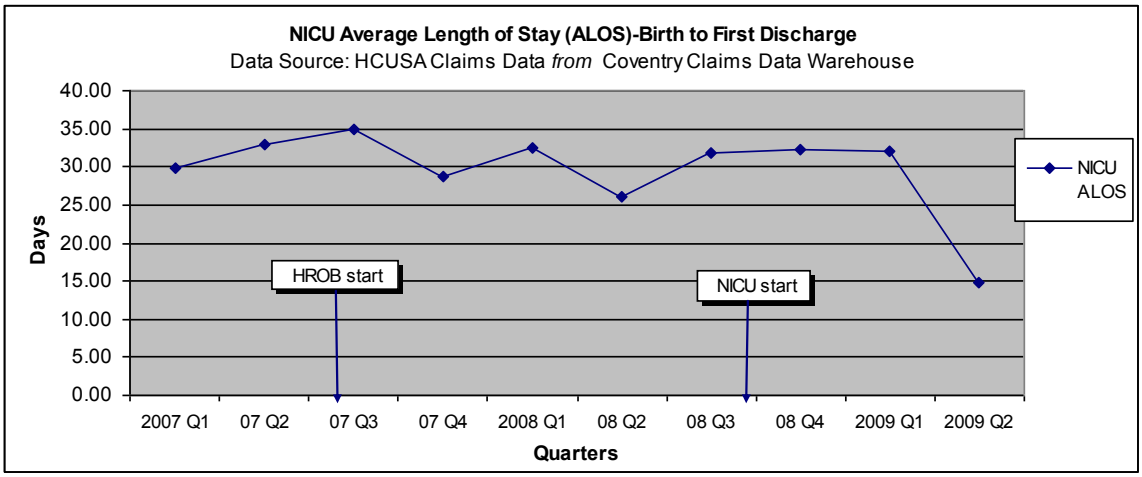
Year over year, the number of births weighing 2500 grams or more has increased in both the disease management population and those not enrolled in disease management. The number of births weighing 2000-2400 grams has not changed significantly and the number born weighing 1101-1999 grams has decreased from 0.4% to 0.2% and the number born weighing less than 1000 grams continues to vary from 0 to 0.2%.



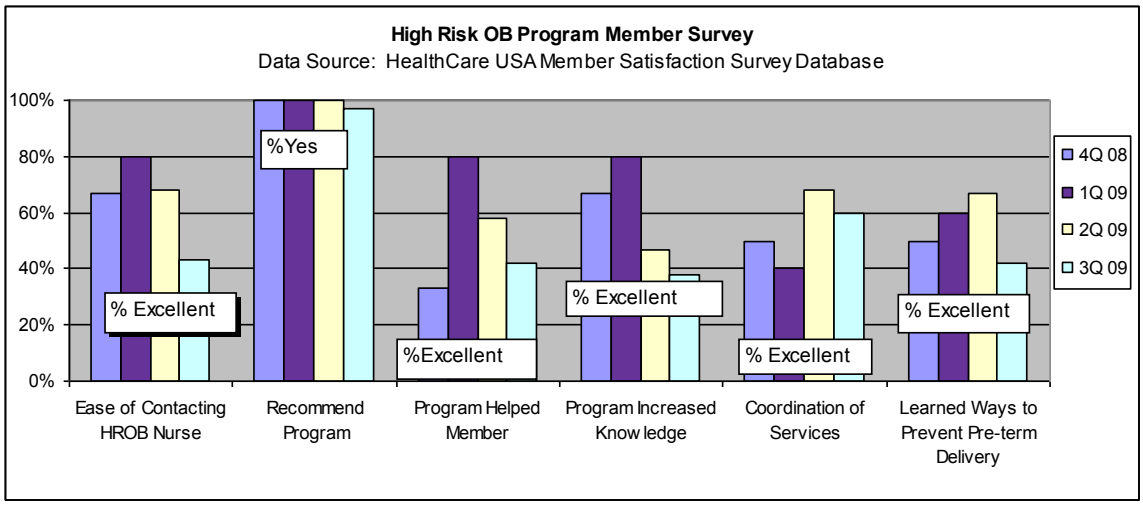
Births weighing 2500+ grams increased for both disease management and non disease management with a decrease in the 2000 to 2400 grams category and the rest remaining essentially unchanged.



Much of the variability related to the high risk OB admits is related to the small number of NICU admissions from this group each quarter (under 30). The general admits group is large enough for more accurate analysis. The number of NICU admissions decreased to the 2008 average level in Q3 09 after peaking in Q2 09 (highest number of admits since 2006) and remains better than the pre-program 2007 baseline.

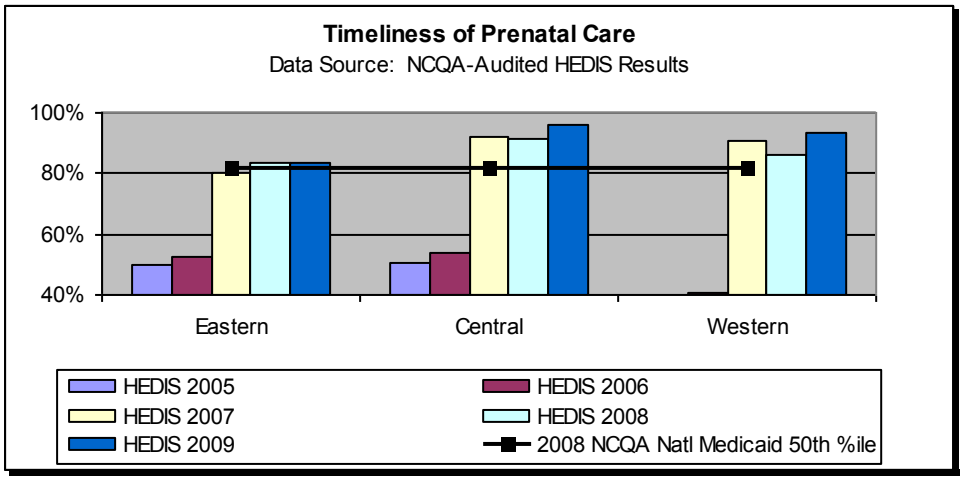


The NICU average length of stay (ALOS) from birth to first discharge has declined from the 2007 baseline rate of 35 days to a 2009 year to date average of 23.75 with an all time low in second quarter of 2009 at 14.76 days. The decrease in ALOS is most likely related to a combination of the improved discharge planning process with a discharge readiness checklist that the UM nurses started using in Q4 of 2008 and the increase in gestational age and weight related to the High Risk OB Disease Management program.



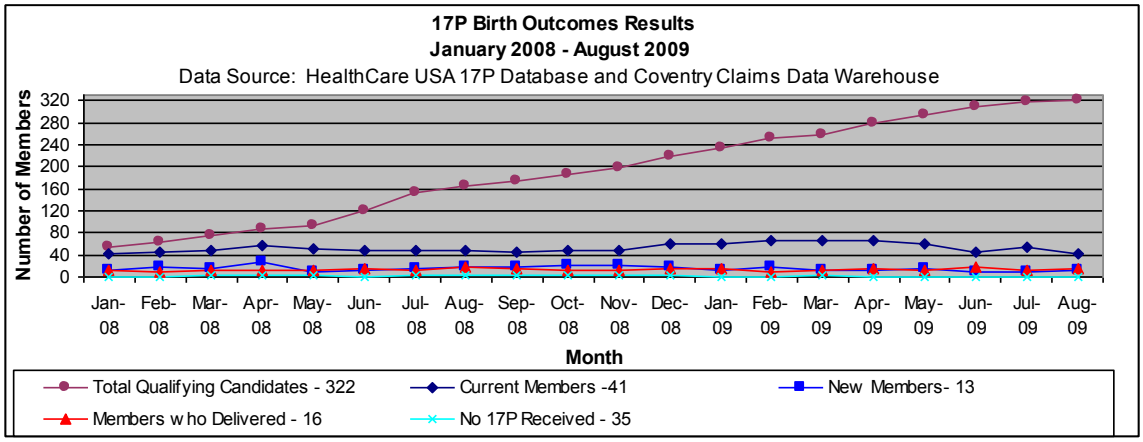
For 3rd Q09 353 surveys were sent: 20 were returned with wrong address, 65 were returned for a 19.5% return rate, which is about the same return rate each quarter. Response choices are: Excellent, Very Good, Good, Fair and Poor. The overall positive response (>Good) was 85%. Answers with lower ratings than the prior two quarters are most likely related to 4 FTEs on leave during the second and into the third quarter of 2009.

Provider Relations representatives distributed the provider surveys in July and August of 2009. Of those, 26 surveys were returned, which represents a less than 2% return rate and means that the results are not statistically valid. Provider surveys are being re-distributed using a different process.

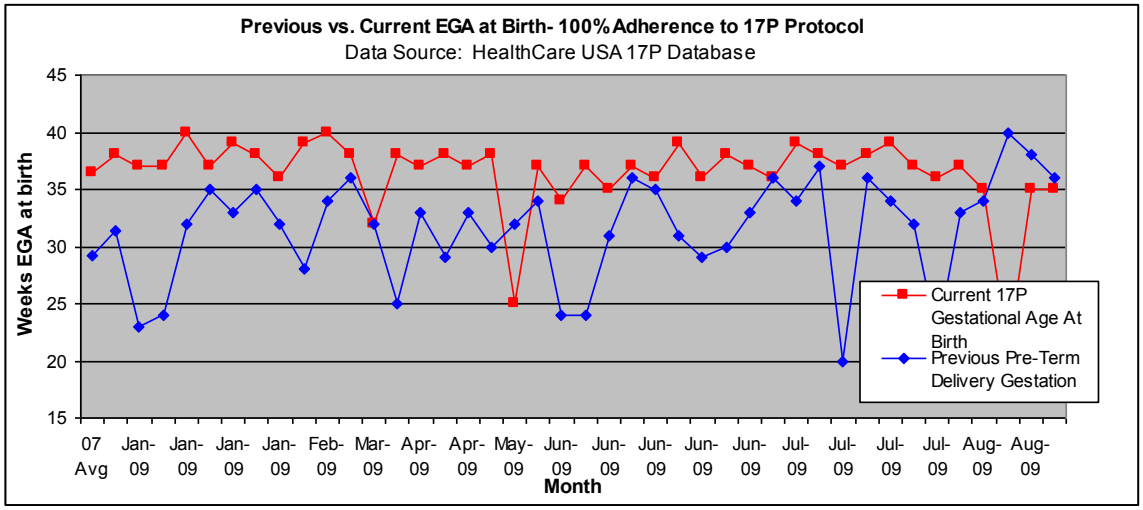


There was a statistically significant increase in the Western region in the percentage of women who started prenatal care in the first trimester or within 42 days of enrollment (level of confidence 0.05, p=0.00). There was also an increase in the Central region. All regions remain above the 2008 NCQA National Medicaid 50th percentile.

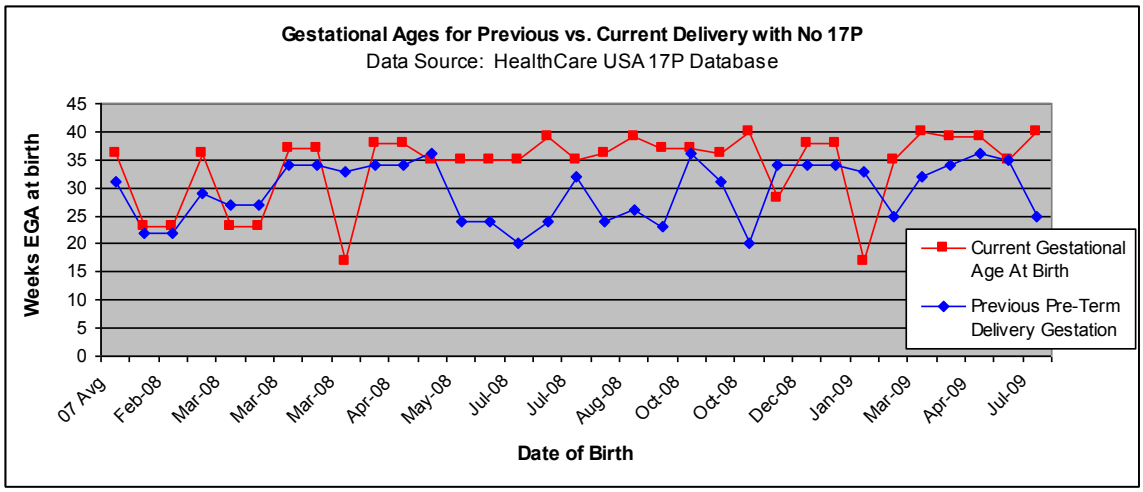
In 2008, HealthCare USA's High Risk OB Task Force identified an opportunity to improve appropriate utilization consistent with the ACOG statement for 17P Alpha-hydroxyprogesterone. Candidates are more aggressively identified and there is increased collaboration with the member's OB healthcare provider and the high risk OB disease manager. HealthCare USA is using a database to track outcomes as shown below.



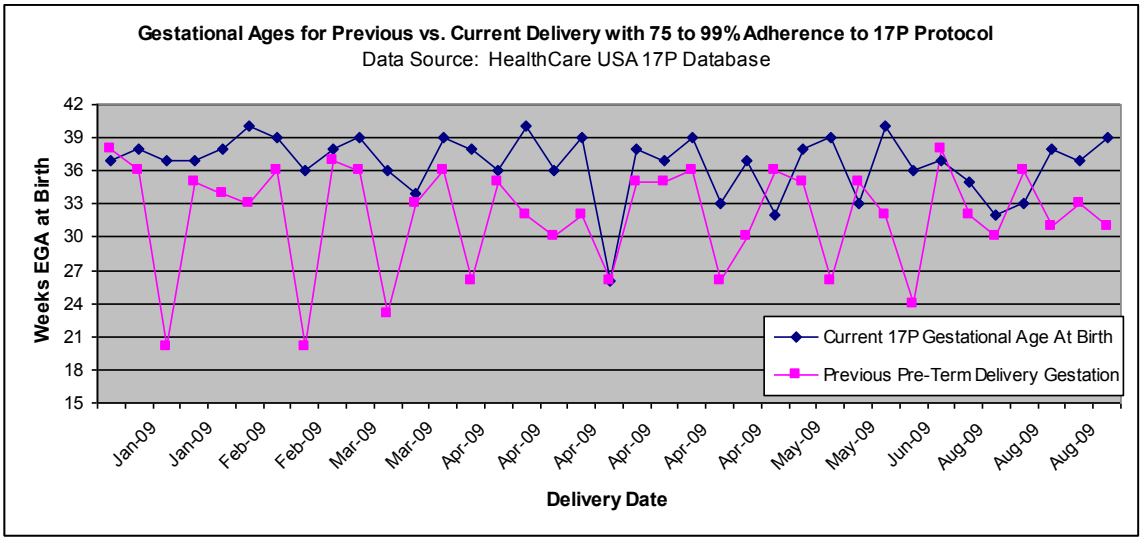
The number of members identified as having had a previous preterm birth has increased from approximately 100 in 2007 to 100 in the first 6 months of 2008 and in 2009. When a member is identified as potentially qualifying, a letter is sent to the member's OB including the process for obtaining prior authorization for 17P.



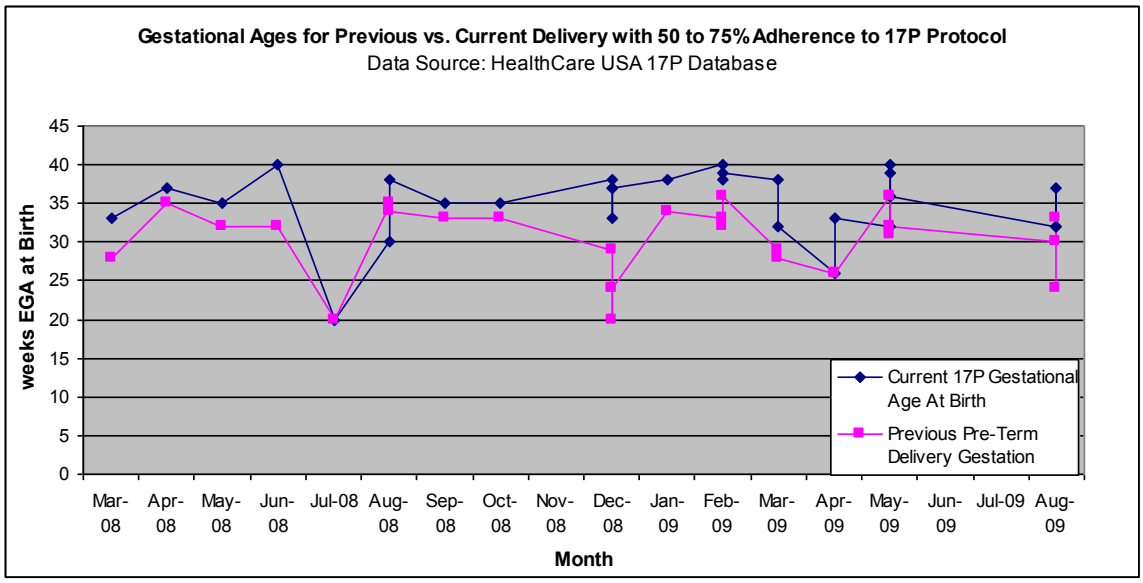
In 2007, with 100% adherence to the 17P protocol, the average previous gestational age (GA) at birth was 29.2 versus the current delivery GA of 36.4 weeks. In 2008, average previous GA was 31.44 and average current delivery GA was 38.0 weeks. YTD 2009, prior preterm birth average GA is 31.6 weeks; current deliveries are 36.4 weeks for those with 100% adherence to 17P protocol.



In 2007, average previous GA was 31 and current delivery was 36 weeks. In 2008, the average gestational age of the prior preterm birth was 27.35 and current birth with no 17P was 33 weeks. Year to date in 2009, there have been 7 members with no 17P, four of them carrying to full term. The volume in this category, at 4-7 per year, is too small to be statistically significant or valid.



In 2008 the average gestational age for the prior birth was 29.84 and current birth with 17P was 36 weeks an average increase of over 6 weeks. Year to date in 2009, the average prior was 31.9 weeks and current with 17P was 36.6 weeks for an average increase of 4.8 weeks.



There have been 29 members who fell within this category. They had a mean increase in the gestational age of 4.8 weeks.

Behavioral Health Care Management including Case Management

MHNet continued the Quality Improvement Project, Improving Post-Discharge Management of Members Discharged from an Inpatient Service for Mental Illness (see Performance Improvement Projects – Clinical). Results of the QIA are clearly seen in the HEDIS rates for Follow-up after Hospitalization for Mental Illness; however, MHNet includes all members (including those not meeting HEDIS inclusion criteria) in discharge planning activities.

MHNet continues to focus on ambulatory follow-up and dedicate significant case management resources to improving follow-up rates. Efforts have included a clinician dedicated exclusively to discharge planning activities and outreach to all inpatient facilities to encourage the facilities to partner with MHNet in securing follow-up appointments for members. During FY 2009, MHNet developed a plan to expand the discharge planning team to allow for more comprehensive case management for members being discharged from an acute setting. This included hiring of an additional Discharge Case Manager and a supportive assistant. MHNet also has plans for FY 2010 to restructure the discharge planning and case management teams to maximize available care for members.

MHNet Behavioral Health and HealthCare USA are offering a preventive health program for parents of children who have been diagnosed with attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD); see details of the program in the Clinical PIP section. This program is designed to improve adherence to prescribing guidelines and follow up care through implementation of a preauthorization process for the first prescription for ADD/ADHD medications, by providing the parents educational information about the importance of follow up care after medications are started and by sending primary care providers notice of psychiatric interventions and prescribing with a written notice. The program helps facilitate access to and use of behavioral health resources by parents of children or adolescents with ADD/ADHD.

Through this program, parents are also offered a variety of resources ranging from educational materials to individual behavioral health treatment, to parents who may benefit from them.

Clinical Practice Guidelines

The QMC approved several new guidelines and updated many clinical practice guidelines. A summary of the guidelines and links to these original guidelines can be found on the HealthCare USA provider website. The following grid lists the guidelines, the organization responsible for the guideline, who at HealthCare USA reviewed the guidelines and date of approval by the QMC.

Guideline	Organization	Guidelines Reviewed By	Date of Quality Management Committee Reviews
17-P	American College of Obstetrics and Gynecology (ACOG) *January 2005* *(www.acog.org)*	HealthCare USA Staff HealthCare USA Med Dir QMC Committee PAC	July 2007 Dec 2008 Oct 2009
ADHD-Diagnosis and Evaluation of the Child with ADHD	American Academy of Pediatrics (AAP) Clinical Practice Guidelines *May 2000* *Updated :October 2001* *(www.aap.org)*	HealthCare USA Staff HealthCare USA Med Dir QMC Committee	March 2007 Dec 2008 Oct 2009
Asthma Management	KCQIC Guideline Adopted from the National Institute's of Health: National Heart, Lung and Blood Institute's Guidelines for the Diagnosis and Treatment of Asthma *December 2007* ; *released July 2008* *(www.nhlbi.nih.gov/guidelines/asthma/index.htm)*	HealthCare USA Staff HealthCare USA Med Dir QMC Committee PAC	Sep 2006 March 2007 Nov 2007 March 2008 Dec 2008 Oct 2009
Bipolar Disorder	American Psychiatric Association; Practice Guidelines for the Treatment of Patient's with Bipolar Disorder *MHNet 1994* *(www.psych.org)*	HealthCare USA Staff HealthCare USA Med Dir QMC Committee	March 2007 Dec 2008 Oct 2009
Bronchiolitis-Diagnosis and Management	American Academy of Pediatrics Clinical Practice Guidelines *October 2006* *(www.aap.org)*	HealthCare USA Staff HealthCare USA Med Dir QMC Committee	March 2007 Dec 2008 Oct 2009
Chlamydia Screening and Treatment	California Chlamydia Action Coalition; CA Department of Public Health *March 2007* *(www.std.ca.gov)*	HealthCare USA Staff HealthCare USA Med Director QMC Committee	March 2007 Dec 2008 Oct 2009
COPD Management	Global Initiative for Obstructive Lung Disease *June 2006* *Updated February 2009* *(www.goldcopd.com)*	HealthCare USA Staff HealthCare USA Med Dir QMC Committee	March 2007 Dec 2008 Oct 2009

Guideline	Organization	Guidelines Reviewed By	Date of Quality Management Committee Reviews
Depression, Major	American Psychiatric Association; Practice Guidelines for the Treatment of Patient's with Major Depression. *April 2000* *(www.psych.org)*	HealthCare USA Staff HealthCare USA Med Dir QMC Committee	March 2007 Dec2008 Oct 2009
Diabetes Management	American Diabetes Association; Standards of Medical Care in Diabetes *January 2009* *(www.ada.org)*	HealthCare USA Staff HealthCare USA Med Dir QMC Committee PAC	Sep 2006 March 2007 Dec 2008 Feb 2009 Oct 2009
Eclampsia and Pre-eclampsia- Evaluation and Treatment of	American College of Obstetrics and Gynecology (ACOG) *January 2005* *(www.acog.org)*	HealthCare USA Staff HealthCare USA Med Dir QMC Committee PAC	July 2007 Dec 2008 Oct 2009
Diabetes- Gestational	American College of Obstetrics and Gynecology (ACOG) *January 2005* *(www.acog.org)*	HealthCare USA Staff HealthCare USA Med Dir QMC Committee PAC	July 2007 Dec 2008 Oct 2009
Heart Failure Management	KCQIC Guideline Adopted from American Heart Association and American College of Cardiology. July 2006 *(www.medscape.com/viewarticle/520123)*	HealthCare USA Staff HealthCare USA Med Dir QMC Committee	Sep 2006 March 2007 Dec 2008 Oct 2009
Hyperlipidemia- Diagnosis and Management	KCQIC Guideline Adapted from American Heart Association; National Cholesterol Education Program; National Institute of Health *June 2007* *(www.NIH.gov)*	HealthCare USA Staff HealthCare USA Med Dir QMC Committee	Dec 2008 Oct 2009
Hypertension (Essential) Management	KCQIC Guideline adopted from Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure *August 2006* *(www.nhlbi.nih.gov/guidelines)*	HealthCare USA Staff HealthCare USA Med Dir QMC Committee	Sep 2006 March 2007 Dec 2008 Oct 2009
Immunizations- Adult Recommended Schedule	Centers for Disease Control (CDC) *January 2008* *Updated January 2009* *(www.cdc.gov)*	HealthCare USA Staff HealthCare USA Med Dir	March 2007 Nov 2007 Dec 2008 Oct 2009
Immunizations- Child Recommended Schedule	Centers for Disease Control (CDC) *January 2008* *Updated January 2009* *(www.cdc.gov)*	HealthCare USA Staff HealthCare USA Med Dir QMC Committee	March 2007 March 2008 Dec 2008 Oct 2009
Lead Exposure in Children: Prevention, Detection and Management	American Academy of Pediatrics Clinical Practice Guidelines *October 2005* *(www.aap.org)*	HealthCare USA Staff HealthCare USA Med Dir QMC Committee	March 2007 Dec 2008 Oct 2009

Guideline	Organization	Guidelines Reviewed By	Date of Quality Management Committee Reviews
Obesity-Identification, Evaluation, and Treatment of Obesity in Adults and Children	KCQIC Guideline Adapted from National Heart Lung and Blood Institute(NHLBI) Obesity Education Initiative *November 2004* *(www.ama-assn.org)*	HealthCare USA Staff HealthCare USA Med Dir QMC Committee	Sep 2006 March 2007 Dec 2008 Oct 2009
Otitis Media-Diagnosis and Management	American Academy of Pediatrics Clinical Practice Guidelines *May 2004* *(www.aap.org)*	HealthCare USA Staff HealthCare USA Med Dir QMC Committee	March 2007 Dec 2008 Oct 2009
Pregnancy Management – Prenatal and Postnatal	American College of Obstetrics and Gynecology (ACOG) *January 2005* *(www.acog.org)*	HealthCare USA Staff HealthCare USA Med Dir QMC Committee PAC	March 2007 Dec 2008 Oct 2009
Preterm Birth-Assessment of Risk Factors	American College of Obstetrics and Gynecology (ACOG) *January 2005* *(www.acog.org)*	HealthCare USA Staff HealthCare USA Med Dir QMC Committee PAC	July 2007 Dec 2008 Oct 2009
Preterm Labor	American College of Obstetrics and Gynecology (ACOG) *January 2005* *(www.acog.org)*	HealthCare USA Staff HealthCare USA Med Dir QMC Committee PAC	July 2007 Dec 2008 Oct 2009
Preventative Adult Health Care (18-49 years)	Centers for Disease Control (CDC) *October 2007* *(www.cdc.gov)*	HealthCare USA Staff HealthCare USA Med Dir QMC Committee	Dec 2008 Oct 2009
Preventative Adult Health Care (50-65+ years)	Centers for Disease Control (CDC) *October 2007* *(www.cdc.gov)*	HealthCare USA Staff HealthCare USA Med Dir QMC Committee	Dec 2008 Oct 2009
Preventative Pediatric Health Care Recommendations (EPSDT)	American Academy of Pediatrics Clinical Practice Guidelines *March 2008* *(www.aap.org)*	HealthCare USA Staff HealthCare USA Med Dir QMC Committee	March 2007 Dec 2008 Oct 2009
Schizophrenia	American Psychiatric Association; Practice Guidelines for the Treatment of Patient's with Schizophrenia *April 2004* *(www.psych.org)*	HealthCare USA Staff HealthCare USA Med Dir QMC Committee	March 2007 Dec 2008 Oct 2009
Substance Abuse Disorders	American Psychiatric Association; Practice Guidelines for the Treatment of Patient's with Substance Abuse Disorders. *August 2006* *(www.psych.org)*	HealthCare USA Staff HealthCare USA Med Dir QMC Committee	March 2007 Dec 2008 Oct 2009
Synagis-Guidelines for Coverage	American Academy of Pediatrics Clinical Practice Guidelines *January 2006* *Updated: September 2009*	HealthCare USA Staff HealthCare USA Med Dir QMC Committee	March 2007 Dec 2008 Oct 2009

Guideline	Organization	Guidelines Reviewed By	Date of Quality Management Committee Reviews
	(www.aap.org)		
Tobacco Control	KCQIC guidelines adopted from the Institute for Clinical Systems Improvement (ICSI) Tobacco Use Prevention and Cessation for Adults and Mature Adolescent; American Lung Association *December 2005* *(lungusa.org)*	HealthCare USA Staff HealthCare USA Med Dir QMC Committee	Sep 2006 March 2007 Dec 2008 Oct 2009
Vaginal Birth After Cesarean Delivery (VBAC)	American College of Obstetrics and Gynecology (ACOG) *January 2005* *(www.acog.org)*	HealthCare USA Staff HealthCare USA Med Dir QMC Committee	July 2007 Dec 2008
Hospital Discharge of High-Risk Neonates	American Academy of Pediatrics *November 2008* *(www.aap.org)*	HealthCare USA Staff HealthCare USA Med Dir QMC Committee	Dec 2008 Oct 2009
Preventive Dental Guidelines for Infants, Children, and Adolescents	American Academy of Pediatric Dentistry *2007* *Updated 2009* *(www.aapd.org)*	HealthCare USA Staff HealthCare USA Med Dir QMC Committee	Feb 2009 Oct 2009

Credentialing and Re-Credentialing

HealthCare USA has the sole right to determine which primary and specialty practitioners it shall accept and retain as HealthCare USA providers. The Credentials Committee, with Medical Director leadership, provides oversight of all credentialed and re-credentialed practitioners and the credentialing process.

HealthCare USA monitors the effectiveness of the credentialing program on a quarterly basis. The key indicators include:

- Average turn around time for credentialing and re-credentialing for all files was 19.76 days.
- Number of providers credentialed and re-credentialed for the fiscal year:
  - 3rd Quarter 2008 – 530
  - 4th Quarter 2008 – 392
  - 1st Quarter 2009 – 359
  - 2nd Quarter 2009 - 237
- There were 476 providers who were terminated and/or de-credentialed.

HealthCare USA conducted oversight of eight (8) delegated credentialing entities to ensure compliance with the requirements of the health plan, URAC, NCQA and the State of Missouri. The annual audit consisted of reviewing randomly selected credentialing and re-credentialing files, policies and procedures, and committee meeting minutes.

It is HealthCare USA's standard that each delegated entity achieve a score of at least 80% or greater. If issues are identified during the auditing process, clarification is requested and corrective actions are taken should the facility be unable to comply. Audit results are presented to the Credentialing Committee and Quality Management Committee (QMC). Recommendations are made on an "as needed" basis.

Of the delegated entities, 100% attained a score of 80% or greater. HealthCare USA will continue to provide oversight of its delegated entities. Currently, HealthCare USA delegates credentialing and re-credentialing to the following providers:

- BJC Medical Group
- Children's Mercy Health Network
- Citizen's Memorial Hospital
- Family Care Health Center
- Peoples Health Center
- SSM Health Care
- St. Louis Connect Care
- Truman Medical Center
- Unity Health Services
- Washington University Physician Network

Medical Record Review

HealthCare USA's Quality Improvement Department continues to conduct on-site on-going provider monitoring and medical record reviews based on the Credentialing Committee list of providers credentialed and re-credentialed. The process for selecting providers for on-site audits was revised this year. 100% of providers who do not have a "clean and green" credentialing or re-credentialing file are scheduled for an on-site audit at least 3 months after the credentialing/re-credentialing process is completed and within the first year of the credentialing cycle. A random sample of 5-10% of all other providers credentialed or re-credentialed are also selected for an on-site audit.

This compliance review ensures maintenance of adequate, detailed and comprehensive medical records and adherence to clinical practice guidelines in an effort to improve clinical outcomes and patient safety. An environmental assessment and a claims to clinical documentation review are also completed. In 2009, the audit tool was updated and revised to provide a more comprehensive and user-friendly tool for the person doing the audit and to provide a more comprehensive and detailed review tool for providers. A copy of the revised tool created in an excel spreadsheet for ease in automatically calculating the score is in the provider handbook and pasted below.

HEALTHCARE USA
A Coventry Health Care Plan

PROVIDER ON-SITE REVIEW FORM

Reason for visit: ☐ Initial Credentialing ☐ Recredential ☐ Revisit ☐ Other

Other: (specify Reason):

Type of Facility: ☐ Physician Office ☐ Other (Specify Type) : _____

Provider Name: _____ Specialty: _____

Practice Name: _____ Facility Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ Owner/Office Manager: _____

Emergency Phone Number: _____ Fax: _____

Reviewer: _____ State License No: _____

Reviewer Signature: _____ Date: _____

Summary of On-Site review given to: _____ Date: _____

Author and Date Letter sent:

Administrative, Facility & Clinical Score:	**N/A**	**Number core reqm'ts not met:**	**N/A**	Corrective Action Plan?	**N/A**	CAP Comp Date
Medical Record Keeping Score:	**N/A**	**Number core reqm'ts not met:**	**N/A**	Corrective Action Plan?	**N/A**	CAP Comp Date

On going monitoring audits are completed when member complaints center around the physical appearance of the facility or when potential quality issues are identified that can not be fully investigated through collection and review of records and other information from the provider. The process is documented in a policy. A copy may be obtained by asking Provider Relations or QI.

This information is being collected under circumstances that do not require patient authorization. (See "Availability of Records" in the Provider Manual). Medical information should be maintained in a safe, secure and confidential manner. Member/patient personal information should not be redisclosed without additional patient consent or as permitted by law. Unauthorized redisclosure or failure to maintain confidentiality could subject an individual to penalties described in federal and state law.

IMPORTANT WARNING: All information collected and reviewed is intended for the use of the person collecting the data and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. Any dissemination, distribution, or copying of this information is ***STRICTLY PROHIBITED***. If you receive this information in error, please notify us immediately and destroy the information.

ADMINISTRATIVE		Y, N, NA	Weight	COMMENTS
1*	Grievance procedure		2.00	
2	Informed consent policy/procedure		1.00	

3	Lead testing protocol		1.00	
4	Member health education materials available		1.00	
5	Personal health behavior material available		1.00	
6	Visit note for each claim in the sample of claims		2.00	
7	Advanced Directives process for those 18 and older		2.00	
ADMINISTRATIVE SUBTOTAL:		-	10.0	**Score N/A**

PHYSICAL FACILITY		**Y, N, NA**	**Weight**	**COMMENTS**
1*	Handicap entrance		2.00	
2	Handicap parking		1.00	
3	Adequate parking		1.00	
4	Adequate seating		1.00	
5	No smoking signs visible in office		1.00	
6	Exit signs visible in office		1.00	
7	Environment maintained to provide for physical safety		1.00	
PHYSICAL FACILITY SUBTOTAL:		-	8.00	**Score N/A**
MEDICAL RECORD KEEPING		**Y, N, NA**	**Weight**	**COMMENTS**
1*	Medical records are stored securely and maintained in compliance with HIPPA guidelines		1.0	
2*	Medical records are easily retrievable		1.0	
3*	Legible file markers		1.0	
4*	There is one medical record per patient		1.0	
5	Member/patient name is on each page of the record		1.0	
6	There is a standardized form for a medical problem list		1.0	
7	There is a standardized form for a medication list		1.0	
8	There is a standardized form for a medical progress note and all progress notes are dated and signed by the provider, including credentials		1.0	
9	There are designated areas in the medical record for lab reports, x-ray reports, consults, etc. & those present		1.0	

	are signed			
10	Allergies prominently displayed		1.0	
11	Pages in the medical record are secured		1.0	
12	Communicable diseases are routinely reported		1.0	
13	Information given to patient on Advanced Directives		1.0	
MEDICAL RECORD KEEPING SUBTOTAL:			13.0	**Score N/A**
CLINICAL		**Y, N, NA**	**Weight**	**COMMENTS**
1	Biographical sheet present		1.0	
2	Consent for procedures (including Imms)		2.0	
3	Allergies Documented		2.0	
4	Allergic Reaction documented if applicable		2.0	
5	Problem list or health maintenance flowsheet		2.0	
6	List of past and current medications		2.0	Short term meds on progress notes is ok
7	Past medical history (only applies to 3 or more visits)		2.0	
8	Weight (or growth chart 0-2 years)		2.0	
9	History and Physical complete (Subjective & Objective)		2.0	
10	Diagnosis or assessment		2.0	
11	Plan of Action/Treatment Plan		2.0	
12	Return Visit or f/u care determined		2.0	
13	Lab, X-Rays, imaging & ancillary reports present/signed		1.0	
14	Consultation/Specialist reports present/signed		1.0	
15	Immunizations UTD or notation of current status		3.0	
16	VFC documentation of immunizations is complete		1.0	
17	All 10 components of an HCY/EPSDT visit are completed for those 20 years of age and under		3.0	
CLINICAL	*continued on next page*	Y, N, NA	Weight	COMMENTS
18	*Lead risk assessment guide is completed at each visit for those 6 years of age and under*		3.0	
19	*Lead testing results are present by 12 & 24 months of age*		3.0	
20	*Substance abuse/ETOH/ smoking*		2.0	

	screening and applicable advice is completed for those 12 and older		
21	*Mental Health screening assessment is completed for at least those 18 years and older*		2.0
22	*STD, HIV screening is completed for at least 16 and older*		2.0
23	*Asthma: an Asthma Action plan is present & complete*		2.0
24	*Asthma: medications are prescribed*		1.0
25	*Diabetes: Annual HbA1c test results are present*		2.0
26	*Diabetes: Advice for or results of annual eye exam*		2.0
27	*Diabetes: Annual neuropathy assessment present*		2.0
28	*Diabetes: Annual LDL-C screening completed*		2.0
CLINICAL SUBTOTAL:			**Score N/A**

PROVIDER SITE VISIT

For Plan Use Only:

Is Provider (or designee) satisfied with HealthCare USA's Health Plan Clinical Resource Management Processes:

☐ YES ☑ NO ☐ N/A

Education materials reviewed and left with the provider:

Any other resources given to the provider:

COMMENTS:

This information is being collected under circumstances that do not require patient authorization. (See "Availability of Records" in the MSA Provider Manual Chapter 1, p 39). It should be maintained in a safe, secure and confidential manner. Redisclosure without additional patient consent or as permitted by law prohibited. Unauthorized redisclosure or failure to maintain confidentiality could subject an individual to penalties described in federal and state law".

IMPORTANT WARNING: All information collected and reviewed is intended for the use of the person collecting the data and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. Any dissemination, distribution, or copying of this information is ***STRICTLY PROHIBITED***. If you receive this information in error, please notify us immediately and destroy the information.

Any provider with a clean and green credentialing/re-credentialing file that does not have at least 30 claims is not included in the on-site audit process. HealthCare USA continues to provide advanced directives education through the provider newsletter, through follow-up after on-site and mail audits, in the new provider orientation packets and at PAC and PMAC meetings at other annual provider education seminars.

Probably the most important aspect of the on-site audit is the opportunity to provide direct, reflective, objective education to the provider and the provider office staff. This education includes feedback on the provider‘s strengths and opportunities. Resources that are specific to

the areas needing improvement, including forms, hand-outs, links, and clinical practice guidelines are given to the providers with the review of the audit results.

All results from shared with the provider, the provider relations department. Results of all audits are kept in the providers file. All providers must meet the minimum threshold of 80% on audit. Any provider who scores below an 80% is educated about the deficiencies, what needs to be done to correct the deficiency, and provided resources to accomplish the corrections needed. A plan of correction is completed and a re-audit is completed within 180 days. A subsequent failure after the re-audit results in meeting with the provider and office representative, the HealthCare USA provider representative, and the QI employee who completed the audit. A detailed discussion on the failure points, along with an action plan for improvement are established. Another re-audit then occurs within 180 days of the meeting. If the provider fails to pass the second re-audit the file is referred to the Medical Director for review and determination of a one-on-one discussion with the provider or referral of the case to Peer Review. Progressive corrective action up to and including termination of the provider from the network is completed if a provider fails to achieve a minimum passing on-site audit score.

When the Quality Improvement Department observes exceptional documentation, it is vital to acknowledge these facilities for their efforts. HealthCare USA awards exceptional offices in each region with the Sharing the Vision for Excellence in Quality award.

Recipients of the award for 2008 audits were

- Drs. Ann Gassman, Anuradha Sarma, and Mark Wulff of Cass County Pediatrics
- Dr. Dale Zimmerman of Monroe City
- Dr. Elizabeth Hammer of Union

The award includes a ceremony with presentation of the award by a member of the HealthCare USA management team, a desktop award and wall plaque and catered luncheon for the entire staff. In addition for 2008, all providers who scored a 90 percent or above received a letter from the CEO of HealthCare USA commending them on their accomplishment. These providers‘ accomplishment were also highlighted in a provider newsletter.

HealthCare USA assesses the outcomes of the audits and reports the results to the Quality Management Committee and in the provider newsletter at least annually.

HealthCare USA also assesses the effectiveness of the audit tool and process in measuring the quality and safety. Educational resources and information provided are also reviewed and revised, incorporating provider feedback from on-site audit follow up surveys. In the coming year, resources will be expanded to include the provider‘s HEDIS results from the previous year and additional information about best practices, HEDIS measures and tips for coding.

Subcontractor Monitoring

HealthCare USA maintains collaborative relationships with several entities who provide specific delegated functions in order to provide comprehensive quality services and care to the MO HealthNet Managed Care membership across the Eastern, Central and Western Missouri Regions. Within these relationships, Healthcare USA retains the authority to oversee each

subcontractor for compliance with the applicable statutes, regulations, policies and procedures governing each delegated function.

During FY 2009, Healthcare USA delegated the following functions to external vendors who provide expertise in each area:

Dental Services
Doral Dental USA, LLC (Doral) July 1, 2008 – June 30, 2009
(UM and claims processing)

Transportation Services
Medical Transportation Management (MTM) July 1, 2008 – June 30, 2009
(Claims processing)

Behavioral Health Services
MHNet Behavioral Health, Inc. (MHNet) July 1, 2008 – June 30, 2009
(UM, claims processing, behavioral health case management)

Pharmacy
CVS/Caremark July 1, 2008 – June 30, 2009
(Claims processing)

24 hour Nurse Call Line
McKesson Health Solutions July 1, 2008 – June 30, 2009

Claims Review July 1, 2008 – June 30, 2009
CompPartners
Claims evaluation and review on appeal

Claims Review July 1, 2008 – June 30, 2009
Managing Care Managing Claims (MCMC)
Claims evaluation and review on appeal

Healthcare USA's process for conducting ongoing monitoring of delegated vendors includes routine committee meetings with each vendor. The Oversight Committee meetings are conducted at least quarterly or more frequently as need arises. The meetings include representatives from various departments of HealthCare USA, as well as representatives from the subcontractor. The Oversight Committee is charged with reviewing and monitoring the following for compliance with applicable MO HealthNet Managed Care requirements, applicable URAC and NCQA standards, as well as state and federal regulations. Delegated vendors actively participate in QMC meetings presenting their QI plans, reports and updates to projects including as applicable:

- Utilization Management
- Access and Availability
- Quality Management / Quality Improvement
- Provider Complaints, Grievances, and Appeals

- Member Grievances and Appeals
- Policies and Procedures regarding each subcontractor function
- Member and Provider Satisfaction
- Coordination of Care Activities
- Member Services
- Provider Services
- Claims Processing
- Fraud and Abuse
- Member and Provider Education Initiatives
- Preventive Health Programs
- HIPAA Compliance

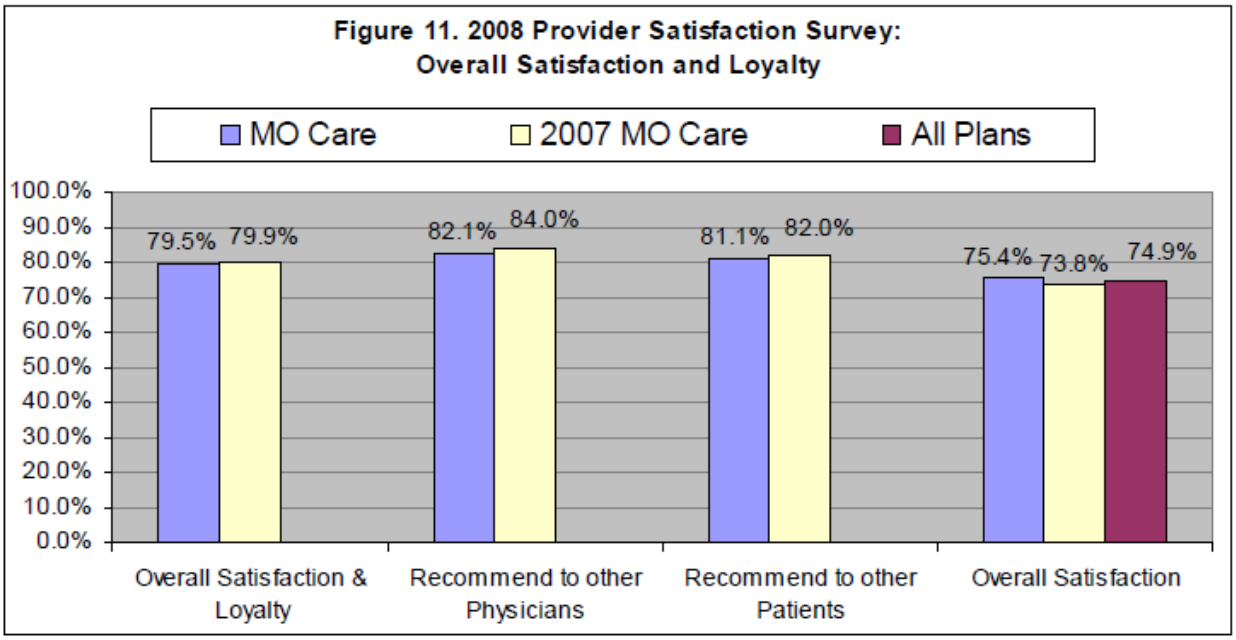
In addition to monitoring of the above, Healthcare USA utilizes the Oversight Committee to initiate and implement corrective actions and address opportunities for improvement with each subcontractor as needed. The oversight meetings are documented through formal agendas, sign in sheets, and minutes. The subcontractor's quality improvement staff also attend and report at the HealthCare USA QMC meetings. HealthCare USA participates in MHNet's regional quality improvement committee meetings.

Healthcare USA provides additional oversight throughout the year by reviewing regular reports, materials, policies and procedures, etc. required of each subcontractor. These documents are disseminated to the appropriate staff at Healthcare USA and discussed with each subcontractor via regular communication and through the formal Oversight Committee. All annual documents, i.e. annual evaluations, program descriptions, work plans, policy and procedure manuals, etc. are also reviewed.

Missouri Care

Provider Satisfaction

The 2008 Missouri Care Provider Satisfaction Survey yielded generally positive responses. Providers rated Missouri Care Health Plan as excellent or very good more often compared to —all other plans in the market" on the following composites: Call Center/Medical Services (i.e., member services), Provider Relations, Network (i.e., availability of specialists), Utilization & Quality Management, Finance Issues (i.e., accuracy and timeliness of claims payment and ispute resolution), and Pharmacy and Drug Benefits (i.e., ease of using the formulary). Additionally, 75% of providers indicated a positive level of overall satisfaction with Missouri Care (Figure 11).



Missouri Care's Perinatal and Post-Partum Care Management Program
Pregnancy is one of the primary eligibility categories of Missouri Care's membership, and deliveries account for more than one-half of all of inpatient discharges. In light of this, assuring that our pregnant members receive timely and comprehensive prenatal and postpartum care is a management priority. Our goal is to ensure the delivery of timely prenatal care in accordance with recommended periodicity schedules, reduce the incidence of poor birth outcomes and low birth weight infants, and improve the rate of postpartum visits.

Missouri Care has established a comprehensive perinatal and postpartum care program to identify, track and coordinate the care of pregnant members, with a focus on attaining positive health outcomes for both the mother and her newborn. The program provides case management to all pregnant members from their date of enrollment (new member) or pregnancy confirmation (existing members) through the 60-day postpartum period. Our overall goal is to assure that these individuals have access to high quality, cost effective prenatal care and timely identification and intervention for postpartum concerns.

Expectant mothers who receive prenatal care are 75% more likely to deliver a healthy baby. Consistent and timely postpartum care supports early identification and intervention for postpartum risks such as postpartum depression, breastfeeding problems, mother-baby bonding issues and family planning.

Prenatal Program
Process for Identifying Pregnant Members
Missouri Care understands that early identification is the first step toward improving birth outcomes. In 2002, in a collaborative effort with MO HealthNet and other health plans, we developed the Pregnancy Risk Screening and Notification form. This form streamlined and standardized communication with our providers resulting in improved early identification of pregnant members and their potential risks. Earlier identification has resulted in earlier and more

effective case management interventions for those at highest risk for poor birth outcomes.

The case manager works collaboratively with the member, the member‘s family, the primary care obstetrician provider and other stakeholders to develop an individualized plan of care that targets those issues identified on the Pregnancy Risk Screening and Notification form. The goal is to improve health outcomes for the mother and her newborn. Interventions include reinforcing provider education, encouraging and supporting the member‘s adherence with treatment recommendations and providing transportation when needed.

Early identification and case management intervention are key to our program. Missouri Care requires primary care obstetricians and PCPs who are also obstetrical providers to complete and submit the Missouri Care Pregnancy Risk Screening and Notification form within two business says of a member's initial visit. A global authorization number, required for reimbursement, is issued to the provider after receipt and review of the form. If any risk issues are indicated on the sreening form, the member is referred for high risk perinatal case management services.

Since the 2002 implementation of the pilot program for the screen and form, Missouri Care has collaborated with our provider network to refine the process. Missouri Care considers the collaboration, development and implementation of the Pregnancy Risk Screening and Notification form a best practice for improving birth outcomes.

Additional strategies to identify and refer pregnant members for high risk perinatal case management include, but are not limited to, the following:

- All plan personnel understand and are educated about our high risk perinatal case management program. Any contact with plan personnel can generate a referral.
- Member services representatives are a frequent first contact point. They refer members who believe they are pregnant or who have questions about maternity-related services
- Concurrent review/prior authorization personnel refer members who are or may be pregnant when they identify them in an inpatient setting or through pregnancy-related prior authorization requests
- PCPs are required to refer members who are or may be pregnant
- Fetal medicine/perinatologists refer pregnant women who are enrolled in our health plan
- The Member Handbook and our web site encourage pregnant members to self-refer. They may use the toll-free number or our web site to contact the plan
- Review of internal reports, such as Emergency Department utilization reports, to identify pregnant members accessing services through the ED

Coordinating Prenatal and Postpartum Care and Services

The goals of Missouri Care's prenatal and postpartum services are:

- *Early identification* - Identify pregnant members as early as possible through collaborative efforts with internal and external resources to improve birth outcomes
- *Ongoing support and interventions* - Follow each member throughout their pregnancy and the 60-day postpartum period
- *Coordination with community support services* - Refer and assist members to access community resources, such as WIC, school and community-based teen pregnancy programs, mentoring programs for pregnant adolescents and depression counseling services

As such, our program consists of the following fundamental strategies:

- *Improving birth outcomes* - Provide case management and care coordination services and assure that prenatal and postpartum interventions are effective and timely
- *Identifying risk factors* - Assess pregnant women to identify any risk factors and conduct periodic reassessments throughout the pregnancy
- *Educating members* - Provide appropriate educational materials and respond quickly to any questions or concerns that the member may have. Inform members about prenatal and infant and child care classes available in the community
- *Enhancing access to community services* - Provide information about and assistance to obtain available community services and programs.
- *Coordination of care for identified risk issues* -
  - Assist with referrals for perinatologists and other specialty providers
  - Refer for screening, counseling and appropriate treatment for HIV and other sexually transmitted diseases (STDs).
  - Referral for domestic violence services
  - Assess for behavioral and substance abuse issues and enrollment into behavioral health services
  - Encourage postpartum follow-up visits and referrals
- *Identifying and resolving barriers to care* - Collect and track information about each member's pregnancy, birth outcomes, case management interventions, compliance with scheduling and keeping appointments and provide any needed assistance with transportation or other barriers to care
- *Ensuring quality of network providers* - Maintain a diverse network of maternity health care professionals to meet members' needs and assure members receive comprehensive prenatal and postpartum care from qualified, culturally competent maternity care providers

- *Conducting community outreach* - Conduct member and community outreach and education to "spread the word" about the benefits of early and comprehensive prenatal and postpartum care and the services that are readily available through our health plan
- *Holistic, culturally sensitive care* - Provide special consideration for:
  - Pregnant adolescent members
  - Members with a history of high risk pregnancies (such as previous low birth weight babies)
  - Members with comorbidities (e.g., Diabetes, HIV/AIDS)
  - Pregnant members with a history of substance abuse or mental illness
  - Members with limited English proficiency, auditory disabilities, low health literacy or other potential barriers to care

<u>High Risk Perinatal and Postpartum Case Management</u>

Missouri Care's Perinatal and Postpartum Case Management Program is designed to assess for high risk maternal and fetal issues and coordinate and manage the care of women with high risk pregnancies. We recognize that each member's pregnancy is a unique experience and many behavioral, social and medical factors can result in a high risk pregnancy. Examples of high risk issues addressed in our case management program:

- High risk medical or behavioral health conditions and comorbidities (current or history of) such as:
  - Preterm Labor
  - Asthma
  - Diabetes
  - Sickle Cell Anemia
  - Sexually Transmitted Diseases
  - Depression
  - Serious mental illness
  - Multiple gestation
  - Short spacing between births of < 18 months
  - Hypertension
  - Rh incompatibility
  - Gestational Diabetes
  - Age (e.g., younger than age 15, older than age 35)
- Social Stressors such as:
  - Homelessness
  - Domestic violence
  - Single parent
  - Teen parent
- Fetal factors such as:
  - Exposure to infections, damaging medications and/or addictive substances
  - Serious health conditions for the baby

Women with high risk pregnancies may require monitoring and interventions that closely track conditions, identify complications and evaluate their impact on the baby. These may include additional provider visits, referrals to Perinatologists/Maternal Fetal Medicine specialists, other specialists, amniocentesis and fetal monitoring. Missouri Care's perinatal case managers work

closely with all high risk members to develop a customized care plan that includes supporting the authorization of and monitoring adherence care plans of pregnant women by assessing for and resolving barriers, serving as a center point for communication among all involved parties and identifying community resources to assist members.

Postpartum Care
Timely postpartum care is an essential component of promoting well-being for mothers and babies. The postpartum visit is an opportunity to identify physical and mental health issues, such as postpartum depression, as well as feeding and bonding issues. It is the optimal time for family planning to occur. Our Case Management Program supports this important health step by:

- *Follow-up case management*: Members enrolled in perinatal and postpartum case management receive follow-up calls and assessments. These assessments are geared to identify potential maternal physical and mental health issues and assessment basics for the newborn.
- *Education:* All members enrolled in case management are educated throughout the case management period about the importance of postpartum care
- *Educational Materials:* All new mothers receive the "*You and Your New Baby Book*" which contains helpful information for new moms and stresses the importance of postpartum care
- *Provider Education:* Postpartum care is reimbursed under the OB Global Authorization and providers are encouraged to stress the importance of postpartum care to their patients

Community Partnerships to Improve Prenatal and Postpartum Care
The following are examples of Missouri Care's collaborations to improve the quality of prenatal and postpartum care for our members:

Comprehensive Substance Abuse Treatment and Referral (CSTAR)
Missouri Care's perinatal case managers refer all pregnant woman identified with a substance abuse problem to a specialized Comprehensive Substance Abuse Treatment and Rehabilitation (CSTAR) Program for Women. Pregnant women may be referred by their PCP or primary care obstetricians. A provider can use the Screening and Referral Form available on the Department of Mental Health's web site (www.dmh.mo.gov), or contact the CSTAR provider within Missouri Care's network. These referrals are done in accordance with the State's substance abuse treatment referral protocol for pregnant women under MO HealthNet Managed Care. CSTAR offers clinical services, living arrangements, and support services tailored for each member, including screening, assessment, diagnosis and the development of an individual plan of care. CSTAR may also provide recovery and outpatient services in the member's community.

Progesterone Treatment (17P) Program
17P is used only for pregnant women who have had a history of preterm labor before 37 weeks and are currently pregnant. Women being treated with 17P receive weekly injections beginning after week 16 and before week 20 of gestation and continue through week 36 of gestation (or delivery).

Missouri Care collaborates with Kilgore's Pharmacy to allow providers to order 17P directly from the pharmacy. Kilgore's ships a one-month supply of four pre-filled syringes directly to

providers, which enables them to administer 17P in the office. In addition, Kilgore's has a nurse on staff who may administer 17P in the pharmacy, if needed. Missouri Care's perinatal case manager and senior medical director have also hand delivered 17P to providers' offices to accommodate long weekends and avoid supply issues. We do not require prior authorization for 17P treatments.

Rosebud Program

This program assists Missouri Care with improving health outcomes and reducing costs associated with high risk pregnancies and infants. Working in collaboration with Missouri Care's perinatal case managers, the Rosebud case manager provides education and support to high risk pregnant members to identify and treat complications. The program has resulted in fewer preterm deliveries and fewer high risk infants. Our partnership with the Rosebud Program generated potential NICU (Neonatal Intensive Care Unit) savings of approximately $188,674 in CY 2008.

Lutheran Family and Children's Services Program

This program works collaboratively with Missouri Care's perinatal case managers to improve the health outcomes of high risk pregnant women. Lutheran Family and Children's Services is a non-profit social service agency in Columbia, Missouri with social workers and nurses who provide case management services, including supportive counseling, childbirth preparation, mentoring, parenting skills, behavioral health screening, housing assistance and domestic violence protection, among others. The organization makes home visits along with providing nutritional/dietary counseling and even referrals for childcare when needed to support the high risk mother. Missouri Care coordinates activities with Lutheran Family and Children's Services during our bi-monthly case management meetings as part of our ongoing effort to improve member health outcomes and avoid costly NICU admissions.

Intrauterine Growth Restriction (IUGR) Quality Study

A Missouri Care OB case manager teamed up with medical students to research the potential benefits of managing IUGR in an outpatient vs. inpatient setting. Their conclusion, published in *Modern Physician,* found that IUGR could be effectively managed in an outpatient setting. The University Hospital and Clinics subsequently adopted this policy and Missouri Care's high risk inpatient days per/1,000 have decreased from 54/1,000 in 1999 to 24/1,000 in 2008.

Integrated Case Management Model

Unique among health plans, and supported by our extensive experience, Missouri Care's care model recognizes that members frequently have behavioral and social issues that complicate their medical care. The model is based on an integration of all of the members' needs. The approach to case management focuses on total member health and well-being using the critical components of behavior change, relationship building, and engaging community and social systems that wrap around the member to enhance member resiliency and self-efficacy. The case managers holistically assess members as they present or are identified, including all elements that may impact their health status. The tools and services assist members to decrease the need for unnecessary and invasive care and increase self-management skills to improve health and well being.

Following are Missouri Care's guiding principles for the integrated case management model:

- *Moving from disease focus to member focus:* Evaluating every member for physical, behavioral and social risks to their current and future health
- *Identifying and employing the most effective intensity of evidence-based, plan-covered systems and services:* Facilitating access to a continuum of services based on the intensity and complexity of each member's needs
- *Behavioral engagement for change:* Using a single point of contact to engage each member in a plan that addresses his/her critical physical, behavioral and social needs to promote resiliency, recovery and optimal self-management
- *Teaming with the member and care providers to enhance care outcomes:* Work as an interdisciplinary team that combines core competencies in physical and behavioral health within a systems framework to manage psychosocial complexity and challenging relationships with members and their families
- *Collaboration with plan sponsors to influence benefit design that supports our model:* Focus on coordinating and integrating fragmented services into a system of care that addresses each member's individual needs within the context of their family and cultural community

Missouri Care assigns an interdisciplinary team, including both a physical and behavioral health case manager in the management of members with complex, comorbid physical and behavioral health issues. One primary case manager from the team serves as the member's single point of contact. The plan's fully integrated management information system enables case managers to analyze pharmacy and physical and behavioral health information to support care planning decisions. The physical and behavioral health case managers have access to the same case management data system and documentation.

To support case management activities, Missouri Care uses two hallmark tools, Predictive Pathways™ and CaseTrakker™. Both are integral components in identifying and managing members.

Predictive Pathways™

Missouri Care uses Predictive Pathways™ to identify members who would benefit from enrollment in case and disease management programs (i.e., members for whom we can improve clinical and financial outcomes). The application *prospectively* identifies members who are at risk of becoming high cost or who present opportunities for improved health outcomes, consistent with evidence-based clinical guidelines.

Through Predictive Pathways™, case and disease managers have access to information from critical sources such as medical claims, authorizations, pharmacy and behavioral health data including markers that predict both a member's risk and opportunities for intervention. Using these markers, case managers have instant access to a ranking system for every member that reflects both the level of risk and potential opportunity for improvement.

To accomplish this, Predictive Pathways™ sorts and analyzes the following information:

- Claims history
- Pharmacy records
- Clinical and available laboratory data

- Demographic information
- Variances from evidence-based guidelines
- Diagnostic categories

Predictive Pathways™ uses an empirically sound database to identify members based on the following indicators:

- Patterns of care for chronic conditions (i.e., over-and-under utilization of services)
- Physical, behavioral health or substance abuse conditions
- Hospitalizations
- Readmissions within 30 days of discharge
- Conflicting or potentially unsafe drug therapies
- Comorbidities (behavioral or physical) which may compound a primary condition and increase future health care risk

Predictive Pathways™ funnels this information into an online member profile. The member profile enables case and disease management staff to access a concise, rolling 12-month view of the member's health care utilization activity, including all hospitalizations, urgent care and emergency department visits, as well as pharmaceutical records. Predictive Pathways™ also acts as a tool to support the facilitation of care coordination between all medical management functions (concurrent review, prior authorization, and case management).

CaseTrakker™

To support case management and assessment process, Missouri Care uses CaseTrakker™, a customized care management tracking application. CaseTrakker™ stores and retrieves member assessments and care plans and triggers pre-defined actions for care coordination. For example, if a member indicates during an assessment that he/she is not taking medications as prescribed, the system will auto-generate a care plan intervention to educate the member about the importance of his/her medications as well as an outreach to the provider to do the same.

Together, Predictive Pathways™ and CaseTrakker™ enable Missouri Care's case management staff to identify members with conditions *prior* to the onset of a significant future medical event. This can include existing members who receive a new diagnosis (e.g., cancer, chronic pain, HIV/AIDS). These tools provide a state-of-the-art foundation for our case management activities, including:

- Gathering the results of member questionnaires that address physical and behavioral health conditions, including complex comorbidities
- Identifying the predicted risk that the member faces given the member's condition(s) and changes over time
- Developing the member's individualized care plan, which coordinates and integrates physical and behavioral health care activities for both covered services and those available through other sources (e.g., community resources and state agencies)
- Monitoring an up-to-date record of the interaction between case managers and members/caregivers, providers and other supports (e.g., community resources, external case managers)

- Analyzing the member's historical and current service utilization, including physical and behavioral health and pharmacy

Specifically, these applications enable our case managers to perform the following functions:

- *Coordination of care*, including:
  - Detecting inappropriate patterns of care (e.g., over- or under-utilization of services, including pharmacy)
  - Identifying diagnoses or multiple comorbidities that place members at risk for serious consequences
  - Providing immediate support to members in need in order to reduce inappropriate care
- *Monitoring compliance with treatment protocols*, including:
  - Untreated comorbid conditions (missed opportunities)
  - Gaps in care, such as a failure to fill prescribed medications or get a flu shot based on evidence-based guidelines
  - Use of medications that are less than optimal for chronic conditions (e.g., rescue medication for Asthma when controller medications would be more optimal)
- *Provider education*, including:
  - Providing evidence-based clinical guidelines
  - The provision of preventive screenings and treatments
  - Distribution of member-specific utilization summary profiles
- *Tracking and trending quality measures*, including:
  - Verifying that emergency and inpatient hospital services are appropriately used
  - Ensuring post-hospital discharge services are adequate, including medication regimen
  - Reducing unnecessary inpatient readmissions
  - Preventing inappropriate use of the emergency department (ED)
  - Integrating pharmacy data with other information sources to achieve effective care coordination

The Case Management Department provides a mix of case management specialties to ensure that members receive comprehensive, quality services. We place an emphasis on training. In 2008, each Missouri Care case manager was required to attend 12 "core biopsychosocial" trainings that provided additional insight into the foundation for the integration of managing the physical and behavioral health needs of members. Additional value-added trainings are provided each year of their employment to continually reinforce Missouri Care's integrated case management program. In 2009, we will present six new value-added trainings in addition to these core trainings.

Identifying the Right Members for Case Management

Missouri Care's Case Management program is available to all enrolled members as determined to be medically necessary. We identify potential candidates for enrollment in case management through the following processes and strategies:

- Predictive modeling, as described above
- Information provided through enrollment counseling
- Information provided from the state health risk questionnaire

- Internal and external (e.g., waiver programs) MO HealthNet referrals, screenings of members, including Welcome Calls, prior authorization, concurrent review and prevention and wellness outreach activities
- Referrals from our network of providers, MO HealthNet, advocacy groups, schools, community-based organizations, as well as members and their families

By employing the identification strategies above, staff are able to successfully identify, at a minimum, those members whom the State requires be offered or assessed for case management such as:

- Pregnant members (including those with substance abuse issues)
- Children under age six with elevated lead levels equal to or above 10 mg/dL
- New members with specific diagnosis or existing member who receive a new diagnosis (e.g., Cancer, cardiac disease)
- Children with special health care needs including those with autism spectrum disorder
- Members experiencing certain events that put them at risk (e.g., high ED utilization for physical and/or behavioral health conditions, residing in foster care placement)
- Members admitted to a psychiatric hospital or residential substance abuse treatment program

Care Planning

Following the identification and assessment process, Missouri Care's case managers work collaboratively with the member, the member's caregiver, PCP, specialist providers and other stakeholders, as appropriate, to tailor an individualized care plan including mutually agreed upon short- and long-term goals.

Missouri Care recognizes that the success of the Case Management Program is dependent upon the effectiveness of the care plan, the member's level of motivation and the ability to monitor and evaluate the care plan on both an individual and programmatic level.

Missouri Care's case managers regularly evaluate care plans to assess their effectiveness and to provide feedback to the member, the member's caregivers and his or her health care home. The objective of this process is to determine the level of compliance with the care plan and the degree to which the member is attaining mutually agreed upon goals. The evaluation process incorporates a certain degree of flexibility because a member's situation and needs often change. The process also considers the member's stage of readiness to change and covers the spectrum of his/her physical and behavioral health and psychosocial needs.

Case managers conduct care plan evaluations at varying intervals, depending on the member's individual circumstances and intensity of care management.

Member Education – Krames On-Demand Consumer Health Information

Missouri Care will implement Krames On-Demand for use by our case management staff in 2009. Krames is a tool for providing member education specific to understanding the disease and process, as well as the importance of preventive services.

Krames is a nationally recognized provider of consumer health information products and services. The company is known for its collection of patient education materials called "HealthSheets," containing colorful graphics and easy readability levels in 37 specialty areas. Currently, more than 4,400 single-topic HealthSheets are available on numerous conditions, procedures, medications, self-care instructions and health prevention information. This extensive library of evidence-based, peer-reviewed information was written specifically for individuals with low health literacy and covers diseases and conditions, diagnosis and treatments, surgeries and procedures and wellness and safety for people of all ages and walks of life. The HealthSheets are available in 10 languages.

Missouri Care's care management staff will use Krames On-Demand to generate customized health information folders that address the specific needs of individual members, in accordance with their care plans.

Members and providers will also be able to access the entire Krames On-Demand library through a link on the Missouri Care web portal. The content and functionality of the Krames On-Demand library will be presented to the Missouri Department of Social Services, MO HealthNet Division for review and approval prior to making it available to our members.

Case Management Closure

There are a number of circumstances that can lead to the closure or termination of a member's enrollment in case management, including:

- Achievement of the goals included in the member's care plan, including stabilization of the member's condition, establishment of effective links to needed community supports and education, and improved member health
- The member requests to disenroll from case management or Missouri Care
- The member fails to comply with recommended treatment guidelines (e.g., keeping scheduled appointments, complying with medication regimens, etc.), following at least three attempts to engage the member and the member's caregiver. Examples of such efforts include attempting to contact the member and/or caregiver before, during and after regular working hours, sending letters with an address correction request and checking with the member's PCP, pharmacist, WIC provider, etc.

Missouri Care also reviews all cases for closure from prenatal case management 60 days after delivery. As appropriate, PCPs and other involved providers are notified that the member is no longer participating in our case management program.

DISEASE MANAGEMENT PROGRAMS

Missouri Care's care management programs encompass its' parent company, Schaller Anderson's, NCQA certified disease management programs for Asthma, Diabetes, Congestive

Heart Failure (CHF) and COPD. The disease management programs for Diabetes and CHF include management of depression and obesity, since these frequently present as co-occurring disorders for persons with these types of chronic conditions. New for the 10/1/2009 state contract is a stand-alone Depression disease management program. All disease management programs recognize: 1) health literacy, 2) ethnic and cultural disparities in care, and 3) linguistic issues that may impede the treatment and management of a member's medical conditions. The programs aim to reduce the frequency and severity of exacerbations caused by one or more chronic conditions.

Schaller Anderson developed these disease management programs based on Medicaid population disease prevalence, including comorbid conditions, and the ability to intervene effectively to improve patient outcomes. The approach combines member education, member self-management, and evidence-based practice guidelines with established metrics to monitor provider compliance with those guidelines.

Schaller Anderson's disease management programs promote productive interactions between active and engaged members (as well as their caregivers) and a prepared team of health professionals with the goal of delivering effective, timely, member-centered, efficient and equitable support. To achieve the aim of motivating and engaging members and preparing disease management staff to support their needs, the program places emphasis on providing self-management support, designing an effective delivery system, and enhancing decision support and clinical information systems.

Outreach and Education

Missouri Care educates members and providers about our disease management programs through a variety of strategies, including, but not limited to:

- Member Welcome Call
- Member Handbook and Provider Manual
- Member newsletters, bulletins and informational flyers
- Provider newsletters, bulletins and informational flyers
- Targeted member and provider mailings
- Outreach calls
- Missouri Care's web portal

Missouri Care also includes information about our disease management programs in the New Member Welcome Packet and during new member welcome calls. Members who have been identified as low risk and targeted for enrollment are sent a disease-specific mailing which outlines the program and its benefits. Members who are identified with elevated risk factors are contacted telephonically by disease management staff.

The objective is to enroll members in disease management as early in the development of the disease state as possible. To this end, an "opt out" enrollment methodology is used to automatically enroll identified members in the program unless they specifically request to be excluded.

Member Identification and Referral

Missouri Care utilizes Predictive Pathways™, a proprietary risk modeling application, to identify potential candidates for disease management.

In addition, Missouri Care employs a variety of other methods and tools to identify members who could potentially benefit from disease management, including:

- Member, family or caregiver referrals
- Provider referrals
- Referrals from community-based organizations and programs
- Referrals from Missouri Care's care managers, hospital concurrent review nurses, medical directors or discharge planners

Program Components

Schaller Anderson's disease management programs provide members with the following:

- Disease/chronic condition assessments and care planning
- Member education, including targeted member specific educational mailings, quarterly education mailings, individual member health profile, and a web site with access to searchable data for additional information and education (e.g., Medline Plus and Krames)
- Provider involvement, including notification of member enrollment, collaboration on goals and care plan, follow up on member appointments and compliance with care plans, sharing of individual member health profile, and web site access to searchable data for additional information and education (e.g., Medline Plus)

Interventions by Risk Level

Regardless of risk level, members enrolled with disease management receive:

- Introductory letter from the Disease Management Program explaining the program benefits
- Educational materials to improve members' health knowledge, including quarterly disease-specific newsletters that provide articles on living with disease conditions
- Access to the Aetna web site for program overview, educational materials, and clinical guidelines

Low-risk members also receive monthly health reviews through ongoing monitoring of claims (physical health, behavioral health and pharmacy) activity and other tools to confirm risk and appropriate program intervention level.

High risk members also receive:

- A Welcome Call from a disease management care coordinator, who answers questions, provides more information about the Disease Management Program, completes a short questionnaire and schedules a health history call with a disease management nurse
- An in-depth health history, including clinical information using a biopyschosocial foundation, by a disease management nurse

- Tailored educational materials designed specifically for the member's identified disease condition

- Outbound calls, scheduled based on member needs, to provide education, coaching and goal setting on self-care management, and assistance in resolving issues and/or barriers

In addition to the above, providers are notified of the member's participation and identified goals and are informed of the member's healthcare utilization through the member's health profile.

Disease Management Outcomes

A critical component of disease management programs is the ability to measure and report progress toward program goals and to make projections on the return on investment (ROI) for each dollar invested in disease management.

The financial return component measures the cost savings associated with changes in the mix of utilized services, based largely on the substitution of less costly, more appropriate settings and services in place of more costly options (e.g., ED). In 2006, our measured disease management programs realized a 2:1 ROI ratio; in 2007 that ratio increased to 2.4:1. This ROI is very consistent with the published literature and DMAA documents.

Performance Measures

Missouri Care is continually monitoring outcomes from the disease management programs. The health plan is also actively engaged in the identification of ways to measure the success of the program for the members enrolled. Missouri Care measures disease management outcomes through 1) cost savings, 2) member adherence to treatment plans, and 3) provider adherence to the clinical guidelines. Additionally, specific outcome measures by condition are monitored, including:

Diabetes	Yearly screening of the following: • HbA1c testing • LDL-C • Retinal eye exam • Nephropathy screening test or evidence of nephropathy • Rate of annual flu shot • Percentage of members on ACEI/ARBs
Asthma	• Use of appropriate medications for people with Asthma • Pharmacy adherence with controller medications • Rate of emergency room utilizations and inpatient hospitalizations for Asthma • Rate of flu shots

	• Percentage of members on controller medications
COPD	• Use of spirometry testing in the assessment and diagnosis of COPD • Number of ED visits made • Number of hospitalizations • Rate of flu shots • Percentage of members on bronchodilators
CHF	• Pharmacy adherence to ACEI/ARBs • Pharmacy adherence to Beta Blockers • Number of ED visits • Inpatient days (hospitalizations) • Percentage of members on ACEI/ARBs

Improvement Activities and Initiatives

Missouri Care's disease management experience has proven that simply treating an individual's primary diagnosis is seldom sufficient. The health plan has extensively researched the impact of multiple comorbid conditions on outcomes, and reviewed published information on national and international comorbidity trends. With Missouri Care's internal studies and those of national and international groups like AHRQ, NIH, AHA, CDC and the Dutch INTERMED, the health plan has identified certain critical clusters of comorbidities that closely predict longer-term health problems, especially respiratory (Asthma and COPD) and cardiac disorders. In addition, data on the co-occurrence of behavioral health conditions show an integral link to worsening physical problems and higher utilization.

BEHAVIORAL HEALTH CARE MANAGEMENT INCLUDING CASE MANAGEMENT

Behavioral Care Management

On August 1, 2004, Missouri Care integrated behavioral health and physical health services by bringing behavioral health management "in house." Thus began the provision of coordinated behavioral and physical health care to all members via a staff-based biopsychosocial model implemented across the provider network. The biopsychosocial model of care management, has successfully addressed the global picture of each unique member in a holistic manner. As a result, Missouri Care members demonstrate improved clinical outcomes and greater self-care.

For over a decade Missouri Care has worked to improve member access to behavioral health and substance abuse services and to integrate the management of behavioral and physical health care. Missouri Care's chief medical officer (CMO) and psychiatric medical director collaborate daily in evaluating ways to meet the needs of members with comorbid and/or complex conditions. By definition, complex means "inter-connected parts," which speaks to the need for comprehensive support of individuals experiencing difficult life circumstances as a result of both physical and psychosocial factors.

In SFY 09 Missouri Care's integrated care management efforts achieved the following outcomes:

- Increased utilization of behavioral health services by our members
- Enhanced member and provider understanding about the signs and symptoms of behavioral health conditions and substance abuse
- A larger network of behavioral health and substance abuse providers
- Out of 98 behavioral health providers, 97, or 99%, were compliant with appointment availability standards, and 91 behavioral health providers (93%) were compliant with standards for after hours accessibility. The health plan sent letters to non-compliant providers to address problem areas, and will conduct a follow-up survey in 2009.

Behavioral Health Utilization Review

To evaluate the individual needs of each member, Missouri Care employs a clinical model that fully integrates all co-occurring disorders into a single criterion set consistent with current best practices. In 2004, Missouri Care adopted the Level of Care Utilization System (LOCUS), developed for adults by the American Association of Community Psychiatrists (AACP) as the behavioral health clinical guidelines for determining medical necessity. For children and adolescents, Missouri Care uses the Child and Adolescent Level of Care Utilization System (CALOCUS).

LOCUS and CALOCUS identify six areas of service (Dimension I-VI) needs for assessment:

- Risk of harm
- Functional status
- Physical health, addictive and psychiatric comorbidity
- Recovery environment
- Treatment and recovery history
- Engagement

At the time of admission to an inpatient behavioral health facility, a care manager informs the inpatient provider of the member's recent utilization history, including:

- Psychiatric inpatient admissions
- Emergency room visits for the prior year
- Psychiatric outpatient services for the prior six months
- Medications for the previous 90 days

Discharge Planning

Discharge planning begins at the time of admission. If a member already has an established outpatient provider, the care manager, in conjunction with the facility-based discharge planner, arranges for post-discharge care to maintain the member's continuity of care. If the member does not have an established provider, the care manager arranges for aftercare based on need and availability. This practice has enhanced Missouri Care's ability to provide timely follow-up care for our members. The care manager also works collaboratively with the inpatient facility to

make sure the member is prescribed medications on the preferred drug list or that prior authorization requirements are met before the member being discharged.

Behavioral Case Management

Missouri Care makes case management services available to all eligible members as needed. Examples of the members we typically enroll in case management include those meeting the following criteria:

- Admitted to an inpatient psychiatric facility or residential substance abuse treatment program.
- Frequent emergency room visits for behavioral health related crisis
- Multiple providers without coordination of care (e.g., engaging in inappropriate utilization of pharmaceuticals)
- Repeated failure to comply with recommended treatment that resulted in two or more inpatient admissions in a six-month period
- Chronic suicidal, lethal or dangerous behaviors that could cause harm to self or others
- Previous or repeated suicide attempts
- Lack of support system; isolation
- Unable to navigate health care system without assistance
- Significant physical and behavioral health issues requiring coordination of care with providers to improve clinical outcomes
- Comorbid psychiatric and substance abuse disorders with a history of two or more relapses or hospitalizations with one year
- Discharged from court-ordered evaluation or court-ordered acute care episodes
- Substance abuse issues

To maximize the integration of members' care, an interdisciplinary team consisting of case managers with expertise in behavioral and physical health support management of members with complex, comorbid physical and behavioral health issues. Missouri Care's CMO and Senior Psychiatric Medical Director collaborate in managing the interdisciplinary team. A primary case manager from the team serves as the member's single point of contact. Important features of Missouri Care's case management approach include:

- Use of CaseTrakker™ for review and sharing of care plans and case management activities. The application also enables our case managers to electronically refer members between case management teams.
- Automatic case management enrollment of members who are hospitalized for a behavioral health or substance abuse diagnosis. Case managers arrange an outpatient follow-up appointment within seven days of the discharge date. The member's PCP is notified of recent hospitalizations, diagnoses, medications prescribed and aftercare arrangements.
- Case managers contact members within two business days of hospital discharge for a behavioral health or substance abuse diagnosis to determine if the member:
  - Is aware of his/her upcoming appointment
  - Needs assistance with obtaining medications
  - Needs assistance with transportation

- Missouri Care's fully integrated management information system enables case managers to analyze pharmacy and physical and behavioral health information to support treatment decisions. All case managers have access to the same case management data system and documentation.

Missouri Care's integration of physical and behavioral health services also encompasses the following medical management activities:

- Integrated case tracking
- Attention to social barriers and social support issues
- Integrated grand rounds for members who are enrolled in case management or who may be identified through case-finding to need case management
- Emergency department "high-utilizer" case management
- Use of quality indicators that address both behavioral and physical aspects of care
- Appropriate referral of members to and collaboration with programs administered by the Department of Mental Health, including Comprehensive Substance Treatment Abuse and Rehabilitation (CSTAR), Community Psychiatric Rehabilitation (CPR), Targeted Case Management (TCM) and home- and community-based waiver services

Case managers work with members and their providers to identify needed health services and facilitate referrals and follow up.

2010 Behavioral Case Management Goals

In the future Missouri Care plans to further enhance the integration of physical health and behavioral health services through fully implementing a biopsychosocial model of care. This will include taking such steps as:

Educating providers about Missouri Care's biopsychosocial model of care and how we can partner to provide optimal services to members. This will include:

- Distributing member profiles generated from Predictive Pathways™ to providers, as appropriate
- Evaluating the feasibility of co-locating physical and behavioral health services to provide members with "one-stop" shopping for their health care needs
- Developing "pay-for-performance" incentives for health care homes that serve members with complex health conditions requiring extensive coordination of care and advocacy for better clinical outcomes
- Providing psychiatric consultation to PCPs with questions about behavioral health issues
- Partnering with network hospitals to conduct an initial post-discharge screening prior to members leaving the hospital
- Educating PCPs to utilize PHQ9 Depression Screenings
- Initiating a 24-hour-a-day, 7-day-a-week behavioral health crisis line staffed by qualified behavioral health professionals

CLINICAL PRACTICE GUIDELINES

Missouri Care makes disease management practice guidelines available to health care professionals and encourages their use to improve the utilization of medications and treatments

proven to be effective in treating certain conditions. The disease management practice guidelines used by Missouri Care represent best practices and are based on national standards, reasonable medical evidence and expert consensus. Prior to being recommended for use, the guidelines are reviewed and approved by the CMO, applicable medical committees, network physicians and, if necessary, external consultants.

Disease management practice guidelines are reviewed at least every two years, or as often as new information is available. Disease management guidelines are made available to practitioners in the Provider Manual. Articles in the quarterly provider newsletter inform network providers when new guidelines and updates are available. Practitioners may request copies of guidelines at any time by contacting their provider representative or the Missouri Care office of the CMO.

CREDENTIALING AND RECREDENTIALING

The credentialing and recredentialing processes confirm the qualifications of health care professionals prior to their participation in, as well as on an ongoing basis once they become part of the Missouri Care provider network.

The objectives of the credentialing process are to:

- Maintain a fair credentialing process
- Obtain application information about a prospective participating health care professional's practice and background
- Verify applicable credentials with primary sources
- Obtain information from applicable sources about malpractice, sanction activity and felony convictions
- Complete verification of time-sensitive components within specified time frames
- Maintain the confidentiality and security of credentials files
- Include the chief medical officer and appropriate medical committees and oversight bodies in the credentialing process
- Meet the credentialing standards and requirements of applicable state and federal regulators and accreditation agencies

In SFY 09 Missouri Care approved 319 new providers and recredentialed 146 providers through the Credentialing and Medical Quality Management Committees. Of the providers seeking credentials in SFY 09, ACI presented six denials to the committee for initial credentialing. Two of these denials were upheld and four were approved after committee discussion. There were no recredentialing denials. Missouri Care also provided oversight of approximately 1,000 providers who are under delegated credentialing agreements. Missouri Care performed audits of its seven delegated credentialing organizations. No corrective action was taken for any of the delegates.

MEDICAL RECORD REVIEW

Missouri Care conducts medical record reviews as part of its annual HEDIS hybrid record review process and during the investigation of member quality issues. During the spring of 2009, Missouri Care reviewed more than 2800 records. The following trends were noted: providers are missing opportunities to provide well child services during routine and sick visits; prenatal and postpartum services were provided but not billed, and some postpartum visits were scheduled

outside of required timeframe. When problems are identified, providers are educated on an individual level and trends and areas for improvement are observed for future interventions.

SUBCONTRACTOR MONITORING

Missouri Care has delegated to designated subcontractors the responsibility for provision of pharmaceutical, dental, vision and medical transportation services to Missouri Care members. These activities meet the policies, procedures and contractual requirements of Missouri Care. These designated subcontractors shall fulfill their own quality assessment and improvement processes to ensure that Missouri Care members receive safe, quality services. They must also work with Missouri Care to provide member service satisfaction through continuous quality improvement. Missouri Care retains the oversight function for quality management. Although Missouri Care delegates the authority to perform the function, it does not delegate the responsibility for assuring the function is performed appropriately.
Missouri Care performs annual audits of its subcontractors, holds oversight meetings throughout the year, and submits a separate Subcontractor Oversight Annual Evaluation Report. Oversight outcomes and findings are noted in the following areas: 1) access/availability, 2) fraud and abuse, 3) grievances and appeals, 4) performance projects and measures, 5) encounter data, 6) prior authorization denials, and 7) timely payment.

In SFY 09 Missouri care monitored the following five subcontractors:

- Express Scripts, Inc.
- Crown Optical
- Doral Dental
- PREST
- Medical Transportation Management

Express Scripts, Inc. (ESI)

Express Scripts provides PBM services including but not limited to: Claims Processing, Eligibility Administration, Pharmacy Network Management, Mail Services, Rebate Management, Reporting Services, Formulary Support Services, Web Site access for members and Missouri Care staff, and Account Management Services. Missouri Care ended its partnership with ESI as of October 1, 2009.

Crown Optical

During SFY 2009, there was a increase in replacement glasses, beyond the contracted amount. Crown and Missouri Care worked on the expansion of the vision network for Missouri Care. Missouri Care and Crown Optical terminated their contract in October 2009.

Doral Dental (DD)

Missouri Care began partnership with Doral Dental, in September 2008. DD submitted encounters in a timely manner. Provider demographic data accurately shows all dental providers that are used by Missouri Care members. The Missouri Care network currently includes all providers. Ongoing updates are conducted on a monthly basis to compare additional providers and associated denied encounters.
In the coming year, Missouri Care and DD will roll out a program with PCPs to encourage dental exams.

PREST

PREST provides 24-hour services including precertification, concurrent, and retrospective review, standard or expedited appeals, disability review, medical necessity opinions and consultation. PREST reviews opinions and recommendations which are carefully considered, closely reasoned and directly responsive to the referral question(s). Each review determination is made on the basis of available information, development of additional information and discussion with the provider, if indicated. A report of the review outcome is relayed to the appropriate parties in a timely manner, following state and federal regulations and following URAC and NCQA standards. Missouri Care and PREST continue to work on improving communication between the two entities and in the coming year, PREST will explore providing Missouri Care with secure access to electronically retrieve completed reviews.

Medical Transportation Management (MTM)

MTM submitted encounters in a timely manner. MTM improved its issues with member 'no shows'. Members are notified that they have missed a transportation pick-up which has reduced subsequent 'no shows.' Complaint ratio remains steady at 0.13% which is the lowest complaint ration of all health plans served by MTM. In the coming year, MTM and Missouri Care will continue to work on completing a smooth expansion into the East and West regions.

Molina Healthcare of Missouri

Provider Satisfaction

MHMO contracted with The Meyers Group to conduct a provider satisfaction survey of 1000 providers within its network across all 3 regions (Eastern, Central, and Western) in an effort to receive feedback about their satisfaction with MHMO. A follow-up phone call with providers was instituted in an effort to complete the survey if a survey was not received through the mail. It is essential to obtain feedback from MHMO's providers in order to deliver quality service to its members. The focal point of the survey covers satisfaction in the following areas;

- Customer Service/Provider Relations
- Quality of MHMO of Missouri's Network
- Coordination of Care
- Utilization Management
- Quality Improvement
- Claims and Finance Issues
- Pharmacy and Formulary
- Overall Satisfaction

Composites/Attributes	2009	2008
Customer Service/Provider Relations	36.2%	37.8%
Network	28.7%	32.9%
Coordination of Care	30.6%	NA
Utilization Management	27.1%	25.9%
Quality Improvement	28.7%	28.8%
Claims	28.6%	31.4%

Pharmacy	18.2%	22.3%
Overall Satisfaction and Loyalty	82.6%	77.8%
Recommend to other patients	88.4%	82.4%
Recommend to other physicians	85.3%	80.2%
Overall satisfaction	74.1%	70.8%

Case Management

MHMO's concept of case management is a more intensive support or outreach to members with a variety of clinical conditions and/or social circumstances that, if left to self-management, may reduce the possibility of a positive outcome. The goals of the Case Management processes include, but are not limited to, improving patient care; improving health outcomes; reducing inappropriate inpatient hospitalizations; reducing inappropriate utilization of emergency services; appropriately reducing the total cost of health care; promoting improved education of providers and members as well as increasing self management of chronic medical conditions. Identification of participants for enrollment in case management comes from multiple sources. Examples of the sources are: member request, family or guardian request, PCP/Medical Home request or specialist request, the concurrent review process, pharmacy utilization data, emergency room (ER) utilization reports, Health Departments and other community agencies, state Special Needs reports, state health risk assessment reports, etc. Also, when a new member is enrolled with MHMO they receive a Welcome Call from the Member Services staff. During this conversation several questions are asked and Member Services may obtain information that would prompt a referral to case management for further assessment.

When a referral is received, all information pertaining to the member is reviewed to determine whether the member may be a candidate for case management services. If the case manager determines that additional information is needed, the nurse may contact the provider or member (parent/guardian) to further assess the member's needs. Based on the information received, a participant may be enrolled into case management and assigned to a specific case manager. MHMO assigns Case Managers based on the level of expertise necessary to effectively support the condition and/or circumstances being managed. The Case Manager is responsible for, but not limited to, communication across the health care team continuum; negotiating with providers when appropriate; facilitating, coordinating and documenting individualized treatment plans, health care services and/or community service resources.

Provider education on MHMO policies is supported in the day to day contact with the medical management team for such issues as preauthorization requirements, network access, benefit availability, policy for processing out of network referrals and the process to access case management staff and how to dispute a notice of action determination.

Patient education is recognized to be the responsibility of everyone within the medical management department. Verbal educational opportunities are supported by providing additional state approved materials and/or recommendations for access to information by the medical management staff.

MHMO has policies specific to the types of cases managed under the Case Management program for conditions such as, but not limited to, high risk obstetric (OB), lead, and special needs. The

case management policies refer to the severity of the clinical condition, clinical practice guidelines, benefits, and community services resources that promote the best outcome for the member. The Case Manager works collaboratively with the PCP, specialists and ancillary service providers to promote optimum outcomes for members.

The Case Managers work under the direction of and collaborate with the Department Manager and the Director of Medical Management. The Chief Medical Officer (CMO) is directly involved with the management of participants enrolled in case management. The Case Management team meets weekly with the CMO and as needed to evaluate the participants' needs, identify areas of opportunity and redesign and update interventions and goals as needed.

Disease Management Program

MHMO regularly monitors, analyzes and integrates internal sources of data in an effort to identify chronic conditions that are relevant to its membership, which may result in significant morbidity and mortality of its members. The goal is to improve clinical outcomes through continual, rather than episodic, care and to enable members to manage their symptoms optimally and improve their quality of life. The focus is to empower members with chronic medical conditions to share responsibility in their health care by adopting behaviors, which may prevent disease complications, increase compliance with physician guidelines, and provide preventive care, all of which are supported by nationally recognized evidence-based clinical practice guidelines.

MHMO has implemented the following six (6) disease management/health management programs:

- Diabetes
- Asthma
- Major depression
- Chronic obstructive pulmonary disease
- Cardiovascular disease focused on hypertension, coronary artery disease and congestive heart failure
- Obesity

Multiple sources are used to identify the eligible population for existing programs. They include:

- Member/family request
- PCP/Medical Home request
- Pharmacy claims data
- Encounter or paid claims
- Lab results
- Provider referrals
- Nurse Advice Line
- ER Utilization Reports
- Interdepartmental referral (Case Management, Member Services Department, Utilization Management)
- State health risk assessment report

- Health departments and other community agencies
- State health risk assessment report

When a member is enrolled in a disease management program their PCP is notified and will continue to be updated on an annual basis and as needed.

Once members are identified, disease management services are provided unless the member specifically requests to be excluded from the program. All known member data is considered to assist with the stratification process. Risk stratification results in member assignment into one of three risk levels: low, medium and high. The intensity of outreach efforts and education increases with each level of risk. Members requiring a higher level of intervention will be referred to Case Management for more intensive interventions. Upon completion of the disease specific assessment, the member is mailed a welcome letter and individualized educational kit to include items specific to the management of their condition.

Low Risk – Members receive an initial member mailing which includes an educational brochure and assessment for members to complete and return via prepaid envelope. Telephonic counseling is available at the member's request. Criteria are shared with the PCP, provider and the member as appropriate.

Medium Risk – Outbound calls from the Care Manager to members are performed to complete their disease specific assessment. Evaluation of member health status, medication compliance and general quality of life are components addressed in the development of member individualized care plans. Members in some health plans may receive a home health visit or environmental home inspection based on member need. Upon completion of the disease specific assessment, the member is mailed a welcome letter and an individualized educational kit that includes items specific to the management of their condition.

High Risk – Members screened by clinical staff or Case managers for case acceptance. Case Management staff will coordinate care for members that meet case acceptance criteria. Members that do not meet case acceptance criteria will be referred back to Disease Management (DM) for assessment and individualized care plan development. Upon completion of the disease specific assessment, the member is mailed a welcome letter and individualized educational kit to include items specific to the management of their condition.

Ongoing Contact Includes – Periodic telephonic outreach to assess member health status and continued learning/resource needs; frequency of outreach is determined by member risk status. Adjustments to individualized care plans are made as needed. Educational newsletters containing seasonal or **Healthcare Effectiveness Data and Information Set (HEDIS)-**specific messages are mailed to all participating members.

Six Month Assessment Includes – Care Manager reevaluates member's health status and general needs utilizing subset of questions from initial disease specific assessment. Review of recent utilization and pharmacy compliance will also be assessed to determine revisions to care plans as needed.

Treatment plans and processes are introduced to the member via written materials and DM team member conversations. The disease management interventions are all performed in a culturally appropriate method. This includes having multi-lingual team members. The treatment plans help ensure member compliance and address needs due to co-morbid conditions and psycho-social issues. Members in the DM program are assessed for referral to case management based on results of evaluations, available data and provider input.

Treatment plans are developed for each member in disease management through an assessment and planning process. Treatment plans are re-evaluated and adjusted as outlined in the original treatment plan and on a regular basis and to meet changes in the member's health care status. Members and providers are included in this process as their input is crucial in the planning process. Individualized treatment plans contain interventions that address condition monitoring, member adherence to the treatment plan, co-morbidities and condition-related lifestyle issues.

MHMO operates the disease management program as an opt-out program. Once a member is identified for a DM Program, the member is automatically enrolled. The member is released from DM only if they decline the service or ask to be released, lose eligibility in the health plan or their provider opts out on the member's behalf. Telephone counseling generally includes four to six calls within a six-month follow-up period. If no additional risk is identified, the member's record is put into a passive status, from which they receive newsletters a few times a year. MHMO DM continues to review administrative data to see that the member is doing well or to call on case management if the member needs further support.

Behavioral Health Care Management including Case Management
MHMO encourages its' mental health subcontractor to coordinate treatment services with the members' PCP. Case coordinators meet weekly for case conferencing and to develop follow-up plans as needed to assure coordination between behavioral health, substance abuse and physical health providers.

Clinical Practice Guidelines
Clinical Practice Guidelines are an integral part of MHMO's Case Management and Disease Management programs. MHMO uses clinical guidelines to evaluate the medical necessity of requested services and promote access to the most appropriate services at the most cost effective setting based on sound current clinical practices. Use of nationally based criteria promotes the consistent application of available benefits based on the individual circumstances and/or condition of the member.

These guidelines are reviewed annually or as needed and approved by MHMO's Utilization Management Committee (UMC) and Quality Improvement Committee (QIC).

The current clinical practice guidelines are available on Molina's web site at:
www.molinahealthcare.com

- Upper Respiratory Infection (URI) Clinical Practice Guidelines (CPG) – Adult
- Heart Failure
- URI CPG – Pediatric

- Hypertension (HTN)
- Adult Immunizations
- Missouri Blood Lead Testing
- Alcohol Abuse CPG-1
- Opiate Detox CPG
- Asthma
- Overweight and Obesity
- Bipolar CPG-1
- Preventative Pediatric Health Care
- Center for Disease Control Child Immunizations
- Schizophrenia CPG-1
- Child Bipolar CPG
- Tobacco Control
- Chlamydia Screening and Treatment
- Treating Depression Guidelines PCP
- Chronic Kidney Disease
- Comprehensive CPG
- Chronic Pulmonary Obstructive Disorder (COPD)
- Depression CPG-1
- Diagnosis and Evaluation of the Child with Attention-Deficit Hyperactivity Disorder (ADHD)

Credentialing and Re-Credentialing
MHMO maintains a credentialing program that identifies criteria for participation of licensed health practitioners, and the processes involved in selection, retention and termination of participating practitioners. MHMO‘s selection and evaluation process assures that providers available to serve MHMO members are qualified to perform the services members require and can work well within the delivery system that has been developed. MHMO‘s Professional Review Committee serves (PRC) as the approving body of providers to the network.

Primary source verification of credentialing applications is now performed internally through MHMO‘s Corporate Credentialing department. Cactus software is used to manage credentialing and recredentialing information. MHMO delegates credentialing to some of its subcontractors and larger provider groups. The Delegation Oversight Committee (DOC) and PRC provide oversight of the delegated function and ensure National Committee for Quality Assurance (NCQA) compliance.

Medical Record Review
MHMO requires medical records to be maintained in a manner that is current, detailed, organized and permits effective, confidential patient care and quality review. MHMO has a process to assess and improve, as needed, the quality of medical record keeping.

At the time of re-credentialing, MHMO conducts a medical record review of PCP‘s as indicated by the NCQA standards. Credentialing guidelines adopted by MHMO have been reviewed and approved by the PRC. The PRC considers medical record review reports with other criteria and

information about the practitioner when making recredentialing determinations. A medical record review is conducted for PCP‘s who have 50 or more MHMO members assigned.

In accordance with NCQA standards, MHMO ensures that the offices of all PCPs, OB/GYNs and all other high volume care practitioners meet MHMO‘s site review standards when a threshold of three (3) or more grievances have been filed by MHMO members. A site review is conducted within 60 days of determining the threshold has been met. MHMO assesses the quality, safety and accessibility of the office site where care is delivered to the MHMO members.

MHMO‘s Quality Improvement (QI) Department manages a medical record review program and routinely conducts medical record audits to ensure providers document all patient medical records, age 18 or greater, with respect to the existence or non existence of an Advance Directive. A random sample of medical records was audited on 97 providers who have members 18 years old or greater on their provider panel. 10 providers illustrated compliance with their initial audit, leaving 87 providers who did not submit proper documentation in accordance with advance directive. These providers were educated and provided with documentation modules on addressing advance directives in a member‘s medical record. Out of the 87 providers, 64 have submitted corrective action plans and/or documentation reflecting that advance directives is addressed in the medical record.

Subcontractor Monitoring

During the reporting period, MHMO subcontracted for the following services: pharmacy, mental health management, vision care, dental management and transportation management.

- Rx America, Inc. managed MHMO‘s pharmacy benefit.
    - Rx America was MHMO‘s primary provider of PBM services, specialty injectables, and formulary and rebate management
- MHNet provided mental and behavioral health and substance abuse services through network providers including psychiatrists, psychologists, social workers or other mental health counselors
- Bridgeport Dental provided covered comprehensive dental services, including diagnostic, preventive, ancillary, restorative, endodontic, prosthodontic and orthodontic services and oral surgery
- Medical Transportation Management managed a network furnishing non-emergency medical transportation services for eligible members
- March Vision Care provided routine vision and eye care services for eligible members under the age of 21 and limited routine vision benefits for members 21 and over

The subcontractors are required to adhere to the requirements contained in the state contract with MHMO. Oversight meetings with each subcontractor are held quarterly. Any noted deficiencies are addressed with the subcontractor through an action plan that details time frames and objectives. Information from the quarterly meetings is reviewed by the DOC.

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Rights and Responsibilities

The following information was taken from the MO HealthNet Managed Care health plans' SFY 2009 Annual Evaluations:

Blue Advantage Plus of Kansas City

Provider Complaint, Grievance and Appeal Management
Provider Complaints, Grievances and Appeals are processed in an organized and timely manner in accordance with the Provider Complaints, Grievances, and Appeals Policy and Procedures. The Policy and Procedures are consistent with the requirements of the Federal Government, State Government, and other regulatory entities. BCBSKC reviews and approves this policy annually.

BA+ continues to track and trend Provider Complaints, Grievances and Appeals, in accordance with the State of Missouri contract. Quarterly reports are submitted to the State. The results are presented to the BA+ Oversight Committee.

The following table lists the provider complaints, grievances, and appeals for SFY08 and SFY09 by complaint category.

	SFY08	SFY09
Provider Complaint		
Accuracy	45	0
Medical Necessity	71	70
Denial	110	51
Prior Authorization Process	57	52
Timely Filing	139	45
Reduncant/Subset	24	0
TOTAL	446	218
Provider Grievance		
Accuracy	0	0
Medical Necessity	9	4
Denial	3	9
Prior Authorization Process	8	4
Timely Filing	1	0
Reduncant/Subset	0	0
TOTAL	21	17
Provider Appeal		
Accuracy	0	0
Medical Necessity	2	0
Denial	1	0
Prior Authorization Process	0	3
Timely Filing	0	0
Reduncant/Subset	0	0
TOTAL	3	3

Member Grievance and Appeal Management
Member Grievances and Appeals are processed in accordance with the Member Grievance & Appeal Corporate Policy and Procedures. The Policy and Procedures are consistent with the requirements of the Federal Government, State Government, and other regulatory entities. BCBSKC reviews and approves this policy annually.

BA+ continues to track and trend Member Grievances and Appeals, in accordance with the State of Missouri contract. Quarterly reports and annual analysis are submitted to the State. The results are presented to the BA+ Oversight Committee.

The following table lists the provider complaints, grievances, and appeals for SFY08 and SFY09 by complaint category. For Member Grievances, transportation continues to be the main reason members file a grievance. The main reason members file appeals is due to medical necessity issues.

	SFY08	SFY09
Member Grievances		
Transportation	85	79
Appropriate Treatment	12	0
Medical Necessity	0	0
Provider Relations Issues	19	7
Cancellation	0	0
Denial	0	0
Office Staff	4	12
Appointment Problems	5	2
Total	125	100
Member Appeals		
Transportation	0	0
Appropriate Treatment	0	0
Medical Necessity	156	87
Provider Relations Issues	0	0
Cancellation	0	0
Denial	50	32
Office Staff	0	0
Appointment Problems	0	0
Total	206	119

PERFORMANCE MEASURES/ANALYSIS
Performance measures used to track Provider Complaints, Grievances, and Appeals and Member Grievances and Appeals are:

a. The timeframe for resolution of member grievances is 30 calendar days. The timeframe for resolution of member appeals is 45 calendar days.
    1. Goal is 95% compliance
    2. In FY2009, member grievances were 98% compliant and member appeals were 96% compliant.
b. The timeframe for resolution of provider complaints is 10 calendar days. The timeframe for resolution of provider grievances is 30 calendar days. The timeframe for resolution of provider appeals is 60 calendar days.
    1. Goal is 95% compliance for all categories (provider complaints, grievances and appeals).
    2. In FY2009, provider complaints were 92% compliant, provider grievances were 88% compliant, and provider appeals were 80% compliant.

Confidentiality
Protection of confidential information has always been of the highest priority at BCBSKC.

BCBSKC educates employees and requires each employee sign a confidentiality agreement at the time of employment and annually. The agreement states that employees have read and accept accountability for adhering to the Standards set forth in the Code of Business Conduct and Corporate Policy and Procedures regarding conflicts of interest and confidentiality, including Corporate Policy and Procedure I-4 Conflict of Interest, Corporate Policy and Procedure I-19 Privacy of Member Information, Corporate Policy and Procedure I-20 Confidentiality of Business Information (non-PHI), and related policies, and understand and agree that any violation of these Standards can lead to disciplinary action up to and including termination for cause where appropriate. Copies of the signed documents and monitoring for compliance are retained in the Human Relations Department.

Another part of confidentiality is making sure the information that is retained or transmitted is protected and secure. In 2005, BCBSKC implemented provisions of the HIPAA Security Rule.

BCBSKC continues to maintain compliancy with these rules through our Corporate Privacy and Security Office functions including among other efforts, training on HIPAA accountabilities, monitoring of privacy and security practices, reviewing and updating existing procedures and responding to member‟s rights for requests and authorizations.

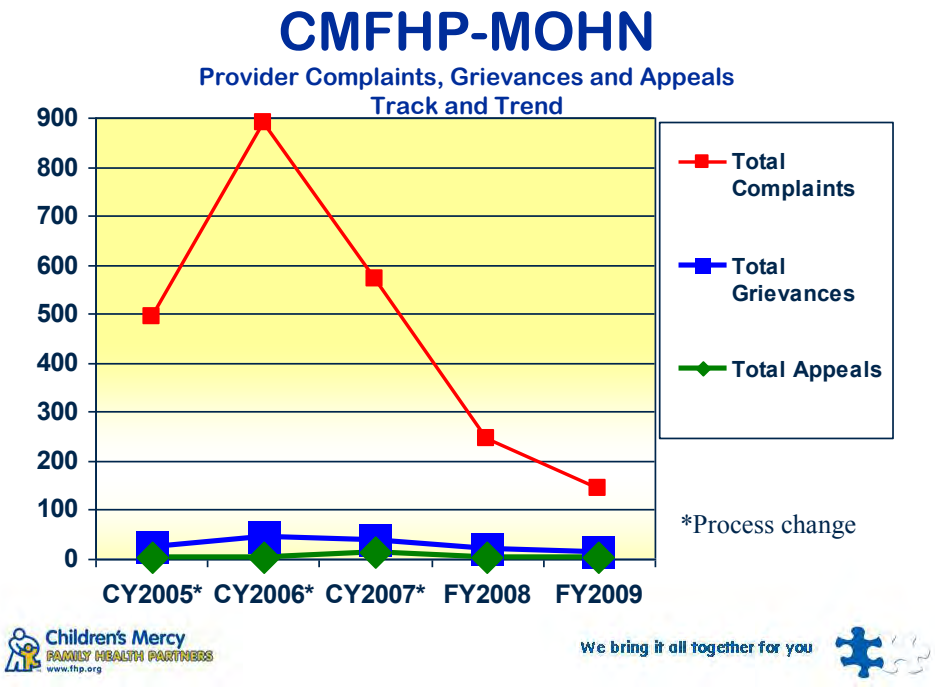
Children's Mercy Family Health Partners

Provider Complaint, Grievance and Appeal Management
Children‟s Mercy Family Health Partners (CMFHP) recognizes the importance to providers of having available effective complaint, grievance and appeal mechanisms in the event that they do not agree with a health plan decision. CMFHP offers these mechanisms to address, for example,

potential disagreements regarding medical necessity, denials of services, changes in services, or claim payments.

Since 1997, CMFHP has coordinated the program‟s evolving complaint, grievance and appeal service delivery requirements similar to those described in the Request for Proposal.

Data and Trends



Provider complaints, grievances and appeals were received and resolved promptly and within required timeframes. The provider complaints have consistently decreased since 2005 with improvement processes. Complaints decreased 84% from 2006 to the end of the fiscal year 2009. Grievances have decreased 72% from 2006 to the end of the fiscal year 2009 and appeal rates are consistent within the range.

Analysis
CMFHP‟s provider complaints and grievances decreased as result of internal process changes that clarified coding and cosmetic coding denials.

CMFHP‟s provider appeals are consistent across the tracking timeframe. One aberrant year is noted in 2007.

Strengths
CMFHP has an established and consistent grievance and appeal process for tracking and resolution.

Weaknesses
CMFHP identified no weaknesses within this process during the reporting period.

Opportunities
CMFHP uses the analysis of complaints, grievances and appeals as a mechanism to identify areas for improvement. Complaints, grievances and appeals are grouped by category and prioritized. Actions are then developed to reduce complaints, grievances and appeals related to the identified issue.

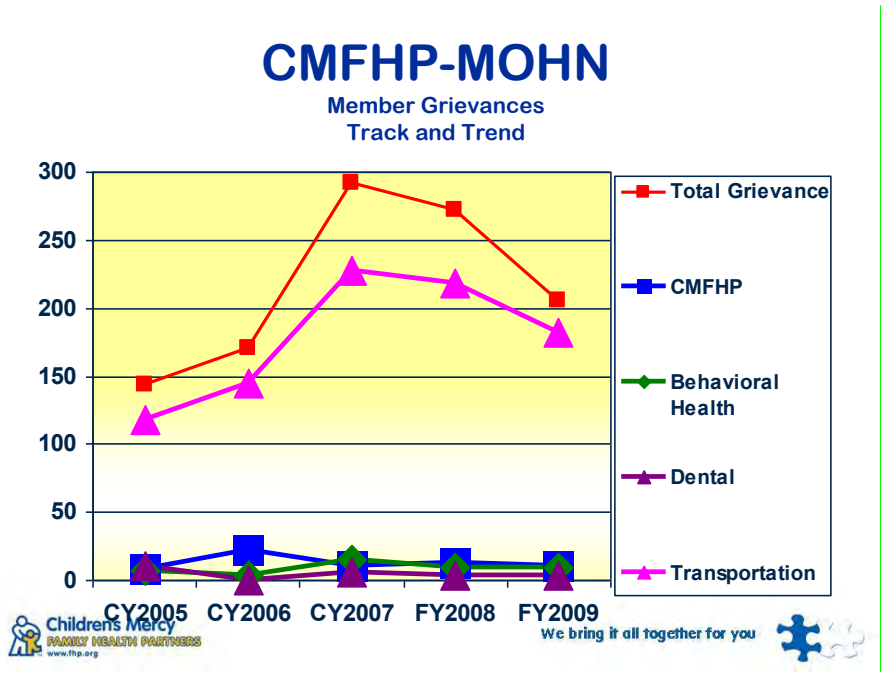
Since 2000, CMFHP has tracked and trended complaints, grievances and appeals received. Children"s Mercy Family Health Partners did not implement any new initiatives during the current reporting year July 1, 2008 through June 30, 2009, but monitored the rate of complaints, grievances and appeals. No new issues merged.

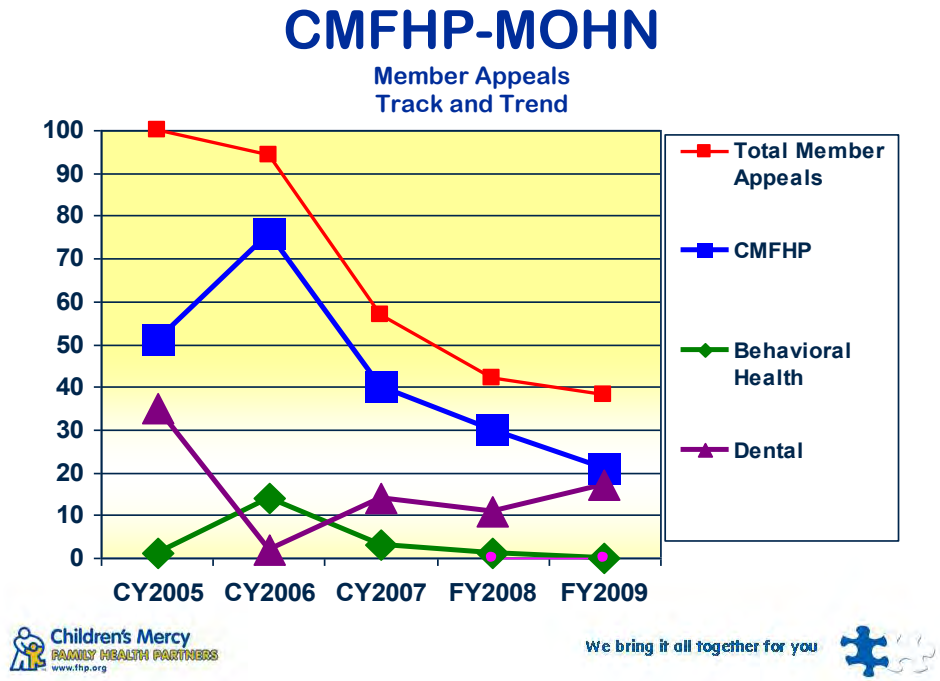
Children"s Mercy Family Health Partners continues to monitor the effectiveness of the complaint and appeal activities and works to identify additional initiatives that will result in process improvement. CMFHP will monitor the new requirements for complaint and appeal activities in this next fiscal year.

Member Grievance and Appeal Management
Children"s Mercy Family Health Partners (CMFHP) recognizes the importance to members of having available effective grievance and appeal mechanisms in the event that they do not agree with a health plan decision rendered on their behalf. CMFHP offers these mechanisms to address, for example, potential disagreements regarding medical necessity, denial of services, change in services, or claim payments.

Since 1997, Children"s Mercy Family Health Partners has coordinated the program"s evolving grievance and appeal service delivery requirements similar to those described in the Request for Proposal.

Data and Trends





Member grievances and appeals were received and resolved promptly. The member grievance and appeal rates decreased over time.

Analysis
CMFHP"s member grievances are decreasing overall. Transportation continues to be the most frequently reported member grievance. CMFHP"s member appeals are decreasing overall.

Strengths
CMFHP has an established and consistent grievance and appeal process for tracking and resolution.

Weaknesses
CMFHP identified no weaknesses within this process during the reporting period.

Opportunities
CMFHP uses analysis of grievances and appeals as a mechanism to identify areas for improvement. Grievances and appeals are grouped by category and prioritized. Actions are then developed to reduce grievances and appeals.

Since 2000, CMFHP has tracked and trended grievances and appeals received. In the reporting period July 1, 2008 through June 30, 2009, one issue emerged as high volume: member grievances for transportation. No issues emerged as high volume appeals. To address these findings and decrease the number of grievances received relating to transportation, Children"s Mercy Family Health Partners identified the following interventions:

- Tracking and trending of member grievances regarding transportation: Resulted in a total of 205 transportation grievances

- Continued customer service outreach to members on the "did not show" list.

Since the implementation of these grievance and initiatives, CMFHP has been able to improve various health plan services to the benefit of all members.

- The transportation member grievances reported to Transportation Subcontractor Quarterly meetings resulted in a subcontractor change in 2007. Ongoing tracking and trending of transportation grievances resulted in a health-plan performance improvement project. The current transportation provider continues to provide increased coordination and responsiveness. Analyses from the quarterly meetings and grievance tracking demonstrated a twenty-seven percent (27%) increase in utilization of transportation services and a twenty percent (20%) decrease in overall transportation related member grievances from fiscal year 2008 through fiscal year 2009.

Children"s Mercy Family Health Partners continues to monitor the effectiveness of grievance and appeal activities and works to identify additional initiatives that will result in improvement.

Confidentiality
At the time of employment, Children"s Mercy Family Health Partners employees are required to sign a Confidentiality Agreement. This agreement is maintained in the employee"s Human Resource file. The Confidentiality Agreement, in conjunction with the Code of Conduct and other Compliance Policies, provides the employee with guidelines which represent the corporation"s commitment to ethical behavior and actions, including the employee"s responsibility to ensure confidentiality of member, provider and plan information.

All CMFHP employees are required to complete HIPAA annual training online. Each employee also received education and training on privacy and security of data during the company"s new employee orientation. Confidentiality issues are also covered during annual compliance training, which is mandatory for all employees.

The Compliance Officer provides articles for the employee newsletter, *In the Know*, on a regular basis regarding privacy and security related issues. In addition, employees have access to the Hospital"s Compliance department newsletter on the Hospital Intranet which hosts additional resources and information regarding privacy and security.

Harmony Health Plan of Missouri

Provider Complaint, Grievance and Appeal Management
Member Grievance and Appeal Management
Organizational Structure
The Appeals team is proactively determining how they can better assist members via improved Appeals processing, as well as stronger control points to ensure compliance with all state and federal regulations and contracts.

Scope and Methodology

Project – Enhanced Training

Analysis – Decentralized triage and staffing model for handling Appeals, which resulted in limited staff experience and knowledge of specific LOB requirements.

Objective/Purpose – Create more accurate, comprehensive, and easy to use employee training materials, which includes job aids and workflows.

Implementation/Improvements – Appeals employees will be required to take and pass training with at least a 90% score annually. Additionally, Step Actions, Job Aids and Workflows are in the process of being revised and updated, with a target completion of November 2009.

Project – Added Management staff and Changed Management

Analysis – Staff required additional oversight, direction and coaching to maintain compliance. Appeals workers had also expressed a feeling of being dictated to by management. The workload of the department had a significant impact of this cultural issue.

Objective/Purpose – Added management staff and establish an "open-door" policy within new department leadership.

Implementation/Improvements – Added new nurse position dedicated to expedited appeals to maintain compliance in that area. A Director of Appeals position was also added to staff and a two supervisory positions had increased responsibilities added and changed to manager positions. Two newest leaders in the Appeals department, Senior Director of Health Services and Manager of Member Appeals have led the change in culture and tone of the department. The new management has introduced a style being approachable at all times, offering a confidential listening ear and creating a true team environment.

Project – Operationalize Department

Analysis – Metrics such as daily volumes, weekly goals and YTD trends are not common knowledge to department. Additionally, there is an absence of visually displaying the metrics for all to see and they are not driving daily activities.

Objective/Purpose – Create transparency and communication of all pertinent metrics pertaining to Appeals.

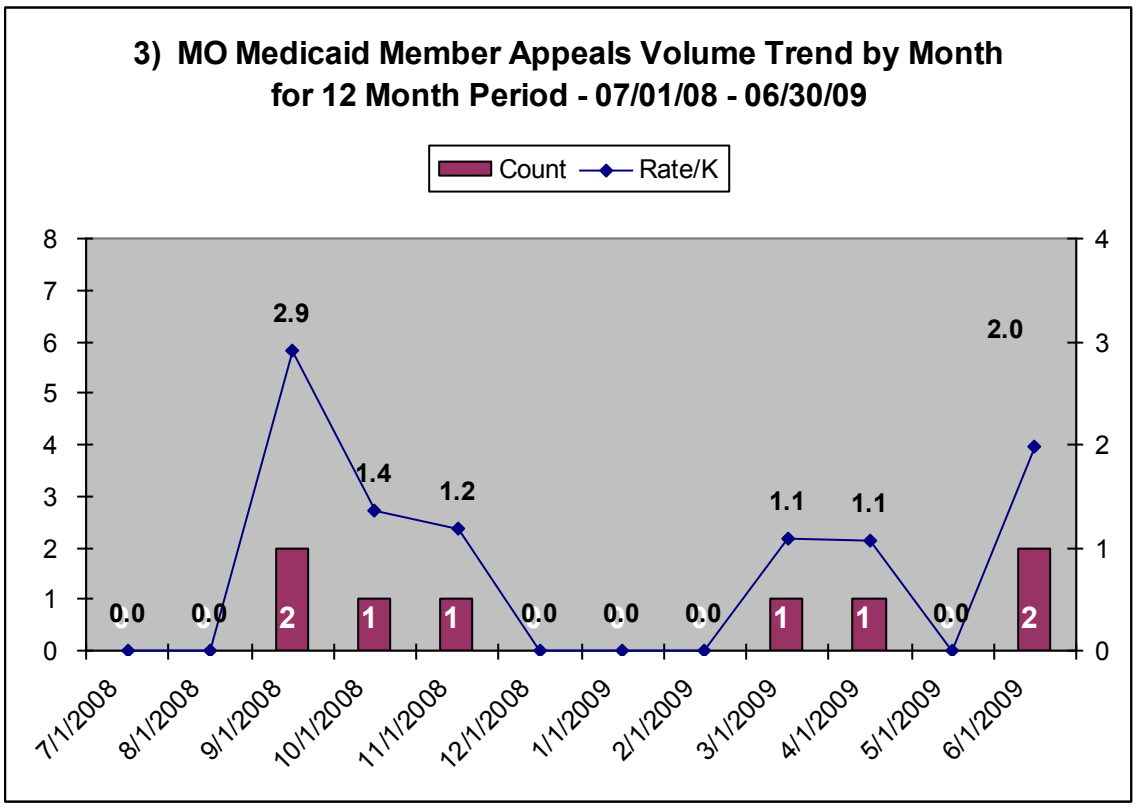
Implementation/Improvements – The Management team will develop new reports to show Appeals metrics and trends. They will create department Team Boards to display metrics for each department. Additionally, Department Managers and Supervisors will host daily stand up meetings with teams to review goals, trends and recognition.

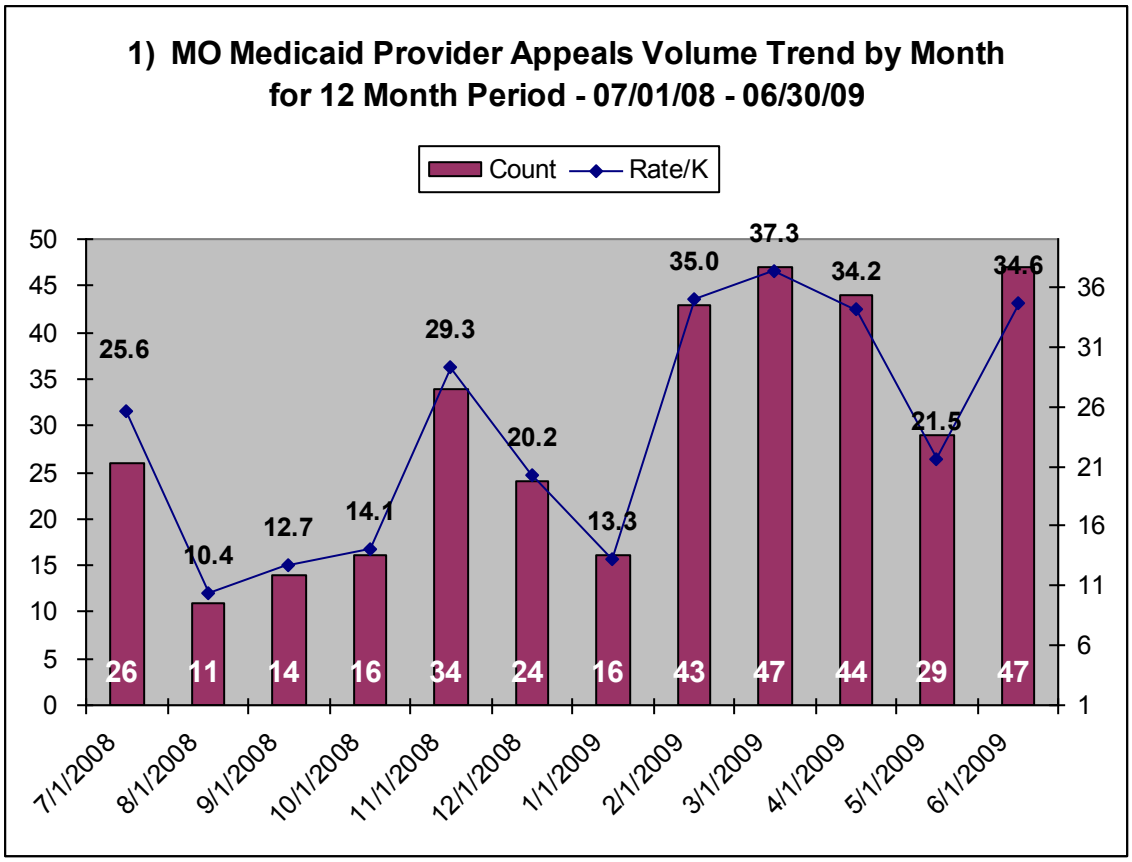
Additional Plans for 2009 – WellCare is in the process of evaluating several different options that will allow multiple departments to use a single system application for processing Appeals, Grievances, Claims and other correspondence. Target implementation is in 2010.

Analysis of Appeals Data

Volumes

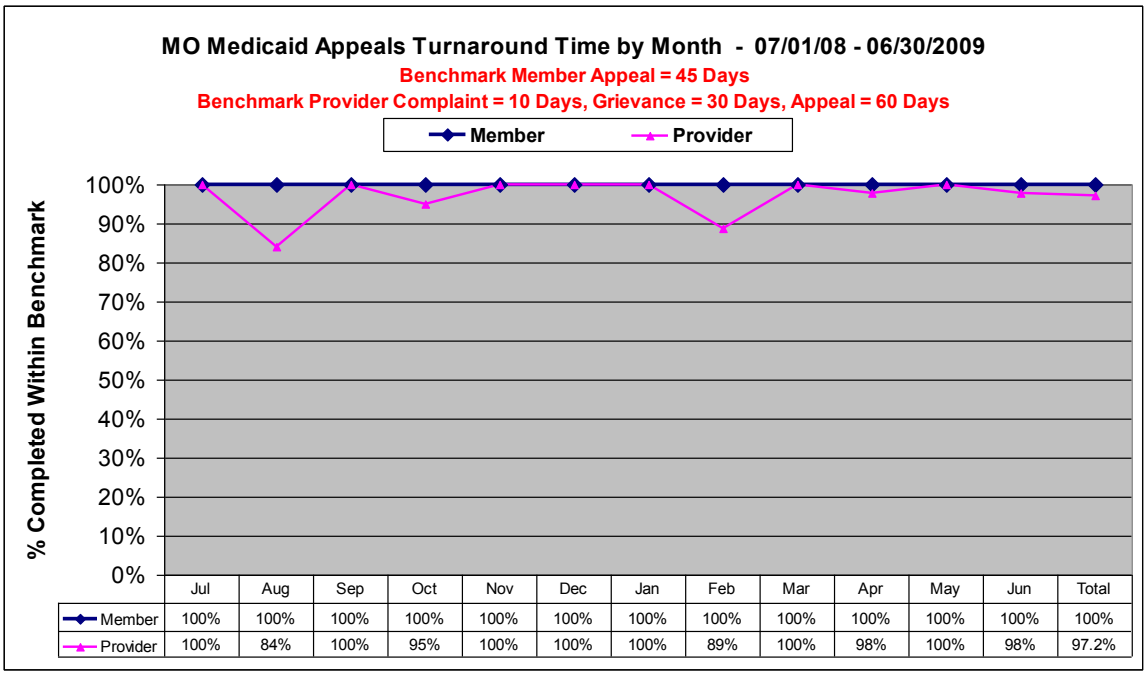
Member appeals only accounted for 8 of the 359 appeals for the year, or 2% of the total appeal volume. Member appeals were only .8 per thousand members. The vast majority of appeals received were from providers all were retrospective (the services have already been provided to the member). There were 351 provider appeals (either a 1st level Complaint, 2nd level Grievance or 3rd level Appeal) averaging 24 per thousand members over the year. See volume charts below.





Turnaround Time

The turnaround time goal is 45 calendar days for member appeals, 10 calendar days for Provider Complaints (1st level appeal), 30 calendar days for Provider Grievances (2nd level appeal) and 60 calendar days for Provider Appeals (3rd level appeal). For member appeals, 100% of the appeals were completed within the goal over the year. Across all provider appeals, an average of 97.2% of appeals were completed within the goal. Those provider appeals that did not meet the goal were largely a result of mis-routing between departments which should be addressed with a new appeals and grievances system in 2010. See turnaround time summary chart below.



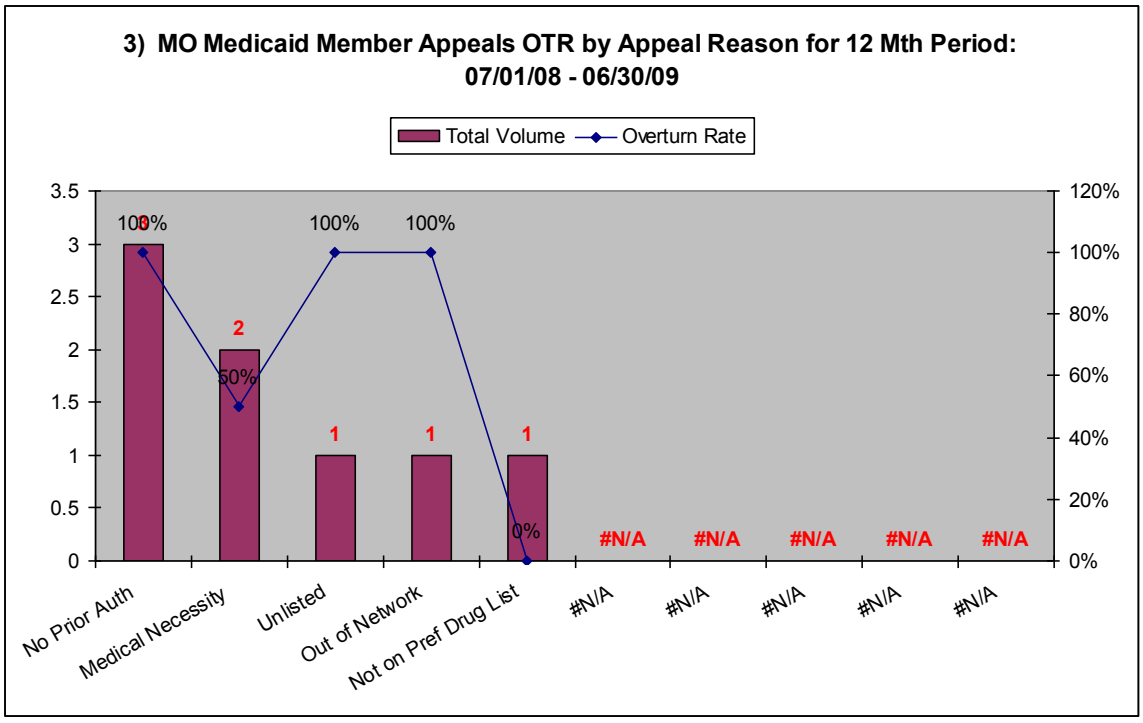
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total
Member	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Provider	100%	84%	100%	95%	100%	100%	100%	89%	100%	98%	100%	98%	97.2%

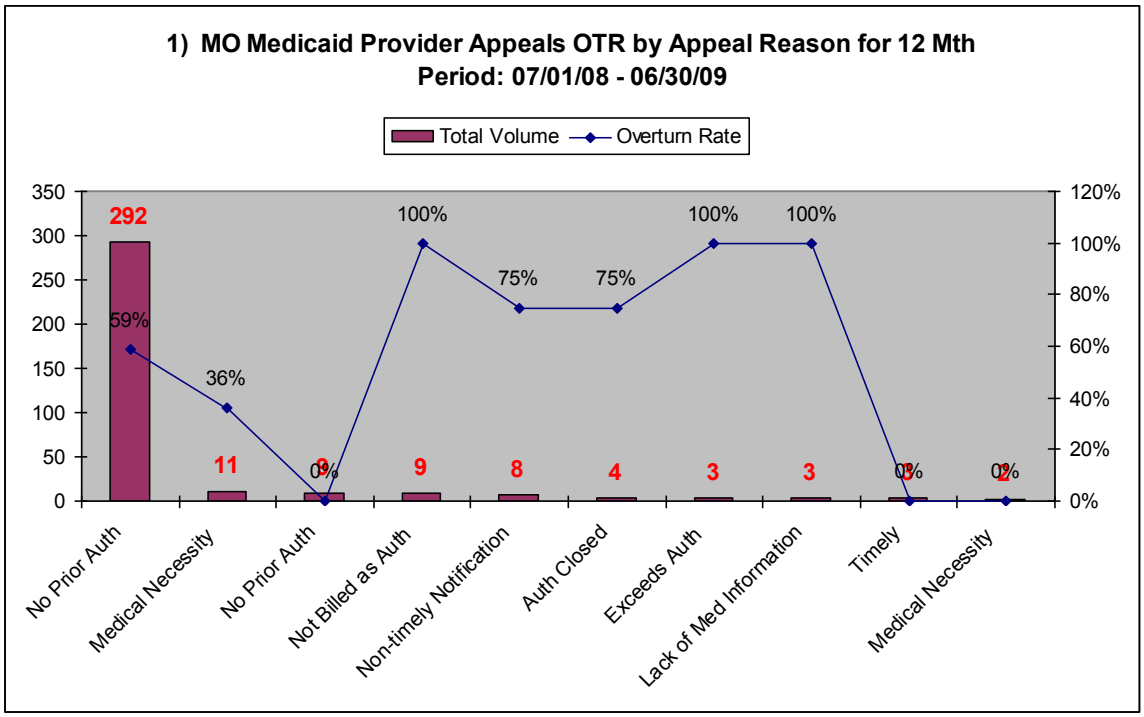
Overturn Rates by Appeal Reason and Service Type

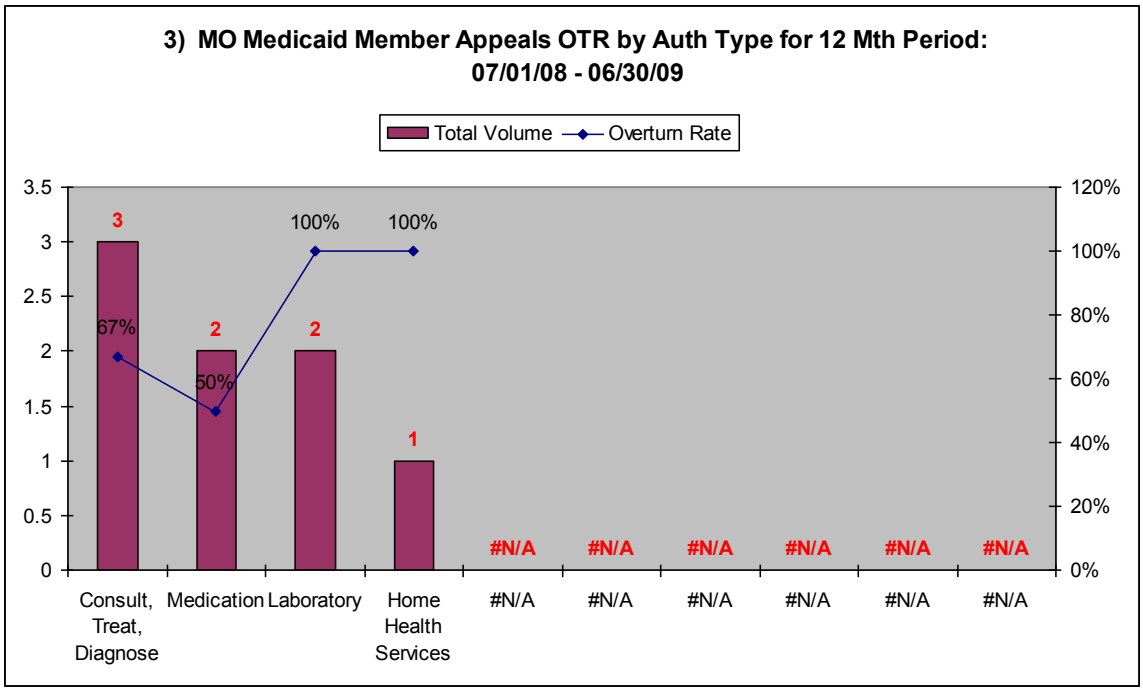
For member appeals, 75% were overturned. No prior authorization and medical necessity were the most prevalent appeal reasons with overturn rates of 100% and 50% respectively. The service with the most member appeals was Consult, Treat and Diagnosis (office visits) with a 67% overturn rate.

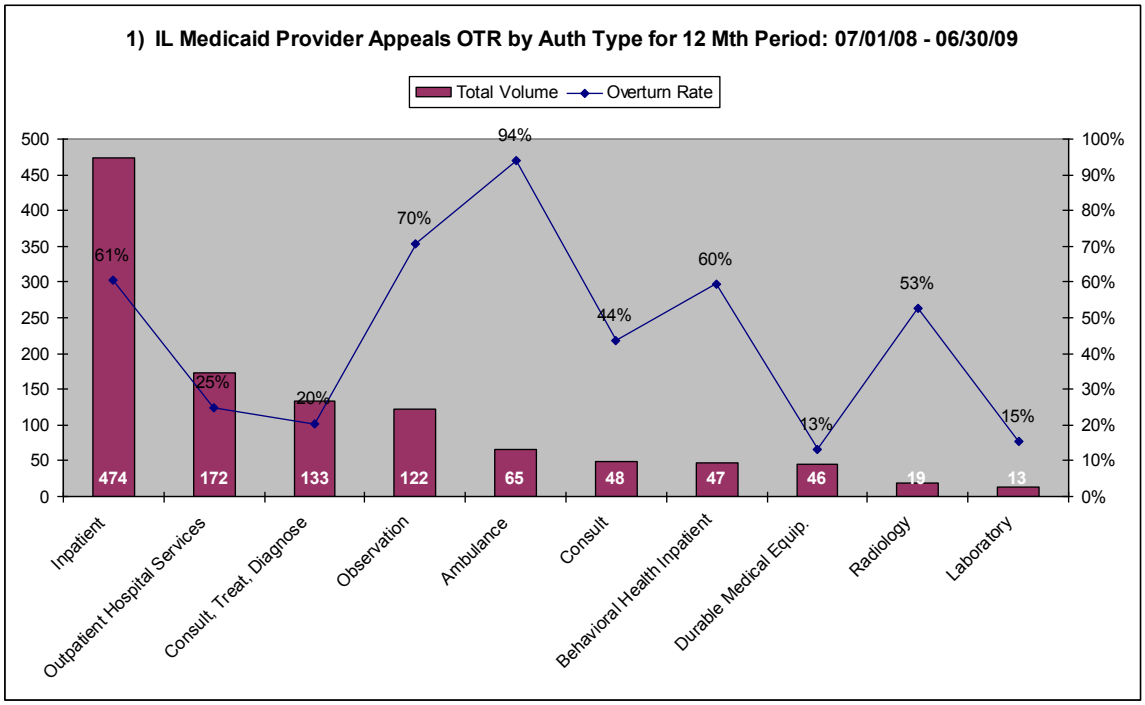
For provider appeals, 57.8% were overturned. No prior authorization (59% overturn rate) and medical necessity (36% overturn rate) were the biggest appeal reasons. The services with the most provider appeals were Inpatient (92% overturn rate) and Laboratory Services (17% overturn rate). The most prevalent reason for the overturns was additional medical information received with the appeal that was not available at the time of the original decision. Also, issues with timing of authorizations and claims processing and errors in claims processing were the next most frequent overturn reasons. See charts for overturn rates by appeal reason and service type below.

CUM 12 Mths		Total Vol.	Overturn Rate
MCD	PROVIDER	351	57.8%
MCD	MEMBER	8	75.0%


3) MO Medicaid Member Appeals OTR by Appeal Reason for 12 Mth Period: 07/01/08 - 06/30/09
Total Volume
Overturn Rate
3.5
3
2.5
2
1.5
1
0.5
0
120%
100%
80%
60%
40%
20%
0%
100%
100%
100%
0%
3
2
1
1
1
#N/A
#N/A
#N/A
#N/A
#N/A
50%
No Prior Auth
Medical Necessity
Unlisted
Out of Network
Not on Pref Drug List
#N/A
#N/A
#N/A
#N/A
#N/A


1) MO Medicaid Provider Appeals OTR by Appeal Reason for 12 Mth Period: 07/01/08 - 06/30/09
Total Volume
Overturn Rate
350
300
250
200
150
100
50
0
120%
100%
80%
60%
40%
20%
0%
292
11
9
8
4
3
3
59%
36%
0%
100%
75%
75%
100%
100%
0%
0%
No Prior Auth
Medical Necessity
No Prior Auth
Not Billed as Auth
Non-timely Notification
Auth Closed
Exceeds Auth
Lack of Med Information
Timely
Medical Necessity





Barriers

The few appeals that missed the turnaround time goal were sometimes due to preventable administrative errors and misrouting of appeals between departments which a better system may have prevented. We are in the process of developing a new, integrated system that will allow easy routing of misdirected appeal requests and prevent manual data entry errors. This is

expected to be implemented in 2010. Additionally the overturn rate is high and reporting enhancements and root cause analysis have been initiated.

Recommendations

- To improve coordination with other departments and to better automate and streamline appeals processing and improve turnaround time, develop and implement a new intake and appeals and grievances system in 2010
- To reduce overturn rates:
    - Develop quarterly reports for all appeals overturned and identify root causes in 4Q 2009
    - Work with the Utilization Management department to ensure that in authorization processing that the full allotted time to receive clinical information is given to providers to reduce appeal volume and overturns related to receiving additional medical information
    - Work with the Claims department to identify the most common claim denial errors and address them in the initial claims processing to reduce appeal volumes and appeals that will need to be overturned
- To ensure an even higher quality of appeals processing, review and improve all step actions and job aids that appeals staff use by 4Q 2009

Organizational Structure

The Grievance Department is comprised of two Teams, Medicare and Medicaid. The dedicated teams eliminate potential confusion around contract specific requirements for each product line that WellCare offers. This adjustment increases the ability to classify and route complaints correctly.

The primary purpose of the Grievance Department is to resolve any complaint or dispute, expressing dissatisfaction with any aspect of the operation‟s activities or behavior within the appropriate specified regulatory requirements.

The Grievance team is proactively reviewing how they can better assist members through faster and more accurate processing of Grievances and stronger controls to ensure compliance with all state and federal regulations and contracts.

Project – Internal Grievance Quality Monitoring Tool

Background- The Grievance Department conducts internal the Post Quality Audits to track progress in order to makes necessary adjustment to maintain the appropriate level of compliance. On a monthly basis, the quality auditor selects a case and validates case findings against the Quality monitoring definition tool to ensure all grievances are resolved according to the State and Federal grievance guidelines, such as case resolution as well as timeliness. This document provides grievance coordinators a clearer understanding of the audit elements for each product and allows for the appropriate focus on Medicaid grievance requirements

The quality auditor provides feedback/coaching directly to the grievance coordinator. If the quality auditor identifies an audit element that is often not met, the auditor will bring it to the supervisor"s attention. The supervisor reviews and discusses the findings with the coordinator on a monthly basis and implements remedial or disciplinary actions with that coordinator if the results do not improve and meet departmental standards in sufficient timeframes.

Objective/Purpose – To improve the quality of grievance case work and reduce repetitive errors.

Results – We are able to give "real time" coaching and feedback to the grievance coordinator. Implement new timing/correction and new procedures. The team scored an accuracy rate of 96% since inception of the tool.

Analysis – The criteria of the monitoring tool has evolved, by allowing the leadership team to add criteria as trends were identified.

Improvements –

- A revised organizational design of the department was implemented. Six senior coordinators were also assigned to the role of quality auditor with the responsibility of performing quality audits coaching, and identifying process improvements. This adjustment increases the ability to classify and route complaints correctly.

- Developed a quality definition document that separated Medicaid and Medicare grievance requirements.

- Staffing levels were increased; as a result, the average caseload per Grievance Coordinator has been reduced by two-thirds.

- WellCare engaged external consultants to observe Grievance Department and review all processes and procedures related to the grievance function.

- Increased focus on quality review via audit tool; Root Cause Analysis performed and remediation plans are developed after each audit, which are then shared in weekly "lessons learned" training with the Grievance team.

- Implemented weekly cross-functional departmental meetings in November 2008 with the Appeals, Utilization Management, and Corporate Compliance Departments to identify task owners and correct routing procedures for complaints received in the Grievance Unit that were not grievance complaints.

Project - Grievance Database

Background: The grievance process oversight was ineffective due the use of inadequate reporting. There were no inventory management tools or practices incorporated to monitor aging of grievance as they approached the compliance date. This led to the inability to consistently meet federally mandated timeframes. The daily reports failed to detail when grievances were received and closed. There was also no segmentation of Medicare and Medicaid inventory

potentially causing inventory levels to be misleading. In June 2008, the database was enhanced to element manual data entry of grievance cases.

Objective/Purpose – Improve the current grievance database to capture and quantify all grievance cases.

Results – Enhance reporting capability to capture common grievance types and the markets in which they are related.

Analysis – Reporting captures top grievance trends for Quality improvement based committees, such as CSQIW, and MAC workgroups to streamline processes and drive improvements throughout the WellCare Organizations.

Improvement:

- Implemented a daily Inventory Aging Report, which provides oversight and awareness of all grievances that are due within 21 days to ensure cases are closed in compliance. In addition, the Grievance Departmental reporting was completely revamped to separate Medicare and Medicaid inventory levels, aging status, as well as the number of grievances received and closed on a daily basis.

- New functionality has been added to the database that notifies the grievance coordinator of which grievances are approaching compliance due dates.

- Improve reporting analysis and line of site to the status of case work in real time.

- Integration with Peradigm system and automate member account information within the Internal Grievance Database.

- Database Enhancements to track misrouted and mishandling outcome of cases.

- Facilitate weekly meetings with various WellCare departments to begin the process of identifying tasks/owners of processes and building bridges.

- Worked closely with other departments and continued „follow-up“ to achieve resolution within the Medicare and Medicaid timeframes.

- Educated and trained to identify grievance and complaints with the newly developed Grievance Coordinator Training module.

- Developed an intake team to review all complaints and grievances to ensure proper classification and routing.

Grievance Department 2009/2010 Initiative:

- The Grievance Department will continue to perform quality audits of grievances and complaints.

- Implementation of an enhanced managed workflow process (Omni Flow system). This system will provide the following:

  - Letter Automation
  - Increase Quality and Productivity
  - Tracking of case through the process
  - Dashboard Reporting capability
  - Extensive root cause analysis,
  - Grievance trending
  - Enhance Reporting and end to end metrics

- Develop state specific Grievance Coordinator training.

- Ensure continued compliance with all applicable state and federal grievance requirements.

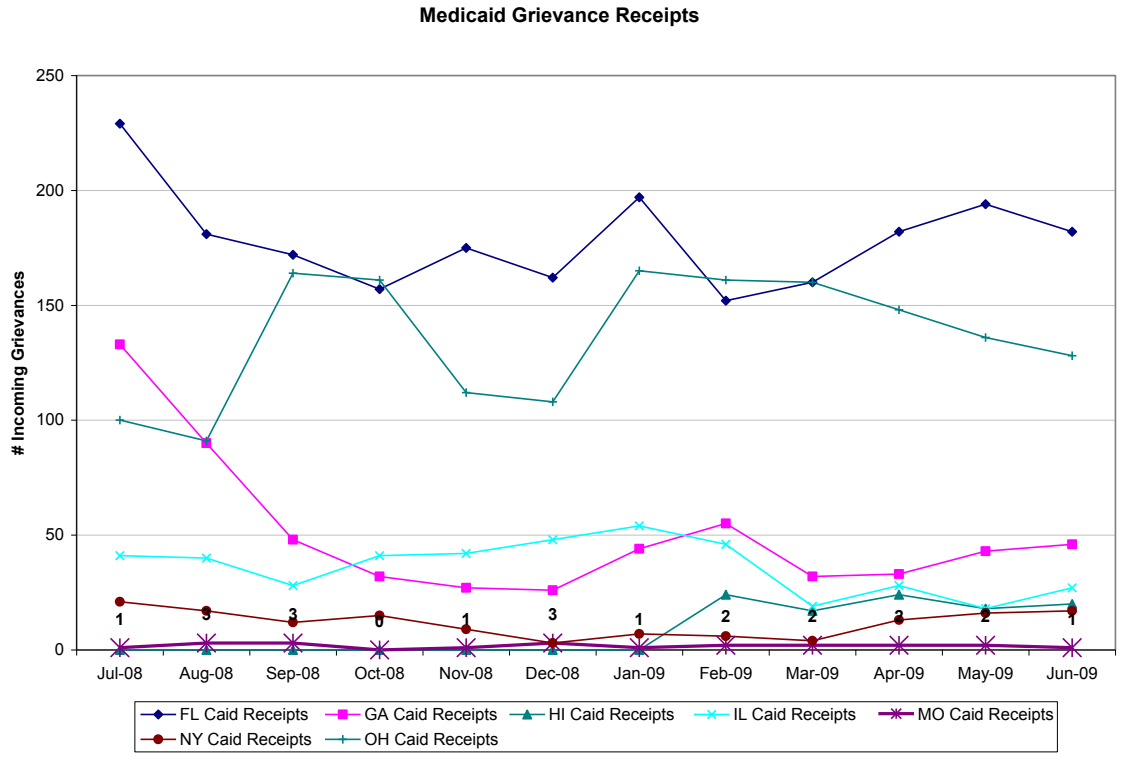


Figure 1: Medicaid Incoming Receipts State Comparison

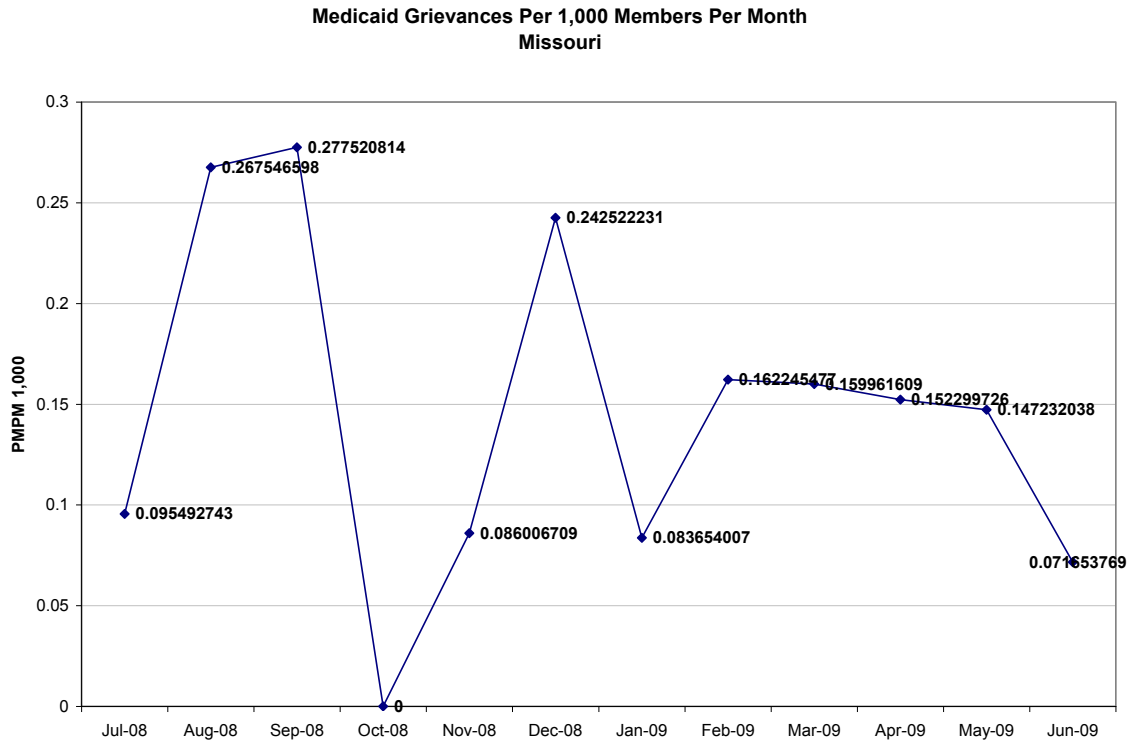


Figure 2: Medicaid Grievance Per 1, 000 Member Per Month (MPM) Missouri

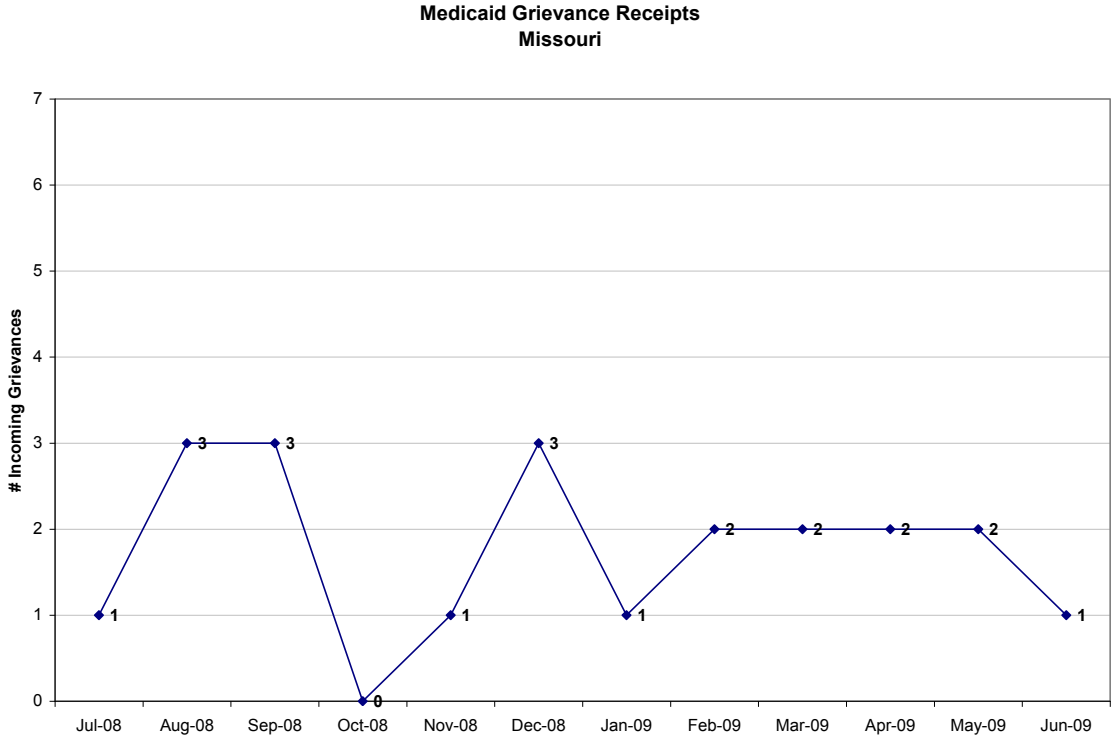


Figure 3: Medicaid Grievance Receipts-Missouri

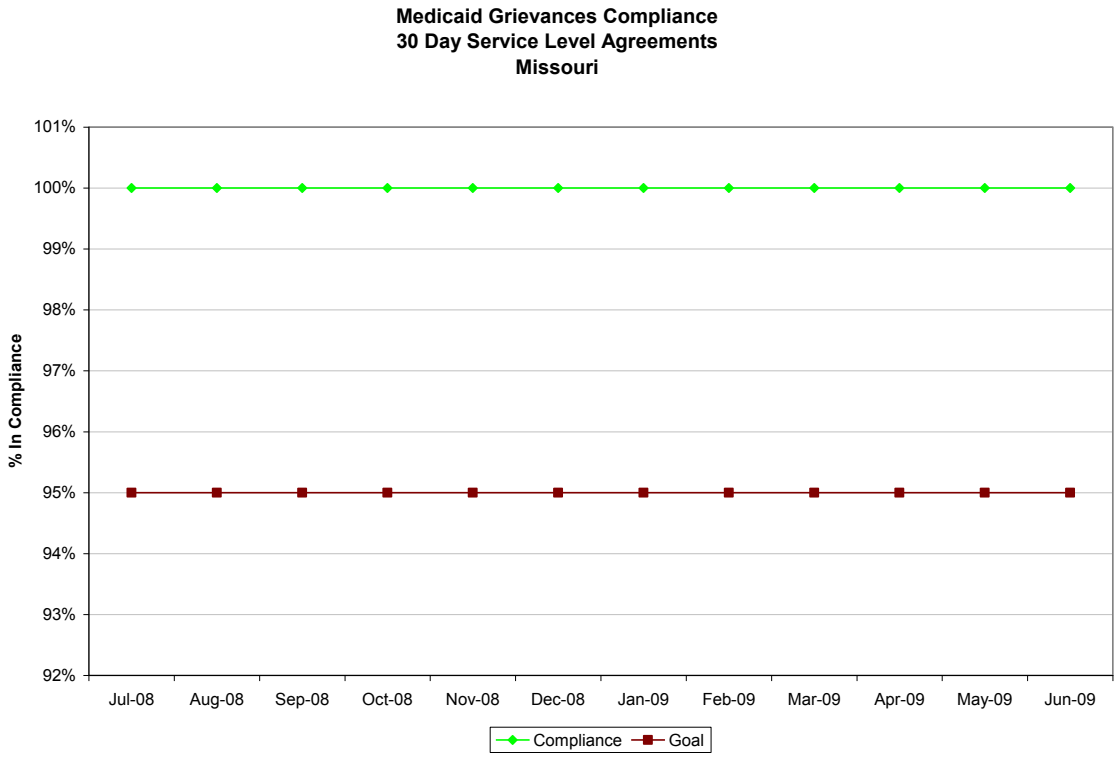


Figure 4: Medicaid Grievance Missouri Compliance

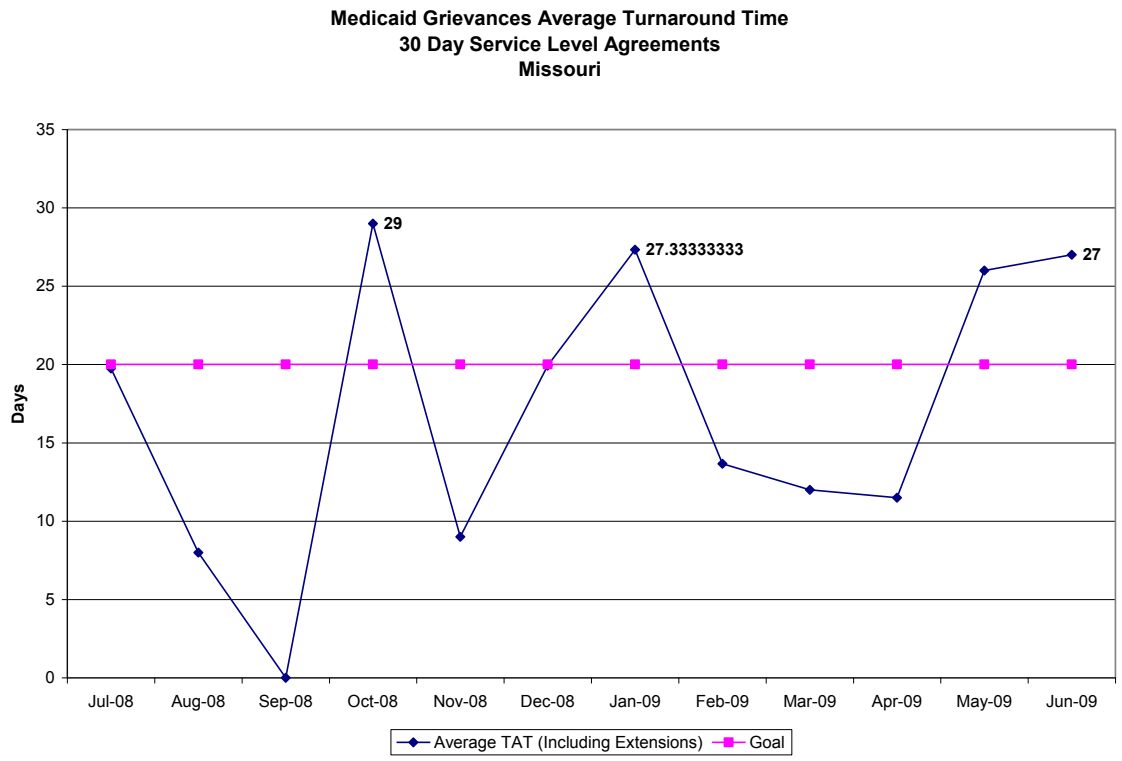


Figure 5: Medicaid Grievance Missouri Average Turnaround Time

Confidentiality

In accordance with WellCare‟s code of ethics and HIPAA Compliance Program, WellCare will safeguard PHI and protect against the unauthorized access, use and disclosure of PHI. In addition to the *Trust* Program detailed below, WellCare has extensively documented the policies and procedures which address all aspects of protecting and safeguarding member PHI. These policies and procedures are included in tab 9.3. To date, there have been no instances of a PHI breach within the Harmony Health Plan of Missouri membership population.

WellCare‟s corporate ethics and compliance program, entitled the *Trust* Program, consists of five structural components: a) the written elements of the *Trust* Program, b) the Vision, Mission and Core Values, c) the Standards of Conduct, d) the Compliance Organization and e) the Policies and Procedures underlying the *Trust* Program.

The *Trust* Program does not attempt to restate all of WellCare‟s existing Policies and Procedures regarding ethical and legal compliance and is not intended to replace any of our Policies and Procedures. Rather, the *Trust* Program is intended to unify and build upon those Policies and Procedures, all of which remain in place and are a vital component of the *Trust* Program.

Scope of the Trust Program
The *Trust* Program applies to the WellCare Group of Companies, its Board of Directors ("Directors"), associates, and, as applicable, its business partners. Any new companies that WellCare may acquire or establish from time to time will also become subject to the *Trust* Program. Additionally, WellCare encourages, and in some cases requires, its business partners, including independent contractors, to follow the *Trust* Program‟s values. WellCare considers our business partners to include, among others, our delegated service vendors (e.g., entities that take risk from WellCare), service vendors (e.g., entities that provide basic services to WellCare), delegated entities (e.g., clinical labs and durable medical equipment companies), WellCare‟s regulatory stewards and WellCare‟s contracted providers (e.g., physicians and hospitals). WellCare believes that our members ("Members") will also benefit from the *Trust* Program because they deserve to have their vital health care needs served by a company with high standards of business ethics.

Purpose of the Trust Program
The *Trust* Program is designed to assist WellCare to conduct its business in accordance with applicable federal and state laws and WellCare‟s high standards of business ethics. Additionally, the *Trust* Program is intended to satisfy the requirements of the Federal Sentencing Guidelines, the Department of Health and Human Services, the regulations of the Office of the Inspector General, the regulations of the various regulatory agencies in each of the states we serve, the Securities and Exchange Commission and the New York Stock Exchange. The *Trust* Program provides a framework for action within WellCare and is a prerequisite to achieving our business goals.

As part of the *Trust* Program, WellCare has created and will continue to create a more detailed set of Policies and Procedures specifically relating to our Medicare plans, Medicaid plans and all other product lines.

Compliance Organization
The Board of Directors of WellCare Health Plans, Inc. has adopted the *Trust* Program, and has required that each operating company within the WellCare Group of Companies adopt the *Trust* Program. The Board of Directors of WellCare Health Plans, Inc. oversees the activities of the Boards of Directors of WellCare‟s regional operating companies through such means as it deems appropriate. Members of senior
management are responsible for ensuring that WellCare, its Directors, associates and, in some cases, its business partners comply with the *Trust* Program, applicable federal and state laws and WellCare‟s high standards of business ethics. WellCare‟s Directors have designated the Chief Compliance Officer, with the assistance of a Corporate Compliance Committee, to have the authority to implement the *Trust* Program. The Chief Compliance Officer is responsible for coordinating the efforts of all associates involved in the *Trust* Program. Additionally, WellCare‟s Directors created the Corporate Compliance Committee consisting of certain senior Area Leaders, the Chief Executive Officer, the Chief Compliance Officer, the General Counsel and such others as may from time to time be necessary as determined by the Chief Compliance Officer.

WellCare has a Corporate Compliance Department within the Legal Services Area which reports to the Chief Compliance Officer and assists the Corporate Compliance Committee in implementing and monitoring the *Trust* Program. The Corporate Compliance Department is supported by a Corporate Compliance Counsel who advises the Corporate Compliance Committee with respect to the *Trust* Program. Certain associates within the Legal Services Area, Area Leaders, department directors and managers and others, as needed, will be designated as "Compliance Coordinators" to assist in implementing and monitoring the *Trust* Program. In that capacity, the Compliance Coordinators will be responsible for ensuring compliance within their areas of operations and for reporting suspected violations of the *Trust* Program, applicable federal and state laws and WellCare"s high standards of business
ethics.

All Directors and associates of WellCare are participants in the *Trust* Program and may be required to certify in writing on an annual basis that he or she has conducted WellCare"s business in compliance with the *Trust* Program.

Education and Monitoring Programs
WellCare will continue to maintain and update training and monitoring programs to educate its Directors and associates on the legal and regulatory requirements of their respective duties and positions, and to detect possible violations. These programs may consist of additional written policies, informational handouts and memoranda or, when appropriate, training seminars in selected areas. WellCare will continue to monitor and promote compliance with new federal and state laws and regulations.

Confidentiality of Medical Information
WellCare, its Directors, associates and business partners must protect the privacy of medical and health information received from and about Members and potential Members.

As part of its business, WellCare receives medical information and Protected Health Information from health care providers and Members, including information relating to individual Members" medical conditions and health status. WellCare will respect and preserve the privacy of this protected medical and health information as required by law. Except to the extent expressly permitted by the Member and by federal and state law, WellCare, its Directors, associates and business partners will not disclose such medical information and Protected Health Information to any third party. Furthermore, WellCare is required to preserve the confidentiality of protected medical and health information that remains in its possession. WellCare, its Directors, associates and business partners must access and disclose protected medical and health information only as necessary for the provision and coordination of health care services and as permitted by applicable federal and state laws in connection with ongoing operations.

All Harmony Health Plan members receive a copy of Harmony/WellCare"s Notice of PHI with their Member Handbook mailing upon enrollment.

HealthCare USA

Provider Complaint, Grievance and Appeal Management

The data provided has been taken from Navigator, the HealthCare USA online system where provider and member issues are recorded. The information presented represents all three (3) regions (Eastern, Central and Western). Data from 2005 is not being used as a comparison. Data from 2005 was collected and analyzed using a different process, making the data not comparable to 2006 and after.

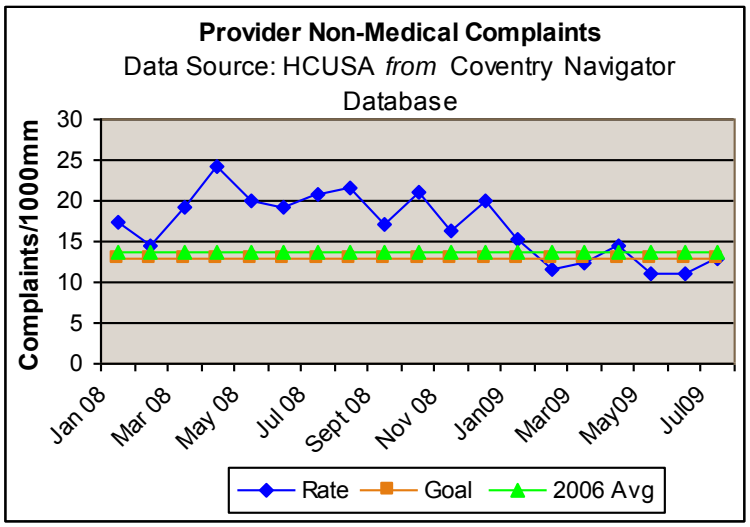
HealthCare USA established an interdepartmental, multi-disciplinary performance improvement team 2006 and revised the team participation in 2007 to review provider"s complaints, grievances and appeals, and member appeals and grievances and timeliness monthly. This group, which continues through 2009, has the authority to initiate process and policy changes. The work group makes suggestions regarding additional training that may be needed by staff. Suggestions are made for educational information to be shared with providers through the provider newsletter.

In 2009 a Member Safety team was established. This team is interdepartmental and multi-disciplinary and addresses any threats to member safety/quality of care from any source, including referrals from the appeals and grievances department and team. This team allows for the most appropriate follow-up for resolution. Since all issues are funneled through one team, trend analysis across departments and processes aid in identification and interventions for prevention of further issues.

Complaints

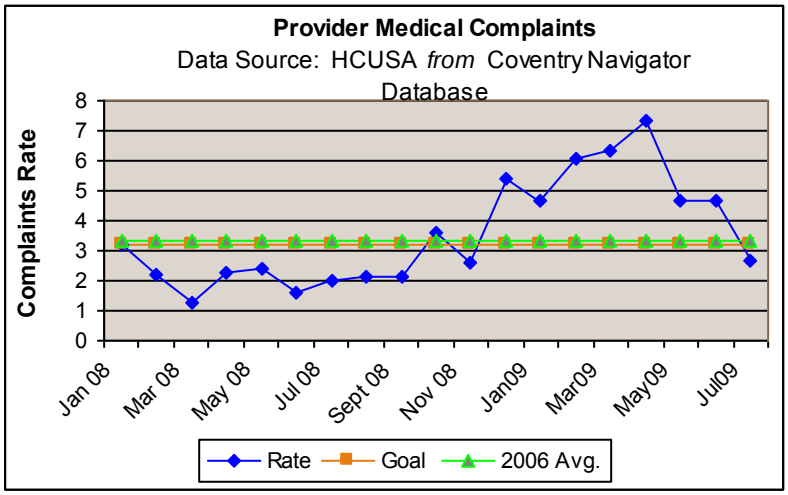
Non Medical

- Increase in complaints at the start of 2008 due to expansion counties. Rate has decreased since that time.
- Large number of complaints in early 2008 due to non par pathology claims being denied for no authorization. An IT solution was identified so that these claims would now pay without needing an authorization.
- Non medical complaints are generally claim related, with untimely filing being the number one complaint. These complaints are reviewed in an interdepartmental meeting to determine what processes can be changed in order to eliminate the need for the provider to file a complaint.



Medical

- Medical complaints increased in 2009 in conjunction with the change in a large provider contract that allowed for retro reviews. The provider submitted a large volume in the first few months of the contract. The rate has steadily declined back to the baseline in 2008 as the volume of retro reviews declines.



Grievances

Non Medical

- Timely filing is one of the top grievances. At this level, the providers are giving information requested in the grievance that also effects overturns.

Medical

- Many of the grievances are from facilities that have hired outside firms to file their appeals. These firms continue to appeal denied days and observation rooms even though they do not meet Interqual criteria.
- Overturns for medical are lower than for the non medical grievances. Grievances are reviewed by like-specialty providers.

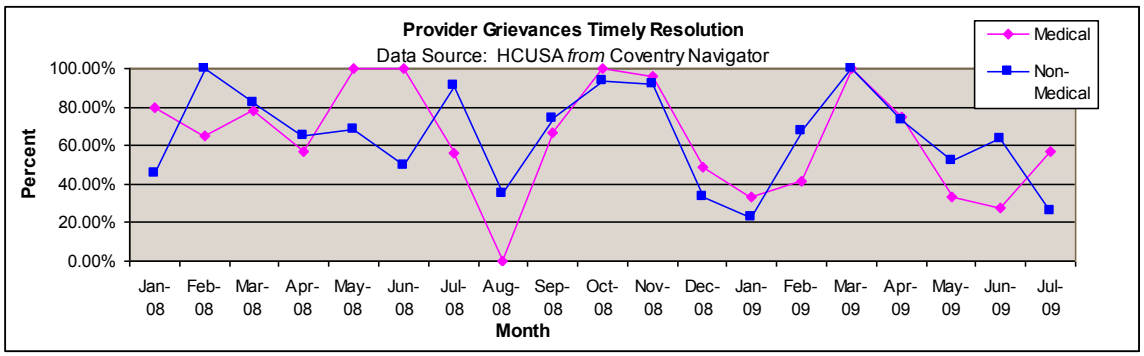
Appeals

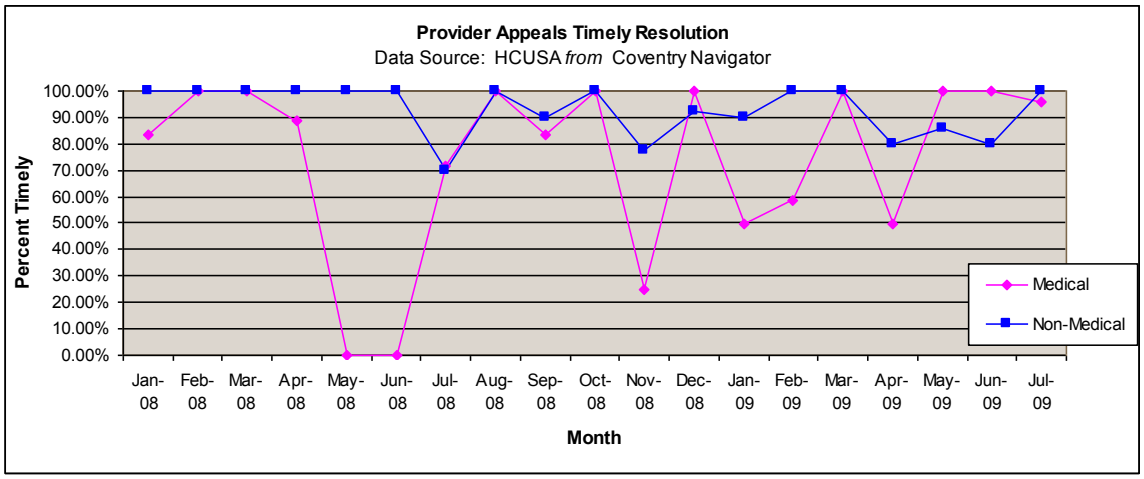
Non Medical

- Non medical third level appeals are low since most of the non medical appeals at any level are claim issues. Again, timely filing seems to be the one area where the providers continue to appeal.
- Overturns are determined by an appeal hearing made up of HealthCare USA management staff. Generally, the appeal is upheld. However, on occasion there may be an overturn. Since the number of third level appeals is small one overturn can make the overturn rate seem high in this area.

Medical

- Most third level medical appeals are completed by the firms representing the facilities.
- At this level, the appeals are sent to two outside reviewers of like specialty to review the issue using Interqual® criteria or other criteria determined by the situation.



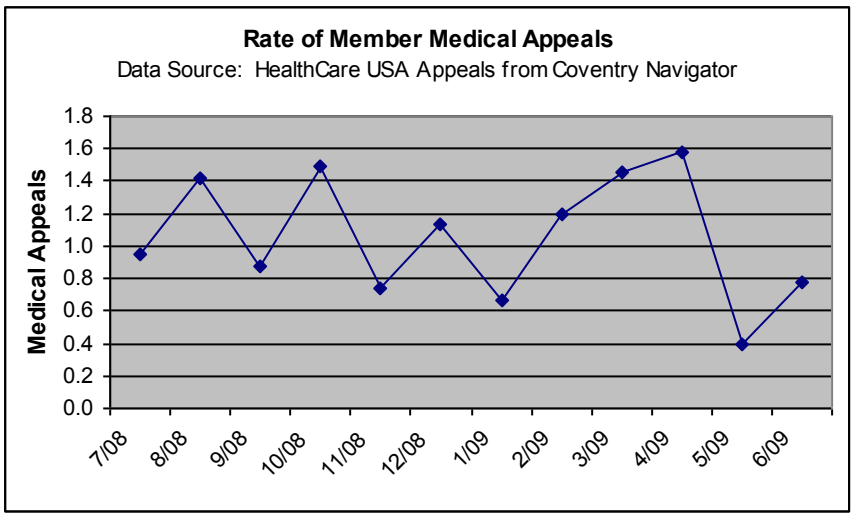


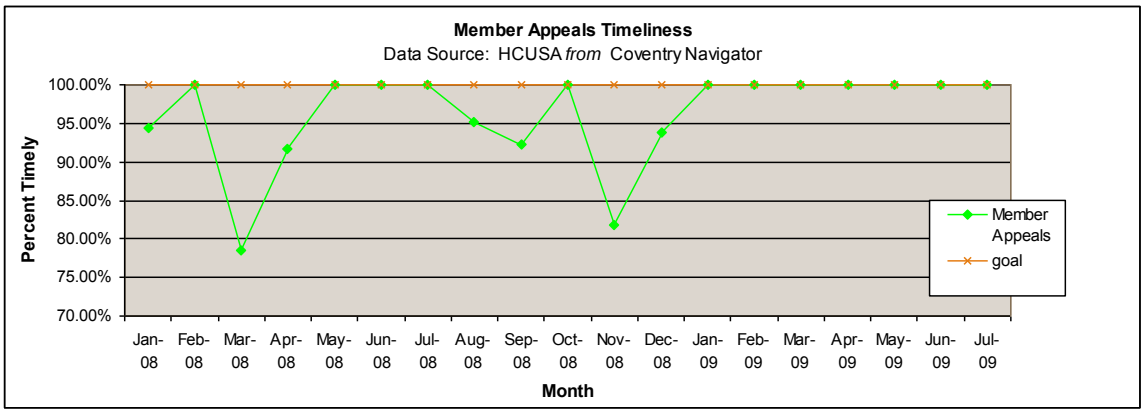
Member Grievance and Appeal Management

Appeals

- The number one member appeal is for orthodontic treatment. Members must meet a score of 28 or higher on the HLD or have an automatic qualifier outlined in the HLD.
- Member appeals are reviewed by two like-specialty providers. Overturns are usually as a result of receiving additional information on the case.

- Overturns for orthodontia have been due to reviews by a different dentist who may allow the braces when the score is close allowing that the molds could be off by enough to make the difference. We have been working with Doral in order to make the original decision the appropriate one.
- Denial letters for orthodontia were created to try to better explain the denial to the member. This has not lowered the number of appeals. 2009 appears to be running at the same rate as 2008.

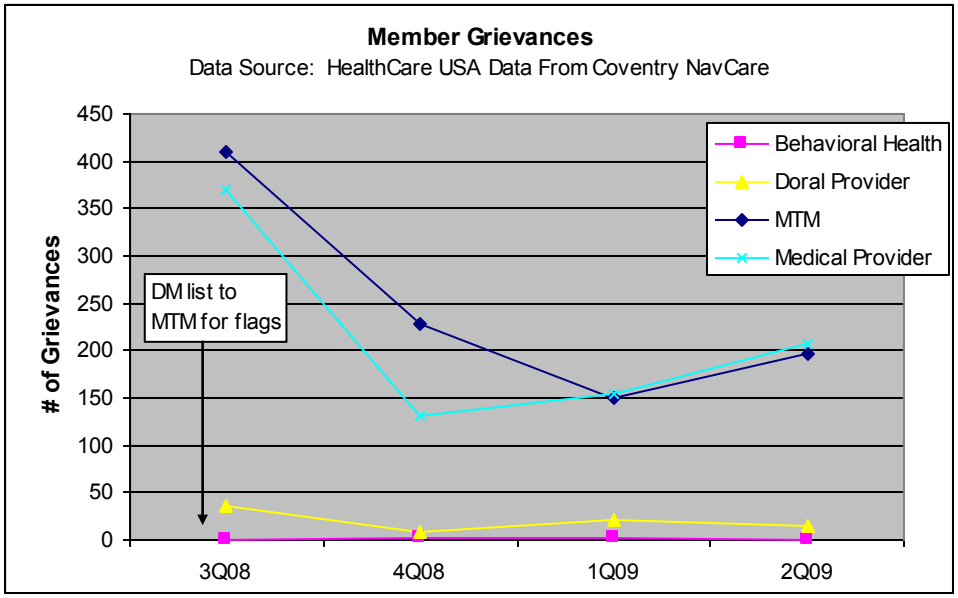


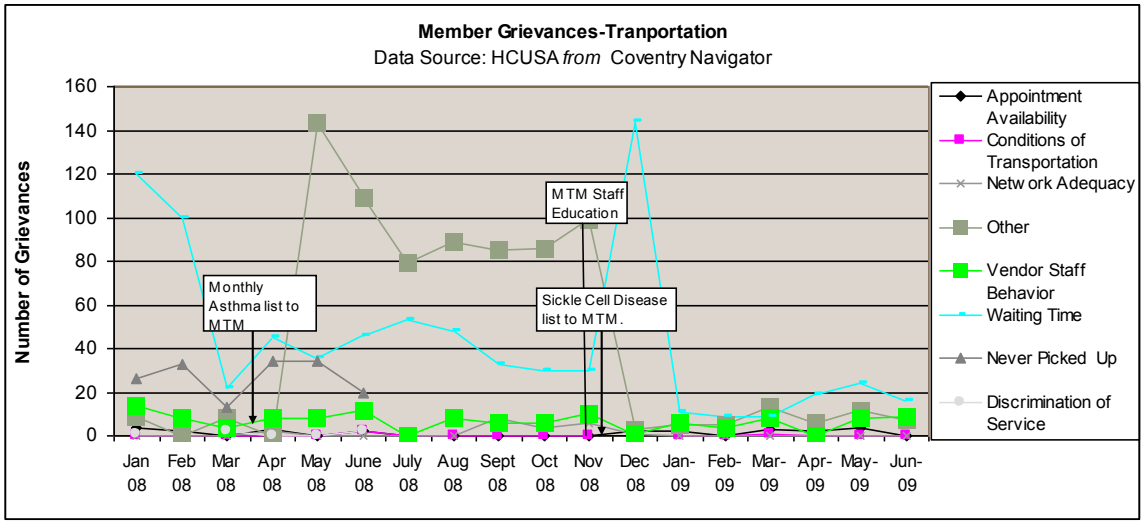


Grievances

- Not being picked up is the number one grievance from members. HealthCare USA works with MTM in order to improve the pick up of our members.
- Beginning February 2007, a list of pregnant members is sent to MTM on a monthly basis in order to assure that these members are given special attention for their transportation needs.
- Beginning September 2008, members in disease management/high risk (sickle cell disease, HROB, asthma, diabetes, NICU) have been flagged in MTM‟s system so that these patients receive special attention with their transportation needs.

- As individual needs are identified, MTM is notified and their system flagged so that special consideration can be given to these members.
- Education is given to members about calling the transportation vendor at least 5 days before their scheduled appointments.
- MTM‟s vendors are educated and disciplined when a trend is noticed.

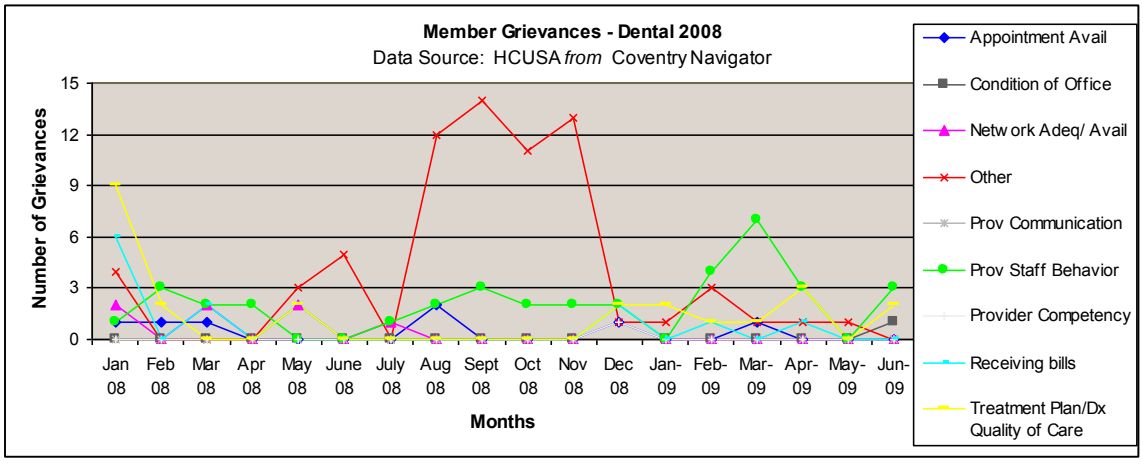




Grievances - Dental

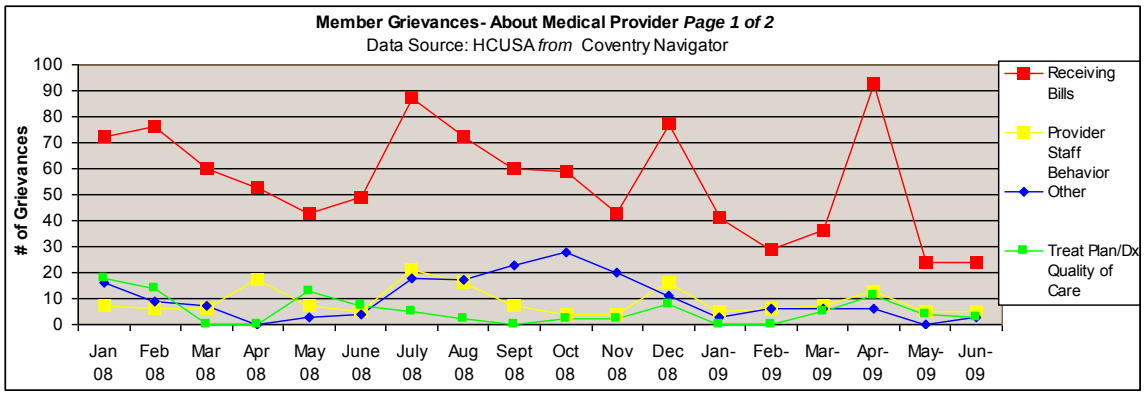
- HealthCare USA has worked with Doral to ensure that there is an adequate network of dental providers.
- Issues that arise due to a dentist‟s behavior or staff behavior are addressed by Doral‟s provider relations department.
- Appointment availability can be problematic as many dentists have a wait for new patients. For emergency care HealthCare USA works with Doral so that the member can be seen sooner.

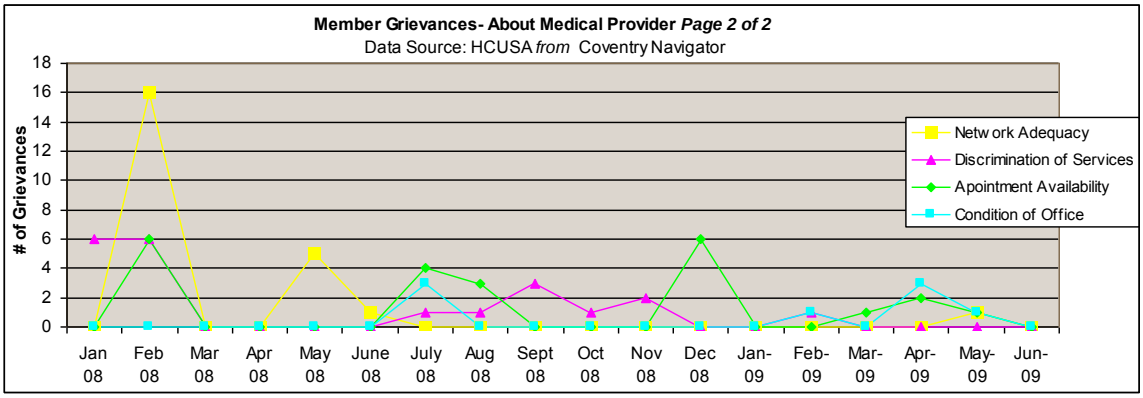
- Doral Dental implemented a state-wide recruitment project with mailings and calls to all dentists, beginning May 2007 and quarterly.



Grievances - Medical

- The main grievance in this category is the provider billing the member. This billing is coming from non par providers, out of state providers and ancillary providers. In many of these cases the member has failed to provide the insurance information at the time of services. Bills are obtained and forwarded to claims for payment.
- Non par facilities out of state do not want to bill Medicaid providers as they have to accept our payment due to a federal guideline. Oftentimes they respond to this requirement by billing the member instead of the insurance company. In some cases the provider will submit the bill to the Plan. In cases where the provider refuses to bill us, the member is asked to forward the bill to HealthCare USA.





Confidentiality

HealthCare USA maintains written policies and procedures regarding member rights and protections and complies with all federal and state laws pertaining to those rights and protections, including confidentiality. HealthCare USA ensures staff and providers take those rights into consideration when furnishing services to HealthCare USA members. All staff are required to sign a confidentiality statement at the time of hire and every year thereafter. Member rights and protections are provided in the Member Handbook, as well as the Provider Manual and include the following:

Member Rights

- Each member is guaranteed the right to be treated with respect and with due consideration for his or her dignity and privacy;
- Each member is guaranteed the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the member"s condition and ability to understand;
- Each member is guaranteed the right to participate in decisions regarding his or her health care, including the right to refuse treatment and the freedom of choice among network providers;
- Each member has a right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage;
- Each member has a right to voice complaints or appeals about the organization or the care it provides;
- Each member has a right to make recommendations regarding the organization"s member rights and responsibilities policy;
- Each member is guaranteed the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation;
- Each member is guaranteed the right to request and receive a copy of his or her medical records, and to request that they be amended or corrected;
- Each member is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the health plan and its providers or the state agency treat the member;
- Each member will be provided with names, locations, telephone numbers, and any non-English languages spoken by current contracted providers in the enrollee"s service area, including identification of providers that are not accepting new patients;

- Each member will be provided with information on grievance and fair hearing procedures;
- Each member will be provided with the amount, duration, and scope of benefits available under the contract to which they are entitled;
- Each member will be provided with information on how to obtain benefits, including authorization requirements;
- Each member will be provided with the extent to which, and how, they may obtain benefits including family planning services, from out-of-network providers;
- Each member will be provided with the extent to which, and how, after-hours and emergency coverage are provided including:
    - What constitutes emergency medical condition, emergency services, and post stabilization services
    - The fact that prior authorization is not required for emergency services
    - The process and procedures for obtaining emergency services, including the 911-telephone system or its local equivalent
    - The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post stabilization services
    - The fact that the member has the right to use any hospital or other setting for emergency care.
- Each member will be provided the post stabilization care services rules;
- Each member will be provided the policy on referrals for specialty care and for other benefits not furnished by the enrollee‟s primary care provider;
- Each member will be provided cost sharing information, if any, and;
- Each member will be provided information on how and where to access any benefits that are available.

Member Responsibilities

- A responsibility to supply information, to the extent possible, information that the organization and its practitioners and providers need in order to provide care;
- A responsibility to follow plans and instructions for care that they have agreed to with their practitioners;
- A responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible;
- A responsibility to contact their primary care provider as their first point of contact when needing medical care;
- A responsibility to follow appointment scheduling processes; and
- A responsibility to follow instructions and guidelines given by providers.

Missouri Care

PROVIDER COMPLAINT, GRIEVANCE AND APPEALS MANAGEMENT

Providers receive information packets at the time of contracting with Missouri Care. The packets contain the complaint, grievance and appeals policies and procedures, specific instructions regarding how to contact the Provider Relations Department and identify the grievance coordinator who receives and processes complaints, grievances and appeals.

During SFY 09, 2,373 provider complaints, grievances and appeals were filed with Missouri Care. Of these, 537 were medical, 326 were behavioral health and 1,510 were non-medical (claim issues and timely filing). In SFY 09, Missouri Care upheld approximately 55% of its original decisions.

MEMBER GRIEVANCE AND APPEALS MANAGEMENT

Missouri Care evaluates and processes grievances and appeals filed by members according to applicable state of Missouri and federal statutes, regulations, contracts and policies. Members can file grievances in regard to any aspect of service, including those related to cultural sensitivity or sexual harassment. In no instance will a member be subject to any punitive action, including charges, for utilizing the grievance and appeal process.

Missouri Care maintains records of grievances and appeals for all Missouri Care members, whether received verbally or in writing, that include a short, dated summary of the problems, name of the grievant or appellant, date of the grievance or appeal, date of the decision and the disposition. The SIC conducts a quarterly review of the number of grievances filed by members and providers to determine if any trends exist. Any identified trends are referred to the appropriate department for review and any necessary education, training or corrective action. All identified trends will also be submitted to QMOC for review. Analyses of grievances are included in provider profiles for review at the time of re-credentialing. Complaints, grievances and appeals are logged in the appeals data base to identify trends.

Sixty-two appeals and grievances were received from members during SFY 09. All issues have been resolved. The plan's original decision was upheld in approximately 38% of the cases.

CONFIDENTIALITY

Missouri Care has written policies and procedures for maintaining the confidentiality of data, including medical records, member information and appointment records for adult and adolescent STDs and adolescent family planning services. The Missouri Care Notice of Privacy Practices provides a formal written description of how the plan may use and disclose protected health information (PHI). The notice explains members' rights to access, change, restrict or receive an accounting of disclosures of PHI. Missouri Care makes the Notice of Privacy Practice available to members in accordance with HIPAA distribution requirements. Additional copies are available to members or their representatives upon verbal or written request.

All marketing and educational materials maintain members' rights to confidentiality. Postcards are folded to protect the confidentiality of the members.

Molina Healthcare of Missouri

Provider Complaint, Grievance and Appeal Management

Molina Healthcare of Missouri (MHMO) assures timely, fair and consistent provision of services to its providers with regard to any dissatisfaction resulting in the filing of a complaint, grievance or appeal. Through monitoring and tracking of provider complaints, grievances and appeals, MHMO is able to conduct investigations and improvement corrective action plans where necessary. The data below reflects the volume of provider complaints, grievances and appeals processed by MHMO during reporting period.

Provider Complaints	**(3Q08)**	**(4Q08)**	**(1Q09)**	**(2Q09)**	**FYTD**
Complaints Received	1751	1779	792	2584	6906
Complaints Upheld	657	758	427	1007	2849
Complaints Partial	14	9	13	17	53
Complaints Overturned	980	805	681	1163	3629
Processed Timely	1254	1068	154	408	2884

Provider Grievances	**(3Q08)**	**(4Q08)**	**(1Q09)**	**(2Q09)**	**FYTD**
Grievances Received	225	193	210	251	879
Grievances Upheld	136	97	21	209	463
Grievances Partial	3	1	1	3	8
Grievances Overturned	85	51	20	36	192
Processed Timely	222	130	31	221	604

Provider Appeals	**(3Q08)**	**(4Q08)**	**(1Q09)**	**(2Q09)**	**FYTD**
Appeals Received	35	34	57	67	193
Appeals Upheld	26	17	33	36	112
Appeals Partial	1	1	3	2	7
Appeals Overturned	8	2	6	3	19
Processed Timely	35	18	40	36	129

MHMO‟s Appeals manager identified a large number of complaints were received due to authorization issues. The statistics were presented to the Member/Provider Satisfaction Committee (MPSC). As a result of analysis, MHMO developed an action plan and has taken the following steps: reviewed the prior authorization guide, removed some services that previously required authorization and provided education to the pre-authorization team with regard to choosing the correct provider and place of service when entering authorizations. Ongoing trending and analysis will continue to be submitted to the MPSC and additional actions plans will be developed if appropriate.

Member Grievance and Appeal Management
MHMO recognizes a member"s right to file grievances and appeals and to request a State Fair Hearing at any stage of the grievance and appeal process. MHMO makes a concerted effort to resolve member grievances and appeals as expeditiously and fairly as possible. Below is data reflecting the volume of member grievances and appeals processed by MHMO during the reporting period.

Member Grievances	**(3Q08)**	**(4Q08)**	**(1Q09)**	**(2Q09)**	**FYTD**
Grievances Received	94	73	85	60	312
Grievances Resolved	91	73	70	326	560
Processed Timely	91	73	68	293	525

Member Appeals	**(3Q08)**	**(4Q08)**	**(1Q09)**	**(2Q09)**	**FYTD**
Appeals Received	21	35	26	52	134
Appeals Upheld	9	26	21	37	93
Appeals Overturned	10	9	3	9	31
Processed Timely	19	35	22	46	122

The Appeals Manager identified issues with members being balance billed for covered services. As a result of analysis, MHMO developed an action plan to educate providers. Provider Relations Representatives are also notified when providers balance bill members to assist providers in understanding the rules of balance billing members covered by MO HealthNet or managed care plans.

An issue with the member transportation vendor was identified by the Member Services Manager. Members complained that transportation drivers were not showing up either before or after appointments. After an investigation and in coordination with Medical Transportation Management (MTM), MHMO found there was miscommunication regarding the pickup point, physician appointments were running behind, and the member was calling the incorrect point of contact when ready for pick up. As a result, the vendor educated members to call MTM directly to arrange pick up and not the driver that completed the drop off. They were also advised to notify their provider they utilized the transportation vendor in an effort to ensure their visit was conducted an expeditious manner. In addition, they were instructed to wait at a specific location for the driver.

Confidentiality
MHMO complies with applicable federal and state regulations related to protecting the privacy of health information. Employees maintain confidentiality by securing member information in the work area; properly destroying reports and documents containing member information, and using discretion when discussing member information to avoid improper disclosure. Employees are required to sign a Non-Disclosure Agreement. New employees take two online Health Insurance Portability and Accountability Act (HIPAA) training sessions and all employees annually take HIPAA refresher courses.

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Utilization Management

The following information was taken from the MO HealthNet Managed Care health plans' SFY 2008 Annual Evaluations:

Blue Advantage Plus of Kansas City

Utilization Improvement Program Scope

The Care Management Program extends across all aspects of the healthcare delivery system, including inpatient services, outpatient services, ancillary services, home services, pharmacy services, new technology assessment, early intervention services, chronic disease management, s self-care and prevention programs.

The Care Management Program includes processes to measure, monitor, and optimize utilization of healthcare services in the above settings at the member and provider level.

Management processes used by the Care Management Department include prospective, concurrent and retrospective review processes, pro-active case and care management and disease management programs. BCBSKC/BA+ has written medical management policies and procedures that include protocols for denial of services, prior approval, hospital discharge planning, and concurrent, prospective, and retrospective review of claims that comply with Federal and State laws and regulations, as amended to comply with MO HealthNet contract. The program monitors and manages to achieve optimum utilization and seeks to identify and eliminate both under and over utilization.

The Care Management Program improves effectiveness by communicating with other areas of BCBSKC that touch members and providers regarding utilization and case management issues. It works collaboratively with Quality Management, Customer Service, Membership, Provider Services, Legal, and others as needed. Care management policies and procedures are clearly specified in provider manuals and are consistently applied in accordance with the established utilization management guidelines.

The Vice President and Senior Medical Director of Care Management for BCBSKC is the designated senior executive responsible for the implementation of the Care Management Program. He is the chairperson of the Quality Council, sponsor of the C and Pharmacy Management Committee and is a member on other senior management committees. He receives information regarding the Care Management Program from the Medical and Pharmacy Management Committee, medical reporting, physician advisory committees and monthly meetings with the Medical Management team. He delegates oversight of some aspects of the program to the Medical Directors, as appropriate.

Discharges Per Year
Inpatient Visits
Average Length of Stay
Re-Admissions
Emergency Department Utilization
Outpatient Visits
Over/Under Utilization

	2007	2008	2009
Discharges Per Year	9.81*	10.28 *	9.97*
Inpatient Visits	32.50 *	34.61 *	32.65*
Average Length of Stay	3.31 Days	3.37Days	2.76 Days
Emergency Department Utilization	59.40*	66.78*	73.99*
Outpatient Visits	302.90*	309.66*	315.48*

*Per 1000 Member Months

Inter-Rater Reliability
Inter-rater reliability of staff and medical directors include criteria selection and medical necessity decisions.

a. The inter-rater reliability activities for the medical directors focused on peer overturned denials on appeal. Review of overturned appeals revealed that the main reason for one medical director overturning another was the receipt of additional information. Other discussion points revolved around the interpretation of benefits, clarification of the reason for the denial, and medical policy interpretation.

b. A web-based inter-rater reliability tool with automated reporting is used by the concurrent review nurses. All concurrent review nurses take five cases per quarter. In 2006 and 2007 the goal of 90% was met consecutively. In 2008, the target goal was raised from 90% to 97%, and all concurrent review nurses met the goal of 97%.

Timeliness of Care Delivery
BA+ maintains a network of providers to assist the member accessing the care they need in a timely manner. The Member Handbook provides the member with specific information on access standards and when care is to be delivered. The Physician Office Guide provides the access standards the provider must keep.

The 2009 Consumer Assessment of Health Plans (CAHPS®) survey indicates that members are able get the care as soon as needed 86.2% of the time. BA+ rates exceed the CAHPS® exceeds the 2008 Quality Compass average and the 2009 DSS Child Medicaid Book of Business average.

Timeliness of Prior Authorization/Certification Decision Making
BA+ monitors the timeliness of nursing review staff and medical directors as it relates to prior authorizations, concurrent reviews and retrospective reviews. a. The scores for timely decision-making were 93.24% for S FY2008. The goal is above 90%. The goal was met for timeliness.

The Utilization Management Department maintains policy and procedures that provide the mandated timeframes for responding to service authorizations.

Children's Mercy Family Health Partners

Utilization Management Program Objectives

- Ensuring that medical necessity and appropriateness of care are the paramount drivers in decisions made concerning the authorization of health care services to members.

- Ensuring effective utilization of resources for all hospital and ambulatory care by reviewing, monitoring, reporting and acting upon issues of over-utilization, under-utilization, and inefficient or inappropriate utilization of resources and services.

- Ensuring that members receive required and appropriate health care services by monitoring the appropriateness and medical necessity of admissions and continued stays, based upon application of nationally recognized criteria, and the provision of screening, prior authorization and concurrent reviews for hospital admissions and certain outpatient procedures.

- Monitoring and assisting in the promotion, maintenance and assurance of high quality care in all areas, through prospective, concurrent and retrospective review, and the application of quality indicators to identify possible quality assurance concerns related to Utilization Management.

- Reviewing and monitoring the appropriateness and medical necessity of durable medical equipment, home health care, and other home health services.

- Assuring systematic data collection, analysis, and evaluation of performance and member health outcomes.

- Assuring the presence of a program of utilization review and that such is a collaborative effort by the physicians and other health professionals, which includes interpretation of data analysis and implementation of change when needed to practitioners.

- Provide timelines for correction/corrective action plans and assign specific health plan staff to monitor compliance and follow up.

- Assessing, coordinating and monitoring appropriate discharge planning needs, and assuring timely referrals to case management services for those with ongoing, complex needs.

- Establishment of protocols for denial of services, prior approval, hospital discharge planning, physician profiling, and concurrent, prospective, and retrospective review of claims to comply with federal and state laws and regulations.

- Consistent application of policies and procedures, which are clearly specified in provider contracts and/or manuals.

- Coordination of services for both covered and non-covered benefits

- Coordination of school based clinic services with benefits provided by the Plan

- Ensuring that provider and subcontractor compensation is not structured so as to provide incentives for the provider or subcontracted vendor to deny, limit, or discontinue medically necessary services to any member.

- Provide regular utilization management and quality assessment reporting to the health plan management and health plan providers, including profiling of provider utilization patterns.

Utilization Improvement Program Scope

The following covered services are monitored under the Utilization Management Program:

Adult Day Healthcare Services
Ambulatory Surgical and Birthing Center Services
Behavioral Health and Substance Abuse Services
Certified Nurse Midwife Services
Core services provided by Local Public Health Departments
Corneal Transplants
Dental Services
Durable Medical Equipment
Emergency Room Services
Emergent and Non-Emergent Transportation
Hearing Aides and related Services
Home Health Services
Hospice Services
Inpatient Services
Pre and Post Transplant Services for solid organ and stem cell transplants
Laboratory, Radiology, and other diagnostic Services
Nurse Advice Utilization and Outcomes

Optical Services
Personal Care Services
Physician and Advanced Practice Nursing Services
Podiatry Services
SAFE-CARE Exams (in-network or out-of-network)
Transplant Services (other than corneal or kidney): before and after admission for transplant, including evaluation (in-network and out-of-network, per member‟s choice)

Discharges Per Year/Inpatient Visits/Average Length of Stay/Timeliness of Care Delivery

Utilization Management Program Organization

Children‟s Mercy Family Health Partners' (CMFHP) Board of Directors is ultimately responsible for Utilization Management activities. Utilization Management activities are reported to the Board of Directors by the Chairperson of the Medical Oversight Committee or CEO at least annually.

The Chief Clinical Officer and Medical Directors are responsible for implementation of the Utilization Management Program, under the supervision of the Chief Executive Officer.

The Chief Executive Officer, or his/her designee, ensures that the departments and Medical Directors fully support and participate in the Utilization Management Program. In addition, the Chief Executive Officer ensures that the Utilization Management Program is developed and implemented by professionals with adequate and appropriate experience in quality assessment, quality improvement, utilization management, and continuous improvement processes.

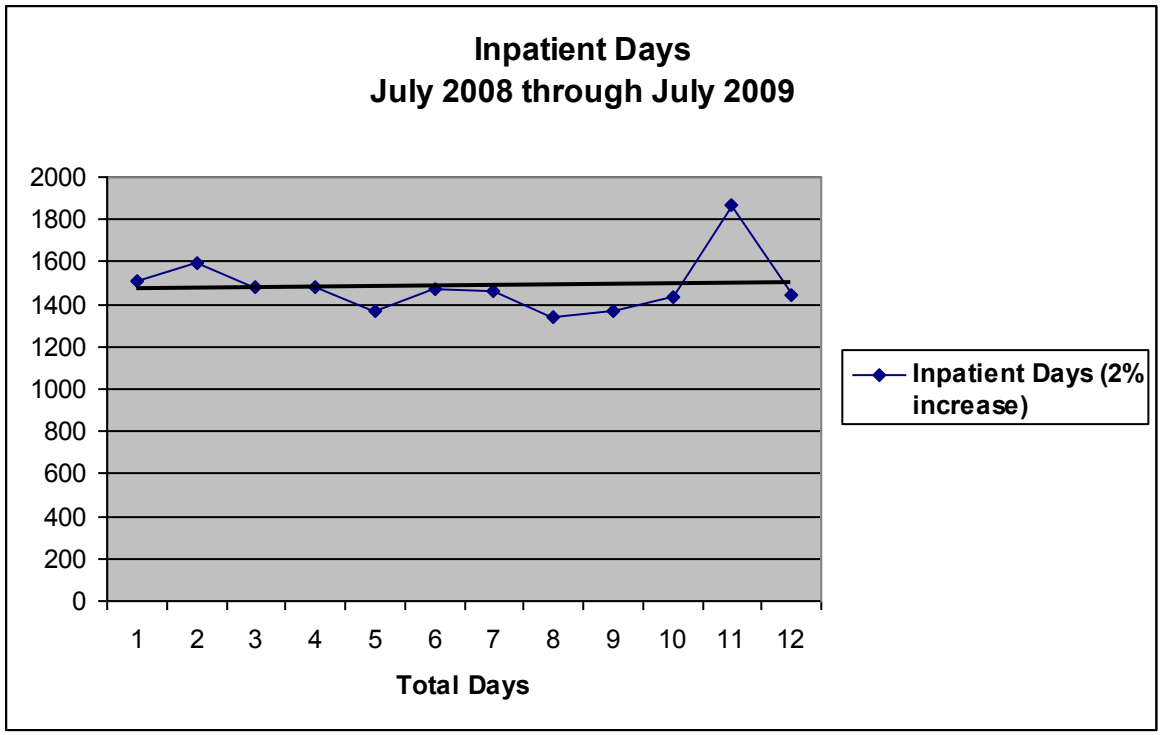
The Medical Oversight Committee evaluates the program activities on at least an annual basis.

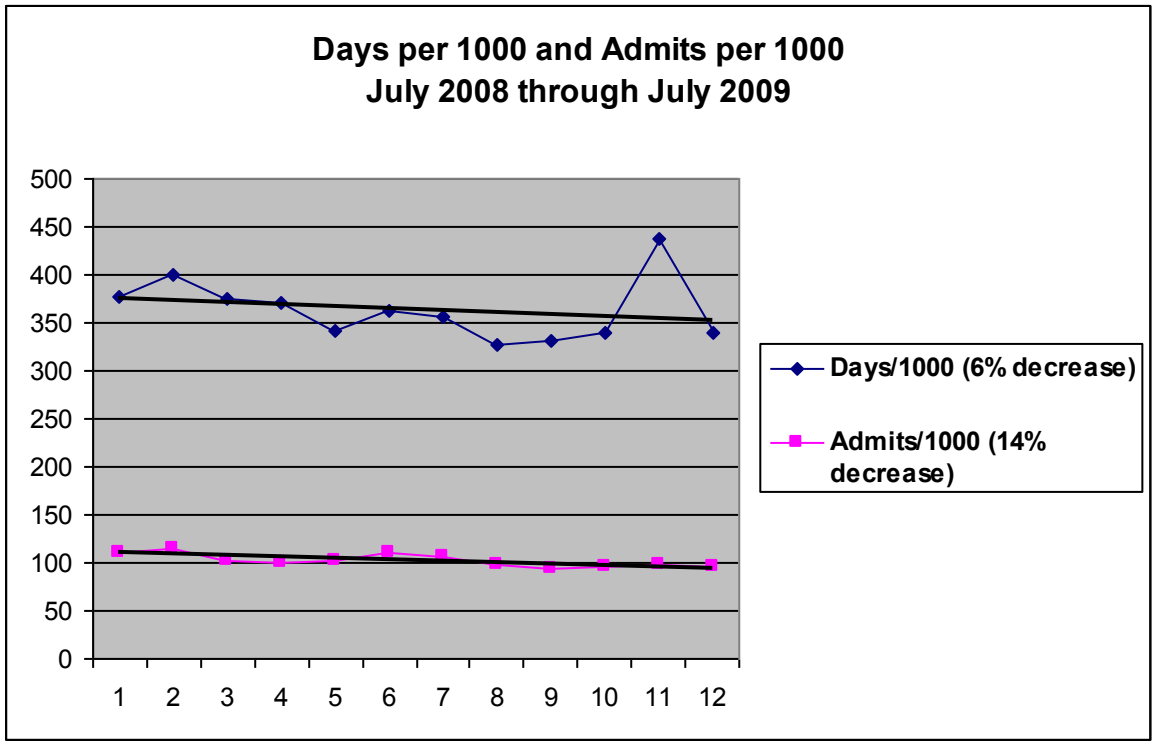
The Senior Medical Director is responsible for oversight of the Utilization Management Program and annual approval of the Utilization Management Program and related policies. The Senior Medical Director‟s responsibilities regarding Utilization Management include:

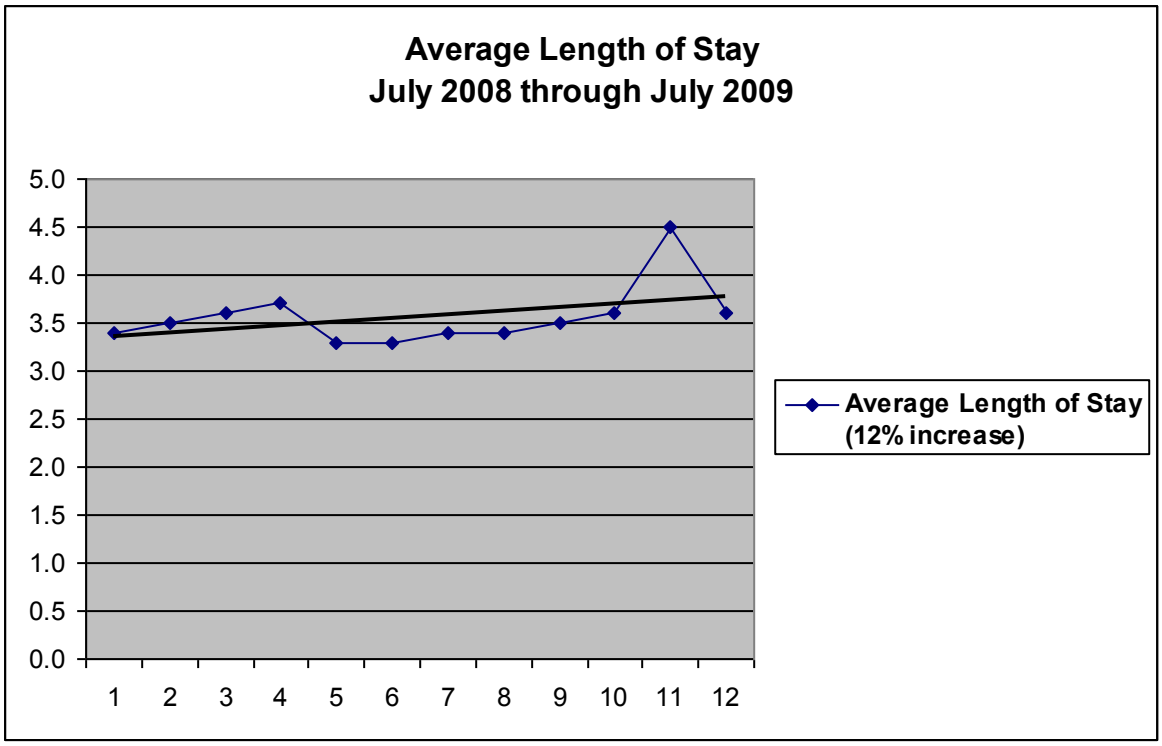
- Assure compliance with applicable state, federal, or contractor/purchaser Utilization Management Standards as described in applicable statute.
- Participate in implementation, monitoring, evaluation and developing improvement of the Utilization Management Program.
- Serve as liaison between the health plan and the network providers.

Inpatient Utilization Trends; July 1, 2008 – June 30, 2009

A. Inpatient Days: 2% Increase
B. Days per 1000 members 6% Decrease
C. Admits per 1000 members 14% Decrease
D. Average Length of Stay: 12% Increase


Inpatient Days
July 2008 through July 2009
2000
1800
1600
1400
1200
1000
800
600
400
200
0
1 2 3 4 5 6 7 8 9 10 11 12
Total Days
Inpatient Days (2% increase)


Days per 1000 and Admits per 1000
July 2008 through July 2009
500
450
400
350
300
250
200
150
100
50
0
1 2 3 4 5 6 7 8 9 10 11 12
Days/1000 (6% decrease)
Admits/1000 (14% decrease)



Re-Admissions

Children‟s Mercy Family Health Partners (CMFHP) reviews a monthly report of readmissions to the hospital with the same diagnosis within 30 days of discharge. This report is currently being used by the Care Managers and Utilization Review nurses as a tool to identify premature discharge, poor discharge planning, failed outpatient treatment, or non-compliance issues. The Utilization Management staff also monitor readmissions "real time." If an issue is identified related to potential premature discharge or poor discharge planning, the case is referred to the Quality Management department for investigation using CMFHP‟s quality of care investigation process. If the readmission is determined to be a result of member non-compliance with the treatment plan, case management is initiated in an attempt to educate the member and reinforce the treatment plan established by the member‟s physician. During this review period, there were 12 quality of care concerns forwarded to Quality Management for review from Utilization Management. All cases were reviewed by a Medical Director. Two cases were referred to the Quality Management Committee for review; no quality of care issues were identified; one case is pending resolution and one case is closed as "track and trend".

Outpatient and Emergency Department Utilization
Outpatient Visits

Children's Mercy Family Health Partners
ER and OP Data - MO HealthNet
Total membership
Table for MO Annual Report - FY2009
(July 2008 to June 2009)

	Qtr1	Qtr2	Qtr3	Qtr4	Total 2009	Total 2008	%Chg
Member Months	143,148	144,318	147,233	151,313	586,012	546,981	7%
Outpatient Medical Cost Incurred							
Emergency Room – All	3,910,617	3,768,554	4,368,651	4,449,762	16,497,584	14,756,516	12%
Outpatient Hospital	6,274,061	6,184,442	6,529,597	7,256,481	26,244,581	21,881,485	20%
Grand Total	10,184,678	9,952,996	10,898,248	11,706,243	42,742,165	36,638,001	17%
Outpatient Visits							
Emergency Room - All	10,033	9,439	10,799	10,815	41,086	37,914	8%
Outpatient Hospital	20,520	21,143	23,832	23,747	89,242	83,822	6%
Grand Total	30,553	30,582	34,631	34,562	130,328	121,736	7%
Visits per 1000 Members							
Emergency Room	841	785	880	858	841	832	1%
Outpatient Hospital	1720	1758	1942	1883	1827	1839	-1%
Cost per Visit							
Emergency Room	390	399	405	411	402	389	3%
Outpatient Hospital	306	293	274	306	294	261	13%
Grand Total	333	325	315	339	328	301	9%

Over/Under Utilization
Children‟s Mercy Family Health Partners (CMFHP) monitors over and under utilization through a variety of reporting mechanisms on a monthly and quarterly basis. CMFHP contracts with ManagedCare.com to assist in analyzing and reporting information. This organization compiles data submitted by CMFHP and prepares various utilization statistics for review of various levels and types of care (provider, facility, type of service, procedure, etc.). The database compares CMFHP‟s data to other similar populations in the database to establish a mean for any particular service. Use of this analysis allows CMFHP‟s management team to identify areas where providers are outliers among their peers.

CMFHP uses the ManagedCare.com data to prepare annual physician profiles for the highest volume primary care physicians. The profile report contains information on office visit coding, emergency room usage, and HEDIS rates for well child care and immunizations. The report compares each physician‟s medical utilization data to that of his or her peer group. The profile report is an informational tool for the physicians to identify potential practice variances and determine if opportunities for improvement exist. The reports are designed to be educational, not punitive.

CMFHP looks at aggregate utilization data monthly on inpatient claims. The data is divided into pediatric, obstetric, and adult and looks at admissions, length of stay, and days per thousand over the calendar year with comparison to the prior year. This allows CMFHP to identify trends that could indicate significant over or under utilization.

CMFHP Utilization Management staff performs onsite review at high volume hospitals and telephonic review for the remaining hospitals. The staff uses Milliman® criteria to review each admission for appropriateness of admission, continued stay, and opportunities for discharge planning. This also includes an evaluation of readmissions, failure of outpatient management, or inappropriate length of stay, which are a component of over and under utilization.
In addition, CMFHP Health Services leadership staff review a weekly high dollar claims report to identify potential outliers and determine if opportunities exist to impact utilization and cost.

Inter-Rater Reliability
The Health Services department at Children‟s Mercy Family Health Partners (CMFHP) performs audits of Pre-certification and Inpatient Review Nurses to measure consistency in staff‟s documentation and clinical decision making. The process involves review of a random sampling of cases per staff member per quarter by the Manager of Utilization Management. A tool is completed on each case to identify areas of deficiencies against the documentation standards. The Utilization Review Nurses can meet with the Medical Director on a daily basis to review current inpatient cases and discuss application of criteria for consistency in decision-making. The manager reviews the audit results with the employees in a one on one meeting.

For the review period July 2008 – June 2009 the audit findings are as follows:

FUNCTIONAL AREA	3rd Qtr- 2008	4th Qtr- 2008	1st Qtr- 2009	2nd Qtr- 2009
PRIOR AUTH STAFF	99.80%	99.%	99%	99.30%
UTILIZATION REVIEW	98%	99.40%	98.80%	99%

The percentages indicate the overall percentage of correct data entered and verified for each functional area for the indicated time frame.

Timeliness of Prior Authorization/Certification Decision Making
A monthly key indicator measurement is an indication of turnaround time on utilization management decisions. Requests are tracked for meeting standard timeframes for decision-making. In the second quarter of 2009, CMFHP implemented an on line Medical Review process. Routine services require a 2 business day turnaround for making a decision after all necessary information is received. Urgent services require a 24 hour turnaround time. Compliance with turnaround times is monitored during quarterly audits of precertification and utilization review staff. In the review period of July 2008 – June 2009, all cases reviewed met the required timeframes.

Analysis of UM Program July 2008 – June 2009:
Inpatient Utilization by number of days per 1000 members has decreased. The Average Length of Stay has significantly increased (12%); indicating an increased severity in illness for inpatient stays during this review period.

Outpatient and Emergency Department Utilization has remained "flat" over this review period, however, the per visit cost has increased by 8%.

Identified Strengths:
During the 4th quarter of 2008, CMFHP developed and implemented a Prior Authorization Manual. This comprehensive manual is a training tool for all Health Services staff and a reference resource. The manual was introduced and reviewed with all Health Services staff during monthly all staff meetings from January – June 2009.

Quarterly audit tools for prior authorization and utilization review were reviewed and revised to more adequately monitor pertinent data points within the authorization process, including timelines.

Cross training of prior authorization, utilization review, and specific administrative tasks were accomplished for assurance of consistent coverage and efficiencies.

Internal Criteria were developed and implemented for services and / or items un- available in the standardized Milliman Care Guidelines. These criteria provide a guideline for staff and assure consistency in meeting member care.

Medical reviews were transitioned to an on –line system for improved efficiency and tracking of data.

Identified Weaknesses:
A formalized Inter-Rater Reliability tool is needed to assess the application of benefit guidelines for prior authorization and concurrent review staff. Quarterly audits are performed on random authorizations per individual; however, an inter-rater reliability tool would identify opportunities for additional training and education for enhanced consistency in determinations.

Compliance with turnaround times is monitored during quarterly individual audits and has met requirements during this review period. An additional semiannual review auditing timelines only would enhance the assurance of meeting required turnaround times.

Opportunities:
- Actively pursue a formalized inter-rater reliability tool for enhancement of training and consistency.
- Develop a semiannual audit of authorizations with documented receipt of request and documentation of authorization determination date.

Harmony Health Plan of Missouri

Utilization Improvement Program Scope
ORGANIZATION MISSION STATEMENT

Harmony Health Plan of Missouri, Inc is dedicated to delivering quality, affordable healthcare that enriches our Member‟s health and quality of life; creating a rewarding and enriching environment within the Harmony community; and providing a competitive return for our investors.

I. PROGRAM DEFINITION
Utilization management (UM) is an ongoing process of assessing, planning, organizing, directing, coordinating, monitoring and evaluating utilization of healthcare services for Harmony.

II. PURPOSE
The UM Program defines and describes Harmony‟s multidisciplinary, comprehensive approach and process to manage resource allocation. The UM process influences the continuum of care by evaluating the necessity and efficiency of health care through

systematic monitoring of the medical necessity, and quality, and maximizes the cost effectiveness of the care and service provided to members.

The purpose of the UM Program is to outline the principles of utilization management (UM) as they are applied on all levels of care and to maintain a comprehensive, coordinated process, which promotes and monitors the effective utilization of health care resources within Harmony „s delivery system.

The UM Program describes the UM processes to ensure that:

- Medically necessary services are delivered at appropriate levels of care.
- Authorized care correlates to member's benefit plan according to the evidence of coverage or, if medical necessity exists, to ensure the well being of the member, authorizations may be granted outside of the benefit plan with the Medical Director approval.
- Services will be provided by Harmony contracted providers unless authorized by the Utilization Management Department staff to meet medically necessary service needs.
- Services are not over or under-utilized. Appropriate, quality-oriented care is provided in a timely manner for members.
- Scheduling for services and resources is efficient and timely.
- Costs of services are monitored and evaluated for appropriateness.
- Standards defined by governmental and accrediting agencies are adhered to, and contract requirements are maintained in compliance with the regulations.
- Application of InterQual, Medicaid, and Medicare criteria and other approved UM decision tools are appropriately used in the utilization management decision process in determining medical necessity.
- Medical necessity is based upon generally accepted medical practices in light of Conditions at the time of treatment, Medically Necessary services are those that are defined by State specific contracts.
- The Hayes Directory and other scientific medical evidence are used as a resource in the development of new utilization review criteria and new technology assessment.
- Qualified health care professionals perform all components of utilization management processes.
- A team of physicians and nurses with unrestricted licenses, currently registered along with certified Health Care Professionals who are appropriately trained in the principals, procedures and standards of Utilization Review shall perform utilization activities. The review activities are performed in accordance within their scope of practice as defined in the position job descriptions for the UM Department.
- A process for Harmony‟s Medical Director to review specialty referrals and inpatient stays when established criteria does not reflect medical necessity in order to assure appropriate utilization decisions are made. To ensure appropriate utilization denial decisions, the medical director may collaborate with the PCP or attending physician. The Medical Director(s) have access to board certified

specialists to use when necessary when making a utilization decision in determining medical necessity.The UM Program is integrated with the Harmony Quality Improvement Program to support quality of care, service, and continuous quality improvement.

- The UM Program, workplan, policies and procedures are reviewed, revised as necessary, and approved on an annual basis by the Utilization Management Committee and, forwarded to the Quality Improvement Committee for review and approval.
- Mechanisms to evaluate the UM Program by analysis of utilization statistics include, but are not limited to:
    - member complaints and grievances
    - appeals by members and/or providers of the appeal process
    - member and provider satisfaction surveys
    - Utilization Management Data to include but not limited to, bed days /K, ER /K, Average length of Stay, Pharmacy utilization, CAHPS.
- A process to evaluate the delegated entities‟ ability to perform UM activities, and monitor performance on an ongoing basis.
- Appropriate professionals including physicians, pharmacists and the contracted NCQA accredited MBHO are involved in the development and implementation of the behavioral health care aspects of the UM Program.
- A process to avoid a "conflict of interest" of the reviewing physician, medical directors, and / or Medical Advisory Committee members.
- Processes are utilized to ensure confidentiality of member and practitioner information in accordance with HIPPA.

III. GOALS

The goals of the UM Program are in accordance with, and contribute to the achievement of the mission and vision statements in the delivery of quality health care in the most cost effective manner for the members

- Ensure culturally sensitive delivery of services that are medically necessary, appropriate, and are consistent with the member's diagnosis and level of care required.
- Provide access to the most appropriate and cost efficient health care services. Ongoing monitoring, tracking and trending of care rendered to the Harmony members in order to ensure quality health care is provided.
- Works collaboratively with the Quality Improvement Department by ongoing monitoring of utilization data, Pharmacy data, physician satisfaction with the UM referral process, and in the identification of potential quality of care issues for review and implementation of intervention plans, as indicated.
- Monitors for over utilization, under utilization, continuity, and coordination of care/services and implement corrective action intervention plans, as indicated.

- Works collaboratively with the Customer Services Department and the Appeals and Grievance Committee with timely review and response to member or provider grievances/appeals relating to utilization management decisions.
- Facilitates communication and partnerships among participants, physician providers, facility providers, delegated entities, and the health plan in an effort to enhance cooperation and appropriate utilization of health care services.
- Develops targeted programs to identify participants at high-risk for incurring extensive healthcare expenses or requiring extensive and ongoing medical care for chronic, catastrophic, or complex conditions as a means of assisting the participant to receive quality care in an appropriate setting available and enhancing the outcome for the member.
- To reduce overall healthcare expenditures by developing and implementing programs that encourage preventive health care behaviors and patient partnership to foster improved care and wellness.
- Identifies members with special needs, potential and/ or high-risk disease states, high resource usage, or high cost diagnosis, and intervene to maximize appropriate utilization and the delivery of appropriate health care through the efficient use of resources.
- Reduce overall health care expenditures by promoting preventive care programs and Disease Management programs.
- Monitors, implements and maintains systems to enable compliance with government and legislative requirements of utilization management processes.

IV. OBJECTIVES

The UM Program is designed to meet and maintain its goals through monitoring and

application of the following objectives:

- Educate providers and physicians regarding medical necessity criteria and provide criteria upon request.
- Monitors selected services for medical necessity to ensure appropriate utilization.
- Monitors contractual arrangements and resource allocation to ensure appropriate services are available to meet the members‟ health care needs.
- Provide comprehensive and cost-effective health care by monitoring the following areas:
    - Emergency Room Utilization
    - Inpatient Admissions
    - Ancillary and pharmaceutical services requests
    - Outpatient services requests
    - Behavioral health care referrals
    - Under / over utilization monitoring
    - Denials / appeals
    - Fraud and Abuse

- Ensure the consistency of decision turn-around time through ongoing monitoring of authorizations.
- Evaluate new technology and application of established technologies for benefit coverage or exclusion.
- Evaluate member and physician satisfaction with the UM processes annually.
- Tracking, trending and monitoring of patient / physician complaints and grievances related to utilization management processes.
- Identify opportunities for improvement in the utilization processes; implement an intervention when indicated in order to maintain goals and objectives of the Utilization Management Program.

V. SCOPE

The scope of the Harmony UM Program is an ongoing process encompassing medical care, behavioral health, vision and dental care, and pharmaceutical management. Behavioral health care is provided through a contracted provider. The Behavioral health provider provides monthly and quarterly reporting of utilization activities to the Harmony Utilization Management Review Workgroup.

The UM Program encompasses all services and physicians who have an impact on the provision of health care. This includes the evaluation of medical necessity and the efficient use of medical services, procedures, facilities, specialty care, inpatient, outpatient, home care, skilled nursing services, ancillary services and pharmaceutical services.

The UM Program includes the delegation of selected utilization management activities to contracted health care providers who demonstrate that they have the capacity to meet and maintain the Harmony UM Delegation standards. The entities must evidence a systematic processes to monitor and evaluate utilization management activities and demonstrate their ability to perform the delegated functions as outlined by the mutually agreed upon delegated agreements.

The Utilization Management Program is designed to meet State specific requirements, as well as the State and Federal Medicaid Manuals/Handbooks and AAAHC or NCQA Accreditation Standards or State specific review agencies requirements.

The Utilization Management Program is operationalized by way of written policies and procedures. The UM Program, guidelines, and criteria are available upon request for physicians and members.

VI. ORGANIZATIONAL STRUCTURE AND ACCOUNTABILITY

- The Board of Directors has the ultimate authority and responsibility for the quality of care and services delivered to its members.
- The Board of Directors provides strategic planning and direction, budget approval, staff allocation of the UM Department.
- The Board of Directors delegates the responsibility for implementation of the UM Program to the Utilization Management Review Workgroup via Quality Improvement Committee oversight.

- The Board of Directors oversees the implementation and adherence to the UM Program utilization management activities through the Utilization Management Workgroup.
- The Board of Directors delegates the Medical Directors the responsibility for the oversight and operations of the Utilization Management Program.
- The Utilization Management Review Workgroup is a sub-committee of the Medical Advisory Committee (MAC) which reports to the Quality Improvement Committee (QIC) who reports to the Board of Directors monthly, at least ten times a year.
- The UM Program, UM Work Plan and Annual Program Evaluation are approved by the QIC, and Board of Directors annually.

Harmony organizational charts accurately reflect the reporting structure and lines of authority within the organization.

Board of Directors: The Board of Directors has overall accountability and responsibility for the quality of care and other services rendered to its members. The Board of Directors delegates the responsibility of the UM Program to the Utilization Management Review Workgroup via Quality Improvement Committee oversight.

Senior Vice President of Health Services/Chief Medical officer: The Senior Vice President of Health Services directs all programs under the Health Services Department and assures that decisions are based on medical necessity, appropriateness and quality. These programs include Utilization Management, Quality Improvement, Appeals and Grievances, Credentialing, Pharmacy and behavioral Health Services. The Senior Vice President reports directly to the Chief Executive Officer.

Clinical Pharmacy Director/Manager: The Pharmacy Director/Manager, who has appropriate education and an unrestricted license in the State, works in collaboration with the Medical Director and UM Department with responsibilities to include, but not limited to:

- Ensures operational execution of the Pharmacy Program and the administration of prescription drug benefit in collaboration with the Senior Medical Director.
- Completes Drug Utilization Review
- Reviews pharmacy prior authorization requests
- Makes recommendations and changes of the formulary changes as determined by the Pharmacy and Therapeutics (P&T) Committee
- Provides education to physicians, pharmacies, and members on the formulary
- Works collaboratively with other departments within Harmony relating to pharmaceutical management and prescription benefits management; Completes ongoing assessment of the efficacy of the Pharmacy Program and makes recommendations as needed.

VII. COMMITTEE STRUCTURE

A. Quality Improvement Committee (QIC)

Overview of Committee: Is responsible for promoting the goals and objectives of the health plan by, but not limited to:

- The QIC approves the Quality Improvement and Utilization Management Program Descriptions, work plans, and program policies and procedures annually.
- Evaluates the efficacy of the Quality Improvement and Utilization Management Programs on an annual basis.
- Reviews and approves utilization criteria, guidelines and decision support tools for use in the implementation of UM activities.

Frequency: Meets monthly not less than 9 times per year.
Minutes: Minutes are recorded and maintained for each meeting.
Reports to: Board of Directors

B. Medical Advisory Committee (MAC)

Overview of Committee: Is the principal physician committee that oversees all clinical quality improvement, utilization management and behavioral health activities.
Frequency: Meets monthly but not less than 4 times per year.
Minutes: Minutes are recorded and maintained for each meeting.
Reports to: Quality Improvement Committee

C. Delegation Oversight Committee (DOC)

Overview of Committee: Coordinates and oversees all delegated activities ensuring that delegated entities adhere to contractual, regulatory, and accreditation requirements. The Delegation Committee ensures compliance with regulatory, contractual, and accreditation standards.
Frequency: Meets monthly but not less than 9 times per year.
Minutes: Minutes are recorded and maintained for each meeting.
Reports to: Quality Improvement Committee.

D. Appeals and Grievance Committees

1. Level I Appeals and Grievance Committee

Overview of Committee: Has final authority of all Level I member and provider medical necessity appeals. Review level II administrative and benefit member and provider medical necessity appeals and grievances and make final determinations. This Committee reports to the MAC.
Frequency: Meets monthly but not less than 36 times per year.
Minutes: Minutes are recorded and maintained for each meeting.
Reports to: Medical Advisory Committee

2. Level II Appeals and Grievance Committee

Overview of Purpose: Has final authority of all Level II member and provider medical necessity appeals. Review level II member and provider medical necessity appeals and make final determinations. This Committee reports to the MAC.
Frequency: Meets monthly but not less than 36 times per year.
Minutes: Minutes are recorded and maintained for each meeting.
Reports to: Medical Advisory Committee

E. Pharmacy and Therapeutics Committee (P&T)
Overview of Committee: The Pharmacy and Therapeutics Committee is an advisory group of physicians and pharmacy providers. The Committee is responsible for recommending the adoption of, or assisting in the formulation of, broad professional policies regarding evaluation, selection, and therapeutic use of drugs by the health plan physicians. The Committee also recommends or assists in the formulation of programs designed to meet physicians‟ and pharmacy providers‟ needs with regard to complete current knowledge on matters related to drug use. The Committee also assists in the detection of possible or potential problems for health plan beneficiaries at it relates to the prescription drug program.
Frequency: Meets monthly but not less than quarterly.
Minutes: Minutes are recorded and maintained for each meeting.
Reports to: Quality Improvement Committee

F. Customer Service Quality Improvement Workgroup (CSQIW)
Overview of Committee: The committee functions as a multidisciplinary task force to identify opportunities for improvement in customer service. The committee reviews data relevant to member and provider complaints and appeals to ensure that individual member and provider issues are addressed, resolutions are appropriate and timely, the process is compliant with regulatory standards, and identified issues are referred for system response through the quality improvement process. Dedicated to the continuous quality improvement process, the committee facilitates open and consistent communication among, members, providers, the QIC and the company‟s departments. The committee‟s focus is on systemic analysis of access and quality of service provided to the members under the health care contract.
Frequency: Meets monthly but not less than quarterly.
Minutes: Minutes are recorded and maintained for each meeting.
Reports to: Medical Advisory Committee

G. Utilization Management Review Workgroup (UMRW)
Overview of Committee: The Utilization Management Review Workgroup is a sub-committee to the Medical Advisory Committee with oversight by the Quality Improvement Committee. The UMRW is chaired by the Senior Vice President/Chief Medical Officer, Health Services with standing membership from the CEO or designee, Senior Vice President, Vice President of Health Services, Vice President of Finance designee Vice President of Provider Relations or designee, Medical Director(s) including Corporate Quality MD, Vice President of Behavioral Health,

Vice President of Pharmacy, and Director(s) of Health Services Corporate and Regional. Additional internal departmental representatives will attend based on identified need.

The UMRW undertakes, but is not limited to the following ongoing activities:

- Analyzes utilization of services and cost of health care trends.
- Reviews utilization statistics, analyzes statistics for trends and recommends interventions when indicated.
- Develops appropriate strategies and programs to improve the quality delivery of health care services.
- Monitors utilization activity toward the Health Plan‟s goals and objectives.
- Monitors, implements and maintains systems to enable compliance with government and legislative requirements of utilization management processes.

Frequency: Meets monthly but not less than quarterly.
Minutes: Minutes are recorded and maintained for each meeting.
Reports to: Medical Advisory Committee

VIII. STAFF QUALIFICATIONS, RESPONSIBILITY AND AUTHORITY

The Utilization Management Department is managed by the Corporate Director of Health Services and Medical Director with an oversight by the Senior Vice President/Chief Medical Officer, and regionally by the Medical Director(s) and Regional Director of Health Services. Under the leadership of the Medical Director the UM Program and policies are implemented accordingly. The Medical Director(s) complete clinical reviews in which medical necessity is not met according to UM criteria and may discuss with the ordering or attending physicians in order to ensure the appropriate utilization decision is made. The Medical Director(s) make all medical necessity denial determinations.

The Regional Director of Health Services works in collaboration with the Regional Medical Director by providing leadership and overseeing operational implementation of the UM Program in order to facilitate the accomplishment of the UM Program goals and objectives.

Registered nurses or Licensed Practical Nurses (LPNs) under the supervision of registered nurses are responsible for inpatient case management/discharge planning, medical case management and authorizations of medically necessary services.

Non–licensed staff experienced in UM provides clerical support for inpatient, outpatient and case management areas and make utilization decision that do not require licensed staff in accordance with the authorization authority matrix and/or supporting Policies and Procedures.

The Director/Manager of Pharmacy works collaboratively with the UM Department to ensure appropriate pharmacy utilization through prior authorization and assessing formulary exceptions.

Outlined are a brief overview of the functions / responsibilities of the UM Department staff, reporting structure, and qualifications:

a. Medical Director(s)
   The Medical Director(s) are board certified, licensed and credentialed physicians who assist the Senior Vice President/Chief Medical Officer in the development and implementation of Utilization Management programs. The Medical Directors have responsibility for, but not limited to:
   - Participate in the implementation of UM Department Program.
   - Provide oversight for all programs related to authorization/pre-certification of ancillary services, inpatient services, including hospitals and skilled nursing facilities
   - Provide oversight of the disease and case management programs
   - Participate on the Medical Advisory Committee, Quality Improvement Committee, Utilization Management Review Workgroup and P&T Committee
   - Conduct UM reviews and arrange for clinical discussion with physicians
   - Participate in accreditation activities, all peer review
   - Have the authority, accountability and responsibility for denial determinations for lack of medical necessity.
   - Consult with the board certified specialists of the specialty panel for review of complex utilization issues, as appropriate

b. Director of Health Services (Corporate)
   The Director(s) of Health Services reports to the Medical Director with responsibilities that include, but not limited to:
   - Development and operational execution of the UM Program in collaboration with the Medical Director.
   - Provides efficient, effective leadership and direction to the UM staff with emphasis on appropriate healthcare utilization and resources use in the most cost-effective manner.
   - Oversees the daily operations of the UM department which includes prior authorization/pre-certification, concurrent review
   - Director of Health Services and/or designee is a member of the Utilization Management Review Workgroup, Customer Service Quality Improvement Workgroup and Delegation Oversight Committee.
   - Works collaboratively with internal departments as it relates to utilization management and health care services.
   - Coordinates the annual delegation oversight audits and monitors the delegated activities ensure compliance with Harmony UM standards and delegation standards

c. Director of Health Services (Regional)
The Director of Health Services is a Registered Nurse with an unrestricted license who reports to the Medical Director with responsibilities that include, but not limited to:

- Development and operational execution of the UM Program in collaboration with the Medical Director and Corporate Health Services.
- Provides efficient, effective leadership and direction to the UM staff with emphasis on appropriate healthcare utilization and resources use in the most cost-effective manner.
- Member of the Utilization Management Review Committee, and Delegation Oversight Committee.
- Participates in the Customer Quality Improvement Workgroup.
- Works collaboratively with internal departments as it relates to utilization management and health care services.
- Coordinates the annual delegation oversight audits and monitors the delegated activities to ensure compliance with Harmony UM standards and delegation standards

d. Manager Utilization Management
The Manager of Health Services is a Registered Nurse or a Licensed Practical Nurse with an unrestricted license who reports to the Director of Health Services with responsibilities that include, but not limited to:

- Manages the coordination of day-to-day operations of concurrent review, case management and outpatient utilization processes.
- Supports in the execution and assessment of the efficacy of the UM Program.
- Member of the utilization Management Review Workgroup.
- Generates and monitors Utilization Management data reports.
- Supervision of prior authorization, inpatient concurrent review, case management and disease management team functions and operations

e. Supervisor of Health Services
The Supervisor of Health Services is non-licensed healthcare supervisor who reports to the Director of Health Services with responsibilities that include, but not limited to:

- Supervises the coordination of day-to-day operations of referral coordinators.
- Supports in the execution and assessment of the efficacy of the UM Program.
- Generates and monitors Utilization Management data reports.
- Supervision of referral coordinators outpatient authorization review team functions and operations

f. Inpatient Concurrent Review Nurse
The Inpatient Concurrent Review Nurse is a licensed nurse with an unrestricted license who reports to the Manager of Utilization Management with responsibilities which include, but not limited to;

- Daily review and oversight of inpatient admissions using InterQual criteria to assure appropriateness of admission, level of care and length of stay taking into consideration, the individual medical/social needs, medical necessity of admission.
- Discharge planning at the time of admission to ensure appropriate services are provided that is necessary to facilitate a safe discharge or placement in the appropriate lower level of care.
- Support in the execution and assessment of the efficacy of the UM Program.

g. Prior Authorization Review Nurse
The Prior Authorization Review Nurse is a licensed nurse with unrestricted license, who reports to the Manager of Utilization Management with responsibilities that include, but not limited to;
- Perform review of requested elective admissions, outpatient services for medical necessity, appropriate delivery setting, and in accordance to existing benefit(s).
- Generate authorizations for services meeting medical necessity and existing benefits.
- Identify and refer members with chronic conditions or frequent outpatient services to Case Management and/or to the Disease Management programs, as appropriate.

h. Complex Medical Case Management Staff
The Case Manager is a licensed nurse who holds unrestricted license and/or Certified Case Management (CCM) designation, who reports to the Manager of Utilization Management with responsibilities that include, but not limited to:
- Identify members that are high utilizers of resources, in a high risk category or have a condition that is considered high cost and provide medical case management services to promote cost effective utilization of resources.
- Assist members in reaching their optimal health status though medical case management services.
- Assess, plan and coordinate necessary services for members in case management to support continuity.
- Facilitates, communicates and provides a personalized case management plan designed to meet individual member needs
- Provide authorization for services that meet medical necessity.
- Support in the execution and assessment of the efficacy of the UM Program.

i. Disease Management Nurse
The Disease Management Nurse is a Registered Nurse or Licensed Practical Nurse who holds unrestricted license and CCM, who reports to the Manager of Utilization Management with responsibilities that include, but not limited to;
- Identify and stratify members with chronic disease appropriate for interventions
- Coordinate educational outreach activities
- Coordinate and arrange for services necessary to improve health outcomes
- Support in the execution and assessment of the efficacy of the UM Program.

j. Referral Coordinator

The Utilization Management Referral Coordinator is a non-licensed Healthcare administrative support worker, who reports to the Supervisor of Health Services with responsibilities that include, but not limited to:

- Review authorizations and provide authorization number for authorizations that meet the UM approved decision criteria/tool for appropriateness.
- Forward authorizations that need medical record review for medical necessity to the Prior Authorization Nurses for review and determination.
- Obtains the appropriate UM decision information to make a utilization decision based on UM decision criteria/tools that includes, but is not limited to CPT and ICD-9 codes, and if appropriate clinical documentation to forward to the Prior Authorization Review Nurse to support medical necessity of requested service.
- Maintain the authorization turn-around-time standards
- Completes the appropriate data entry according to UM policies and procedures.
- Supports in the execution and assessment of the efficacy of the UM Program.

IX. STAFF ORIENTATION, TRAINING AND EDUCATION

Harmony recruits highly qualified individuals with experience and expertise in Utilization Management. Qualification and educational requirements are delineated in the position descriptions of the respective position.

Each new employee is provided a minimum 2-week intensive hands-on training and orientation program with a staff preceptor. The following topics are covered during the program:

- New Employee Orientation
- Use of technical equipment (phones, computers, printers, facsimile machines) Utilization Management Program, policies/procedures, standard operations procedures
- MIS data entry
- Application of Review Criteria/Guidelines

The UM Department supports continuing education and training of employees, in order to maintain and improve competency skills and performance of UM functions. Formal training, including seminars and workshops, are provided to all UM staff on an annual basis to cover topics which include, but not limited to; ICD-9 and CPT coding, review criteria application, and case and utilization management updates.

Communication, coaching, and mentoring in the utilization management department processes occur on an ongoing basis. Monitoring of the appropriate application of review criteria/guidelines, processing referrals/service authorizations, concurrent review and case management documentation by licensed nursing staff occurs on an

ongoing basis. Employees who fall below the established performance standards receive coaching, and are provided additional tools and training to assist in achieving the desired performance expectations. Inter rater reliability is performed on clinical staff per Policies and Procedures as indicated.

X. APPROPRIATE UTILIZATION OF CARE (CONFLICT OF INTEREST/NON-INCENTIVIZATION)

Harmony does not reward practitioners, providers or employees who perform utilization reviews, including those of the delegated entities. No one is compensated or otherwise given incentives to encourage denials. Utilization denials (adverse determinations) are based on lack of medical necessity, or lack of covered benefit.

Harmony and its delegated health plan partners have utilization and claims management systems in place in order to identify, track and monitor the care provided and, to ensure appropriate healthcare is provided to the members.

The following processes must be in place in order to ensure appropriate utilization of health care.

- A process to monitor for under and over utilization of services and take the appropriate intervention when identified.
- A system in place to support the analysis of utilization statistics, identification of potential quality of care issues, implement intervention plans and evaluation of the effectiveness of the actions taken.
- A process to support continuity of care across the health care continuum.

XI. METHODS OF REVIEW AND AUTHORIZATION

Harmony"s utilization management processes include Notification, Prior Authorization/Pre-certification, concurrent and retrospective evaluation of health care services. Qualified licensed and unlicensed staff in accordance with the established "Authorization Authority Matrix" reviews referral requests. The Utilization Management Department maintains a process for gathering pertinent clinical information, applying criteria/guidelines during the utilization review decision making process based on individual needs, age, co-morbidities, complications, progress of treatment, psychosocial situation, home environment, when applicable, and assessment of the local delivery system. Each medical decision must be case specific regardless of available practice guidelines. Authorizations are provided when the requested service is medically necessary and provided in the most efficient and cost effective manner without compromising quality of care

InterQual criteria and other utilization decision tools are used during the review process to validate the medical necessity of the requested service. The authorization process is supervised by a licensed nurse, and a Medical Director who provides clinical knowledge, inherent medical knowledge and expertise in the application of criteria used in the authorization decision making process. The appropriate use of criteria is incorporated in

all phases of utilization decision making processes by licensed staff. The application of clinical guidelines, individual clinical information, and local geographical practice patterns is taken into consideration during the utilization decision process. The Medical Director(s) will seek clarification from the ordering or attending physician when indicated in order to ensure the appropriate utilization decisions are made. Panels of board certified specialists are available to assist the Medical Director in the decision process. The Utilization Management Department will provide copies of UM policies, criteria or guidelines used in the authorization processes to physicians and or members upon request.

Service Authorization Review Process

The authorization process is comprehensive and, includes the following review processes:

- Notifications
- Referrals
- Prior Authorizations/Pre-certification (Prospective Review)
- Concurrent Review
- Retrospective Review

The Utilization Management Department adheres to State specific approved Authorization Turn-Around Time standards for service authorization decisions and adverse determinations and the notification time frames. These standards are applied to urgent or routine requests for prospective, concurrent and retrospective service. Physicians / providers and members may obtain urgent services twenty-four (24) hours a day, seven (7) days a week. Harmony maintains a toll-free (800) number that is staffed by utilization management Referral Coordinators to assist in obtaining services.

Notifications

Notification process involves OB providers notifying Harmony of pregnant women via the Prenatal Notification Form or other means in different States within 30 days of the initial OB visit to expedite case management, the claims process and ensure timely claims reimbursement.

Referrals

The referral process involves services that a primary care physician may initiate without prior contact with the health plan for a member to be evaluated and/or treated by a specialty physician. The UM process does not require a referral form for referrals that do not require prior authorization nor a referral number as condition of payment.

Prior Authorizations/Pre-certification (Prospective Review)

The authorization process involves the process of obtaining authorization in advance of rendering a service which may or may not require a medical review and is required for elective/non-urgent services designated by the Health Plan. Prior authorization/pre-

certification is conducted prior to a member‟s admission, stay or other service or course of treatment in a hospital or other facility. The prior authorization review is performed by non-licensed or licensed clinical staff that has experience in the authorization process. The staff conducting the reviews references the appropriate Health Services Policies and Procedures.

The following information is required to be included when submitting a service authorization request:

- Member demographic information
- Physician / provider demographic information (requesting and referring to).
- Requested service/procedure, including specific CPT/HCPCS Codes
- Member diagnosis (ICD-9 Code and description)
- Location of where the service will be performed
- Clinical indications necessitating service or referral
- Pertinent clinical and laboratory information supporting the medical necessity of the referral.

The utilization management staff is responsible to obtain the above information in order to make the appropriate utilization decision and assure that the appropriate diagnosis and procedure codes are entered into the data system. Various sources to obtain all necessary clinical information are used to include; physicians and ancillary providers clinical notes, referral/ authorization history, facility utilization information.

Concurrent Review

Inpatient Concurrent Review involves the evaluation of a continued hospital, skilled nursing, or acute rehabilitation stay for medical appropriateness utilizing appropriate criteria. This review is performed telephonically or on-site by licensed nurses utilizing information received from the attending physician, hospital UM staff, or hospital clinical staff. Concurrent review is initiated within 24 hours of or on the next business day following notification of the admission. Subsequent inpatient reviews are based on the severity of the individual case and needs of the member, complexity, treatment plan and discharge planning activity. The continued length of stay certification /authorization will occur concurrently based on evidence of continued medical necessity as determined by the individual condition of the member, and InterQual criteria appropriateness for continued stay:

- To assure that services are provided in a timely and efficient manner
- To assure that established standards of quality care are met
- To implement timely and efficient transfer to lower levels of care when clinically indicated and appropriate
- To implement effective discharge planning
- To identify cases appropriate for Complex Case Management

The Concurrent Review Nurse completes an initial assessment of the reported clinical findings taking into consideration the individual needs of the member. An InterQual

criterion is applied to assess IS/ SI in order to assure the appropriateness of the admission and to provide an authorization.
If a member no longer requires acute facility care and can receive care at a lower level of care the Concurrent Review Nurse works collaboratively with the facility in the arrangements for the discharge/transfer. If the attending physician disagrees with the plan for a lower level of care the Medical Director will discuss the member with the attending physician.

When medical necessity for continued stay is not evidenced the Concurrent Review Nurse discusses the case with the Medical Director. The Medical Director may contact the PCP or the attending to discuss the medical management plan and discharge plans to assure stability for discharge home or to a lower level of care and length of stay, prior to implementing a denial action. The Concurrent Review Nurse will notify the hospital utilization department. If the member, or attending, or the facility disagree with the recommendation of discharge by the Medical Director a request for reconsideration of denial/transfer may be made by way of the appeals process. The member (or member‟s representative), or physician may submit the appeal process in writing or verbally. A notice of non-certification letter will be issued immediately by fax, and US mail to the attending physician, facility and member. When the inpatient Concurrent Review Nurse identifies that the most appropriate care for the member based on InterQual criteria, clinical evidence and individual needs of the member needs for a, the attending physician will be notified to discuss the transfer to the appropriate level of care. Information and instructions on how to file an appeal are included in the notification. All care determinations are the responsibility of the treating physician, in conjunction with the patient.

Discharge planning begins on admission, and is designed for early identification of medical/psycho-social issues that will need post-hospital intervention. The goal of discharge planning is to initiate cost effective quality driven treatment interventions for post-hospital care at the earliest point in the admission in support of appropriate utilization.

Discharge planning is a collaborative and cooperative effort between the attending physician, hospital discharge planner, Harmony Concurrent Review Nurse, member, ancillary providers and community resources in the coordinating of care and services.

Retrospective Review
Retrospective Review is performed when a service has been provided and no authorization has been given. Retrospective authorization requests are reviewed for participating provider, continuity of care, date of enrollment and prior receipt of a claims denial.

Adverse Determination Process

If the Utilization Management staff determines that a requested service or continued hospital stay does not meet criteria for medical necessity the referral/request is forwarded to the Medical Director for re-review and determination. A Medical Director or Clinical Professional (pharmacy, dentist or behavioral health) who have the clinical knowledge in the area of requested service will make the adverse determination. The Medical Director may contact the ordering physician to discuss the service authorization request and suggest alternative service if appropriate. In the event of an adverse determination, the requesting physician/ provider are notified via telephone within 24 hours of the decision and will receive a written letter outlining their appeal rights in the mail. Members are notified in writing of the adverse determination. The reasons for an adverse determination are clearly documented and available to the member and the requesting physician. A member, or the representative of a member, has the right to appeal any services denied by the Health Services Department through pre-certification, authorization, inpatient concurrent review, or retrospective review pursuant to the Appeals & Grievances Policies and Procedures. The Member Appeal Process includes an expedited appeal process for adverse determinations where a delay in care may result in jeopardy to the life or worsening of the condition of the member. All notices of action (adverse determination letters) include appeal rights and instructions to file an appeal, the utilization criteria used in the decision process and the name and telephone number of the person who made the utilization decision.

XII. UTILIZATION REVIEW CRITERIA & REFERENCE RESOURCES

The Utilization Management Department uses review criteria that are nationally recognized and based on sound scientific, medical evidence. Physicians with an unrestricted license with professional knowledge and/or clinical expertise in the area actively participate annually in the discussion and adoption and application of all utilization decision-making criteria.

Utilization management criteria are reviewed by licensed professionals with knowledge and/or clinical expertise in the area in order to provide input into the development and adoption of UM criteria and the application of criteria annually or more often depending on the need by the QIC and the Board of Directors.

The UM decision criteria are objective and based on sound medical judgment. The appropriate use of criteria is incorporated in all phases of utilization decision making processes by licensed staff and Medical Directors. They are to be used as a reference resource, screening criteria and guideline in making the decisions regarding medical necessity services and not as a substitute for professional judgment.
The following criteria are utilized by the UM Department along with State and Federal Regulation, but not limited to:

- InterQual Criteria
- Hayes Health Technology Assessment
- St. Anthony‟s Medicare Guidelines

- State specific Medicaid Manuals
- Medicare National Coverage and Decisions
- American College of Obstetrics and Gynecology (ACOG) Guidelines for Perinatal Care
- American Academy of Pediatrics (AAP) Recommendations for Preventive Pediatric Health Care

When the established, approved criteria or tools are not appropriate, or do not meet criteria for medical necessity the Medical Director will be consulted for consideration of the application of additional utilization criteria. The Medical Director evaluates all cases that do not meet medical necessity and will make the appropriate utilization decision based on review of the clinical information provided in conjunction with discussion with the ordering or attending physician.

In compliance with contractual requirements and accreditation standards, Harmony maintains a process for applying criteria/guidelines during the utilization review process based on individual needs, age, and co-morbidities, and complications, progress of treatment, psychosocial situation and home environment when applicable, and assessment of the local delivery system.

The Utilization Management licensed staff documents the review criteria/guidelines utilized to assist with authorization decisions. In the event that a practitioner/provider questions a medical necessity/appropriateness of a modified or denial determination made by the Medical Director they are available to discuss their decision. The utilization criterion used in the decision process is available to the requesting physician upon request.

ADDITIONAL RESOURCE REFERENCES (THE MOST RECENT VERSION OF THE FOLLOWING):

- American College of Physicians - Clinical Practice Guidelines
- American Diabetes Association - Clinical Practice Recommendations
- ACOG - Standards for Obstetric - Gynecologic Services; Developed by the Committee on Professional Standards
- Guide to Clinical Preventive Services; Recommendations for clinical practice on preventive interventions; U.S. Preventive Services Task Force
- Red Book Report of the Committee on Infectious Diseases; Committee on Infectious Diseases, American Academy of Pediatrics
- Patient Care Guidelines for Nurse Practitioners; J.B. Lippincott, Company, Fourth Edition
- American Institute of Preventive Medicine Protocols
- AMA CPT Code Book St. Anthony's Publishing
- ICD-9 CM Code Book St. Anthony's Publishing
- HCPC Level II Code Book
- Physicians Drug Handbook
- Lippincott's Manual of Laboratory Diagnostic Tests
- Physician's Desk Reference
- American College of Physician's Cardiac Rehabilitation Services Guideline

- AMA's Guidelines for the Medical Management of the Home Patient Care
- Utilization Review Accreditation Commission (URAC) Utilization Review Standards
- NCQA Standards for Accreditation of Managed Care Organizations
- Numerous Medical Textbooks

XIII. PRACTICE GUIDELINES

Harmony utilizes nationally recognized, standardized, validated medical practice guideline sets which are based on current scientific knowledge and clinical experience and takes into consideration the dynamic state of medical/health care practices. Sound clinical, scientific evidence is used as a reference in the adoption of the guidelines. All practice guidelines are approved by the Medical Advisory Committee and reviewed and adopted for use by the Quality Improvement Committee annually.

XIV. EVALUATION OF NEW TECHNOLOGY

Harmony evaluates the adoption of and application of existing technology and new medical technologies for medical/surgical procedures, behavioral health procedures, pharmaceuticals and medical devices to be used in the utilization decision process. Initial review of the new medical technology will be presented to the Medical Advisory Committee which is comprised of multiple physicians with varied specialties. The Quality Improvement Committee has the ultimate authority to approve coverage of medical technologies. The Medical Director or designee will complete and present the findings of a detailed formal literature review using multiple sources (including the Hayes Directory literature /rating) to the Committees for discussion, development and approval of new technology guidelines. New technology guidelines are reviewed and approved annually by the Quality Improvement Committee.

The sources used by the Harmony Health Plans, Inc. Committees includes, but not limited to;

- The Hayes Directory of New Technologies' Status
- American Medical Association Technology News
- Peer reviewed medical and scientific literature
- Center for Medicare and Medicaid (CMS)
- Food and Drug Administration.

XV. MONOTORING FOR CONSISTENCY IN REVIEW CRITERIA APPLICATION - INTER-RATER REVIEW

Ongoing, quarterly monitoring is performed of all licensed nursing staff and annually for Medical Directors involved in the utilization decision process and application of criteria through the inter-rater review (IRR) process. This process monitors the application of criteria/guidelines and ensures accurate and consistent application according to the established policy and procedures. Variance from the application of review criteria is

used as an opportunity for improvement with a corrective intervention plan established to support consistent of application and utilization decision making.

The Utilization Management staff and Medical Directors are accountable for identifying potential or actual quality of care issues and/or over/under utilization of health care services through various avenues including but not limited to the IRR Review process and the forwarding of those issues to QI for additional research and identification of possible interventions.

XVI. MONITORING FOR OVER AND UNDER UTILIZATION

Utilization Management monitors and analyzes utilization data for over and under utilization of services. The Utilization Management workgroup selects measurement benchmarks which include but are not limited to; ER utilization, bed days/k, pharmacy utilization, NICU utilization, readmissions, and ALOS. Data is reported to appropriate committees for review and discussion at least quarterly. The committees recommend interventions when a trend is identified and monitor the efficacy of intervention taken in order to support appropriate utilization.

The Quality Improvement and Utilization Management Departments collaborate in the monitoring of utilization patterns across practices and provider sites including primary care physicians and high volume specialists. These activities include monitoring all potential quality issues related to over or under utilization of services, and evaluation of care delivered at the practitioner office by way of medical record review.

XVII MEMBER APPEALS PROCESS

Harmony provides an appeal, grievance and an expedited appeal process to ensure objective resolution for a member (or representative) appealing a utilization decision that is disputed. All appeals are resolved within the local, state and federal guideline timeframes. The Appeals and Grievance Committee has final authority over member and provider medical necessity appeals. The Appeals and Grievance Committee, Utilization Management Workgroup and Quality Improvement Committee monitor appeals trends and appeal turn around rates as part of the ongoing monitoring activities. If a trend is identified of overturned denial relating to medical necessity or benefit coverage, an in-depth review of the utilization decision process will be undertaken with the implementation of an intervention plan, as appropriate.

XVIII COMMUNICATION SERVICES AVAILABLE TO MEMBERS AND PROVIDERS

Harmony provides the following communication services for practitioners and members for incoming calls regarding UM issues:

- Utilization Management staff is available at least eight hours a day to receive inbound calls during normal business hours for information and authorization of care.
- Outbound communication from the Utilization Management staff regarding Utilization Management inquiries is available during normal business hours.

- The Utilization Management staff will identify the organization, their name and title when initiating, receiving or returning calls.
- Members, physicians and providers have access to UM staff during normal business hours to discuss questions regarding the UM process.
- After hours UM access is available either through an after hours service or voicemail box or Harmony UM 24/7 staff depending on the State requirements. Medical Directors are available after hours or non-business days, if State requirement.
- Harmony has a toll-free number to accept collect calls regarding UM issues and is available for members and physicians.
- Physicians and providers have direct access to Utilization Management for case discussion of UM decisions.
- Member Service staff address member utilization general inquiry questions and will collaborate with Utilization Management as appropriate.
- All case specific UM inquiries are triaged to UM and addressed by the UM staff.
- Access to the UM Department is available via Website, fax and telephone.

Instructions on how to access UM staff are included in the Member and Provider Handbooks, and they are also posted on Harmony website.

XIX. COMPUTERIZED SYSTEM SUPPORT

Harmony"s Utilization Management Department uses various computerized data systems, including but not limited to Peradigm and Sidewinder, for the maintenance and tracking of utilization management activities. The systems contain an extensive database of supporting information and the ability to provide tracking and reporting of various utilization management functions.

The following are the on-line information sources available through the system:

- Eligibility and benefits verification
- Authorization status
- Physician and provider network participation status
- Case/Disease Management Status and corresponding notes

The system"s features assist the UM staff to:

- Maintain member"s demographics, clinical data and utilization history
- Identify cases for scheduled review
- Identify CMS and Case Management cases
- Assign system generated authorization numbers
- Identify cases referred for Medical Director review
- Identify cases requiring additional clinical information (pend status)
- Assign LOS according to the review determination

The system has the capacity of generating a wide variety of reports including but not limited to:

- Adverse determination tracking
- Authorizations by type
- LOS vs. ALOS comparison
- Bed Day utilization
- Pended cases
- Practice Patterns by practitioner

The UM management staff and Medical Directors are accountable for identifying potential or actual quality of care issues and/or over/under utilization of health care services and forwarding to QI for additional assessment, research and processing.

XX. DELEGATION OF UTILIZATION MANAGEMENT ACTIVITIES

Harmony retains accountability for utilization management activities that are delegated to the subcontracted providers and health plan partners.

In order to receive a delegation status for utilization management activities, the delegated entity must demonstrate that ongoing, functioning systems are in place and meet the required utilization management standards. There must be a mutually agreed upon written delegation agreement describing the responsibilities of Harmony and the delegated entities. Delegation of selected functions may occur only after an initial audit of the utilization activities has been completed and there is evidence that the Harmony delegation requirements are met. These requirements include; a written description of the specific utilization delegated activities, semi-annual reporting requirements, evaluation mechanisms, and remedies available to Harmony if the delegated entity does not fulfill its obligations. The Delegation Oversight findings are presented to corporate Delegation Oversight Committee (DOC) for approval of granting, continuation or revocation of the delegation status. On at least a quarterly basis, the DOC reports its findings and recommendations related to delegation status to the QIC.

Delegates are required to submit their UM Program, workplan and annual evaluation pre-contractually and on an annual basis. At least annually or more frequently, audits of the delegated entity are preformed to ensure compliance with Harmony‟s delegation requirements. Any entity requiring a Corrective Action Plan (CAP), will be monitored until the CAP is completed and the entity found to be compliant with the UM Program.

XXI. CARE MANAGEMENT PROGRAMS

Harmony developed and implemented multiple case management programs focused on specific type of population, condition or age group. The following programs are offered by Harmony:

1. Complex Case Management

The Complex Case Management Program is a part of the overall Utilization Management Program, and falls under the structure and reporting responsibilities of the Utilization Management Department. It is a clinical Program that is a proactive process designed to efficiently coordinate services for targeted populations at risk. Medical Case Management promotes an interdisciplinary approach to meeting member needs throughout an episode of illness across the health care continuum in outpatient setting.

Key to the program is early recognition, intervention and coordination of care often at the first point of entry into system.

Members who have the potential or who have a high-risk health history, high volume utilization of resources, non-compliance or high cost health care needs may be referred in to medical case management.

The purpose of the Complex Case Management Program (CCM) is to identify and facilitate options and services for meeting the member‟s healthcare needs, while decreasing fragmentation and duplication of care. Case Management is a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet an individuals health needs, using communication and available resources to promote quality, cost effective outcomes.[1] It is one component used to control, direct, and approve access to the services available to members in their benefit packages. Case Management is not a single episode but occurs across a continuum of care, addressing ongoing individual needs rather than being restricted to a single practice setting.

Complex Case Management utilizes a two-fold approach to Case Management, firmly establishing the member‟s Primary Care Physician (PCP) as the principle case manager with the Case Management programs augmenting the physician‟s role in directing. The PCP is responsible and accountable for the routine care of the member.

2. Pediatric Case Management

The purpose of the Pediatric Case Management Program is to facilitate the delivery of quality health care to those members, age 21 and younger, with "special health care needs." In addition, the program works in partnership with our providers in developing and coordinating the appropriate plan of treatment. Members identified for inclusion in the program have a serious or chronic physical or developmental condition that requires extensive preventive and maintenance health care interventions.

3. Pediatric Lead Case Management

The purpose of the Pediatric Lead Case Management Program is to facilitate the testing of children at the appropriate ages for lead poisoning and to identify those children with increased lead levels and recommended follow-up treatment and education. In addition, the program works in partnership with our providers in developing and coordinating the appropriate plan of treatment including all necessary referrals, coordination with specific agencies (as outlined by the State Lead Poisoning guidelines), and aggressive pursuit of non-compliance with follow-up tests and appointments for our pediatric members identified with elevated lead levels. Members are monitored and treatment plans adjusted until the venous sample lead level is below 10 mcg/dl. Early detection of elevated blood

[1] CMSA (1998).

levels and education on lead level screening and prevention will improve outcomes and decrease medical costs.

4. HIV/AIDS Case Management

The Purpose of the HIV/AIDS Care Management Program is to improve the care management of members diagnosed with HIV/AIDS by facilitating the delivery of comprehensive quality care in partnership with our providers.

The coordination of care will allow our members to receive the most current standard-of-care for this evolving illness. It focuses on effective diagnostic modalities and effective maintenance therapies. The interventions to prevent and/or treat co-morbid conditions, advocating for preventive measures and avoidance of risk-associated behaviors to reduce the transmission of the HIV virus in the community are keys to the coordination efforts of this program.

5. Prenatal Case Management

The Harmony Prenatal Program‟s purpose is to improve the care management of pregnant women by starting early in their pregnancy providing educational information and working in partnership with our OB providers to enable members to receive optimal prenatal care and avoid high-risk behaviors. In addition, the program will identify members with potential risk factors that may adversely affect the outcome of their pregnancy. Early prenatal care and education of members will improve outcomes and decrease medical costs. These services will be provided in accordance with generally accepted standards of care and member services. The Prenatal Program will encourage pregnant women to practice good prenatal care through direct mailings of educational materials and advocating for consistent follow-up with their Provider. Close member-provider follow-up is encouraged and members who complete six (6) prenatal visits and one (1) postpartum visit in the appropriate timeframe are eligible to receive a nominal gift.

6. Transplant Case Management

The purpose of Harmony‟s Transplant Case Management Program is to facilitate the delivery of quality transplant-related health care to members throughout the stages of the transplantation process. In addition, this program works in partnership with our physicians and facilities in developing and coordinating the appropriate e plan of care. This process includes the pre-evaluation period, donor search through the UNOS listing, organ/tissue transplantation, and a minimum of one-year post-transplantation or withdrawal from the Plan.

Transplant Case Management achieves and maintains member wellness through a program of advocacy, communication, education and identification and facilitation of services. Transplant Case Management is not an episode but occurs across a continuum of care, addressing ongoing individual needs rather than being restricted to a single

practice setting. Transplant Case Management is one component in a managed care system used to control, direct, and approve access to services available to members in their benefit packages

7. Wound Case Management

The purpose of Harmony‟s Wound Case Management program is to identify members with significant non-healing wounds and to provide appropriate interventions to promote rapid wound healing. Given that wounds are often the result of underlying chronic illness, an important component of the program is member education to optimize the care of the underlying chronic condition that may be contributing to poor wound healing. Good wound case management should contribute to the rate of wound healing, reduce hospital admissions, and decrease the costs associated with chronic wound care.

XXII. DISEASE MANAGEMENT

Harmony recognizes the importance of managing chronic long-term conditions. These conditions are very costly, complex and require education and behavior modification to achieve desired quality outcomes, both in quality of life for the member and cost-effectiveness.

Harmony offers disease management programs for Asthma, Diabetes, and Congestive Heart Failure. These programs aim to provide identified members with education and to empower them to make behavior changes to ensure the choices they make will improve their health and reduce the complications of their disease. The programs also provide member and provider education on preventative measures, standards of care, and current treatment recommendations.

XXIII. INTERFACE QUALITY IMPROVEMENT

Utilization Management is integrated with Quality Improvement. Utilization Management identifies care that exposes members to unnecessary morbidity or mortality and reports these issues to QI. Utilization Management also reports quality of care issues to QI where the issues are investigated and monitored. Utilization Management supports all quality activities including but not limited to related clinical studies and HEDIS®.

XXIV. DATA ANALYSIS AND REPORTING

Health Services staff monitor critical care and service indicators routinely. When opportunities for improvement are identified, interventions are implemented with appropriate follow-up to ensure that the interventions have been effective. Data and action plans are reported to the Medical Advisory Committee and the Quality Improvement Committee, as well as other departments, when necessary. Indicators currently monitored include:

1) Inter-rater reliability
2) Over- and under-utilization
3) Timeliness of Authorizations

4) Telephone Accessibility
5) Other activities as required by local, state and federal guidelines.

XXV. INTERDEPARTMENTAL COMMUNICATION

It is vital to the success of the Health Services Program to have proactive interdepartmental communication regarding utilization issues. Ongoing and active communication is maintained through informal processes as well as through the following activities:

1) Management meetings
2) Staff meetings
3) Inservices
4) Continuous Quality Improvement Teams
5) Committees
6) Adhoc Work Groups

XXVI. REGULATORY COMPLIANCE

Harmony will comply with appropriate regulatory bodies quality improvement and utilization management requirements as outlined in local, state and federal contracts and/or guidelines.

XXVII.CONFIDENTIALITY

Due to the nature of routine utilization management operations, Harmony has implemented policies and procedures to protect and ensure confidential and privileged medical record information in accordance with HIPPA. Upon employment, all employees sign a written statement delineating responsibility for maintaining confidentiality. In addition, all UM staff and Committee members are required to sign a Confidentiality Agreement.

Patient-specific clinical and non-clinical information will not be disclosed except to persons authorized to receive such information in the process of conducting utilization, quality, and case or disease management activities.

The UM staff voice mail phone message line for utilization information, and the computer network system are controlled by a secured password system, accessible only by the individual employee. The facsimile machines used for utilization review purposes are located within the department to assure monitoring of confidential medical record information by UM staff.

XXVIII. UTILIZATION MANAGEMENT WORK PLAN

Annually, the Utilization Management Department develops a Utilization Management Work Plan for the upcoming year. The Work Plan integrates UM reporting and studies, and includes requirements for external reporting.

The work plan includes the following elements:

1) A written measurable objective for each Utilization Management initiative planned
2) An attachment of all clinical care and service indicators, benchmarks, performance goals, and previous year"s results
3) Schedules of reporting to Board of Directors and QIC
4) Schedules of reporting to outside regulatory agencies
5) The name of the person responsible for implementation and management of the initiative, the initiation date, the timeframe, monthly updates, and the targeted completion date

The Utilization Management Work Plan is approved by the Medical Advisory Committee and the Quality Improvement Committee.

XXIX. SATISFACTION WITH UM PROCESS

Harmony participates in annual member and practitioner satisfaction surveys. Satisfaction with UM process is included in these surveys. Survey findings relating to satisfaction with the UM process are presented to UMW for discussion and implementation of an intervention plan for improving satisfaction. Ongoing monitoring of satisfaction with the utilization processes is incorporated into the daily activities of UM. In the event identified issues and trends are noted an intervention will be implemented.

XXX. ANNUAL EVALUATION

The Utilization Management Program will be reviewed and evaluated annually by the Medical Advisory Committee and the Quality Improvement Committee to assess objectives, scope, implementation, organization, and effectiveness.

Summary of UM Statistics
Opportunities and Evaluation and Utilization Management Statistics

UM Program Scope:
The UM Program Scope has not significantly changed in the last contract year, although the implementation of several of the process improvements (for example the inter-rater reliability process and the improved functionality in case management around a health risk assessment for children with special health care needs) has increased the effectiveness of the overall program.

Inpatient utilization:
Acute care utilization statistics are graphed below, with the targets for the days (visits) /1000, admits (discharges)/1000, average length of stay, and readmit rate. Acute care days are defined as the following:

- Medical and surgical days
- OB days and births and
- NICU days

Behavioral health statistics are reported separately.

Discharges Per Year

Admits (discharges)/1000:

The Plan admits per thousand or discharges/1000 decreased for this contract year as compared to the last contract year:

Contract year results=167

Quarter 3, 2008	Quarter 4, 2008	Quarter 1, 2009	Quarter 2, 2009	Contract Year Results
174	170	166	158	167
Quarter 3, 2007	Quarter 4, 2007	Quarter 1, 2008	Quarter 2, 2008	Previous Contract Year Results
239	196	200	204	191

Inpatient Visits

Inpatient Days (visits)/1000:

The days (visits) per thousand decreased in this contract year as compared to the last contract year, but this statistic was still higher than the target goal. The outlier quarter was the first quarter, 2009 due to two set of extremely premature twins, all four of the neonates born with birth weights between 455-704 grams. One set of twins was hospitalized for four months and the other set of twins was hospitalized for seven months. All of their days were assigned back to the month of their birth, which was in the first quarter of 2009.

Contract year results= 576

Quarter 3, 2008	Quarter 4, 2008	Quarter 1, 2009	Quarter 2, 2009	Contract Year Results
578	566	620	542	576
Quarter 3, 2007	Quarter 4, 2007	Quarter 1, 2008	Quarter 2, 2008	Previous Contract Year Results
810	712	592	664	613

Average Length of Stay

The average length of stay increased slightly for this contract year over the previous contract year but is still less than the target of 3.5.

Contract year result=3.46
Goal: 3.5 or less

Quarter 3, 2008	Quarter 4, 2008	Quarter 1, 2009	Quarter 2, 2009	Contract Year Results
3.33	3.33	3.73	3.44	3.46
Quarter 3, 2007	Quarter 4, 2007	Quarter 1, 2008	Quarter 2, 2008	Previous

				Contract Year Results
3.39	3.63	2.95	3.26	3.21

Re-Admissions
The readmit rate for the entire contract year is 5.4% which is slightly higher than the previous contract year, but is still less than the 6% target.

Contract year result=5.4
Goal: less than 6%

Quarter 3, 2008	Quarter 4, 2008	Quarter 1, 2009	Quarter 2, 2009	Contract Year Results
6.1	5.3	4.1	6.1	5.4
Quarter 3, 2007	Quarter 4, 2007	Quarter 1, 2008	Quarter 2, 2008	Previous Contract Year Results
5.6	1.9	5.7	6.2	5.0

Analysis/Barriers:
Due to the high percentage of inpatient days (visits) due to catastrophic cases, the overall Missouri Medicaid acute care days (visits) /1000 were above targets (actual 576 vs annual target of 505) during the contract year. However, despite the high proportion of outlier admits, the overall days (visits) /1000 were lower than the previous contract year. The average length of stay and the readmit rates were within targets.

Recommendations:
Due to the variability of neonatal lengths of stay and the impact of this on our small population, the Plan will begin targeting days/1000 goals only for medical and surgical admissions for the next contract year. Otherwise we will continue the present management.

Emergency Department Utilization
Harmony Health Plan of MO ER Outreach Program
Please see description of the ER diversion program in Section 10.2.
The scope of the ER Outreach Program encompasses any enrolled member of the Harmony Health Plan of IL, regardless of age, sex, race, religion, and/or cultural orientation who are utilizing Emergency Room services more than 3 times per quarter

The purpose of the ER Outreach Program is to insure that members and providers:

- Have knowledge of and utilize the 24 Hours Nurse Triage Line
- Evaluate emergent versus non-emergent symptoms and proceed accordingly
- Have access to and provide/receive continuity of care and coordination of services

- Understand the difference between an Urgent Care Center (Non-emergent) and an Emergency Department (Emergent) and utilize appropriately
- Participate in the sharing/receiving of utilization and educational materials
- Utilize preventive care and case management referral services
- Act as an Advocate for the membership and report access and availability issues

Analysis of ER Diversion Program within Case Management

MISSOURI ER DIVERSION REPORT SUMMARY						
	Total number of member on Report	Total number of members with >4 visits	Number of Members Outreached	Number of members to receive an ER Outreach Letter	Number of Letters sent to Providers	Number of members opened to Case Management
July-08	2263	9	9	9	9	0
September-08	2997	22	22	22	22	0
November-08	2892	24	24	24	24	1 (BH)
December-08	2820	15	13	12	12	1 (DM)
January-09	2862	11	7	7	7	0
February-09	2960	12	9	9	9	0
March-09	3113	10	10	10	10	0
April-09	3144	20	18	18	18	0
May-09	3208	12	0	0	0	0
June-09	3391	9	9	9	9	1 (8 members followed by Health Coach for 2 months)

ER Results: The Plan identified that the rate of emergency room utilization decreased by 4.9% during this contract year compared to the previous contract year. The ER rate (ER visits/1000) during this contract year was 958 compared to 1,007 in the last contract year. This rate is still higher than other Medicaid plans and continues to represent an area of opportunity.

ER Activities and Recommendations: Overutilization of emergency room is an identified problem. The Plan has reinvigorated the ER outreach program where members with multiple ER visits are sent brochures on how to access their physicians and our after-hours nurse line and when to go to the emergency room. We worked with and will continue to work with physicians about implementing longer office hours and will evaluate contracting with after-hours urgent care centers.

Outpatient Visits
Outpatient visits --Type of services/number of requests:
During the year, the Plan had 4,167 requests for outpatient services (excluding observation) from Missouri Medicaid members that require Plan approval, the majority of which were OB global, consult and treat, and consult and treat.

The types of authorizations requests with more than 100 in the last contract year were as follows:

Outpatient Auth Requests.	
AMS	450
CTD	515
DME	176
HHS	309
MRI	132
OBG	1003
OBU	137
OPH	318
RAD	203
RTH	166

Over/Under Utilization
Analysis:
Inpatient: The Plan identified a potential area of over utilization in the days/1000 compared to targets. However, as previously noted, the two sets of two premature babies had a total of 670 inpatient days. Due to the high percentage of inpatient days due to catastrophic cases, the overall Missouri Medicaid acute care days/1000 were above targets (actual 576 vs annual target of 505) during the contract year. Despite the high proportion of outlier admits, the overall days/1000 were lower than the previous contract year.
The average length of stay and the readmit rates were within targets.

ER: The Plan identified that the rate of emergency room utilization decreased by 4.9% during this contract year compared to the previous contract year. The ER rate (ER visits/1000) during this contract year was 958 compared to 1,007 in the last contract year. This rate is still higher than other Medicaid plans and represents an area of opportunity.

Outpatient: The outpatient utilization (outpatient vists/1000) also decreased. The outpatient utilization decreased by 8.2%. The outpatient claims/1000 were 503 during this contract year compared with 548 in the last contract year.

Physician: The physician visits/1000 based off of claims detail increased 3.5% over the previous year.

Activities and Recommendations**:**
Inpatient: Due to the variability of neonatal lengths of stay and the impact of this on our small population, the Plan will begin targeting days/1000 goals only for medical and surgical admissions for the next contract year. Otherwise the Plan will continue the present management.

ER: Overutilization of emergency room is an identified problem. The Plan has reinvigorated the ER outreach program where members with multiple ER visits are sent brochures on how to access their physicians and our after-hours nurse line and when to go to the emergency room. We worked with and will continue to work with physicians about implementing longer office hours and will evaluate contracting with after-hours urgent care centers.

Outpatient: No issues or trends identified. Continue present management.

Physician: Although the physician utilization increased, the Plan does not see this as an area of overutilization. Our goal is to have members see their PCPs and other physician members of the medical team. Our emphasis instead has been to encourage members to see physicians for preventive care, so our activities will be to further increase physician visits.

Inter-Rater Reliability
Inter Rater Reliability (IRR) and Staff Audits:
The Plan conducts inter-rater reliability (IRR) testing annually. In 2008, the Plan changed the IRR process to use a commercially available testing product from McKesson. After retraining, all clinical reviewers were tested. Reviewers who did not achieve a passing score received targeted retraining and tested again. The annual IRR process was completed in December, 2008.

Additionally, the nurses are audited by an internal auditing team every other month to evaluate their performance of the concurrent review processes. The nurses are audited on the appropriateness and timeliness of their documentation and appropriate referrals to behavioral health, case management, disease management and quality. During the first half of 2009, since this process was implemented, the nurses met or exceeded standards.

Timeliness of Care Delivery
The timeliness of the care does not always require Plan approval. For example, most referrals to participating specialists and most referrals for tests at participating facilities do not require Plan approval.
For the services that do require Plan approval, we did not adequately track the turnaround times until 1.1.2009. For the last six months of the contract our turnaround times for referral requests was the following:

- Inpatient: 84% within 2 days, 96% within 5 days, 98,6% within 14 days
- Outpatient and all other: 82 % within 2 days, 91.3% within 5 days, 99.7% within 14 days.

For inpatient requests, we offered providers more time to obtain and transmit clinical information prior to a denial determination. However, we will be less flexible beginning in 2010 as we tighten our processes to comply with NCQA turn around times.

Timeliness of Care Prior Authorization and Decision Making:
Prior authorization for Inpatient and Observation Visit Denials:
The statistics for inpatient and observation denials are noted below.

The denials for inpatient and observation could be either partial (for one or more days of an admit) or total. The types of denials are either medical necessity or administrative (for participating hospitals not following contractual requirements).

2008-2009 Inpatient and Observation Denials

	Admissions	Inpatient Denials	Inpatient Rehab Denials	Observation Denials	Total Denials	Denial Percentage
Contract Year 2008-2009	2,193	35	2	4	41	1.9%

	Admissions	Medical Necessity Denials	Administrative Denials	Denial Percentage
Contract Year 2008-2009	2,193	27	14	1.9%

Analysis/Recommendations: These denial rates are within industry standards and there are no significant variations over time in the either the type or percentage of denials.

Recommendations: An opportunity for the future is to ensure that all pre-service determinations (including all inpatient reviews and any potential denials) occur within one business day to meet the NCQA timeframes. This will be a focus of the inpatient UM activities during the next contract year.

The Plan will also monitor for overturns on appeals by type of service to determine if further process changes are warranted.

Analysis and Recommendations**:** No barriers noted. Continue present management.

Timeliness of Prior Authorization/Certification Decision Making
Decision Making for Outpatient Visit Denials
Wellcare completed a total of 63 denials as outlined in the charts below. WellCare can report a 100 % compliance rate with required review timeframes and member notification requirements.

2008-2009 Outpatient Denials

	Authorization requests	Medical Necessity Denials	Administrative Denials	Denial Percentage
2008- 2009 Contract Year	4,167	20	43	1.5%

Analysis/Recommendations: The denial rate for inpatient services was 1.9% and for outpatient requests was 1.5%, and overall average denial rate of 1.6%.
These denial rates are within industry standards and there are no significant variations over time in the either the type or percentage of denials

Recommendations: Monitor for overturns on appeals by type of service to determine if further process changes are warranted.

Denial Turn around Time Frames for all services (inpatient and outpatient):

Year		2008						2009					
		Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Medical Necessity	0-3 Days	2	2	2	1	0	2	0	1	4	2	0	2
	4-14 Days	1	0	2	4	3	2	5	3	2	5	2	0
	15+ Days	0	0	0	0	0	0	0	0	0	0	0	0
Administrative	0-3 Days	2	1	1	1	3	1	2	3	0	3	0	1
	4-14 Days	2	3	2	2	1	5	2	7	2	5	2	2
	15+ Days	0	0	0	0	1	2	1	0	0	0	0	0

Analysis and recommendations:

There were no issues identified in the outpatient prior authorization/decision making process. The turnaround times are within required timeframes, as the cases with turnaround times over five days typically involve Medical Director review. Member notification requirements were met as well. There are no barriers or opportunities noted.

HealthCare USA

Utilization Improvement Program Scope

The Utilization Management (UM) Program includes pre-service, concurrent and post service or retrospective review of the appropriateness of member health care and services. The Utilization Management program is overseen by a HealthCare USA Medical Director and report to the Quality Management Council. As such, the UM program is included in the Quality program charter, strategy and workplan.

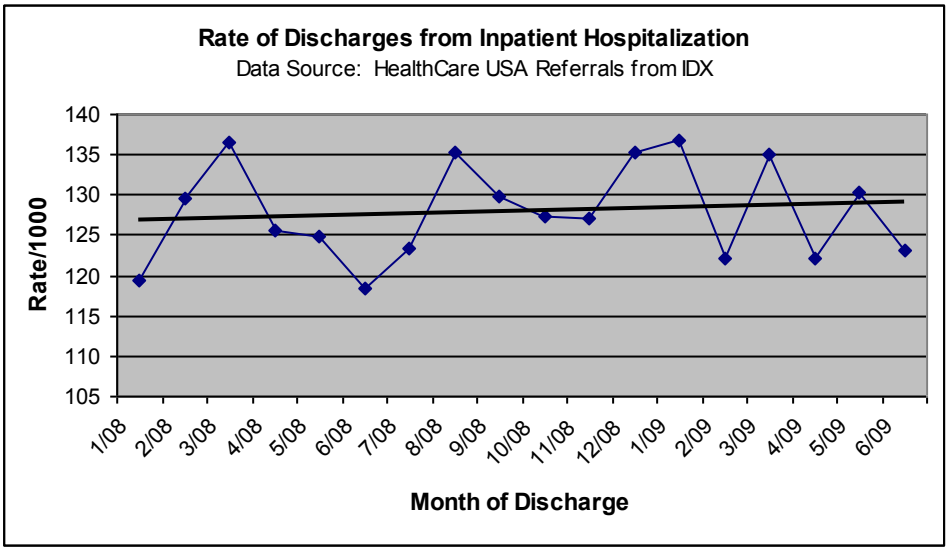
Pre-service or Preauthorization is defined as the review strategy that helps determine appropriate utilization before care is delivered, as compared to concurrent review, which is the review

strategy to determine appropriateness as care and services are being delivered. Pre-authorization is described in detail starting on page 88 of this document.

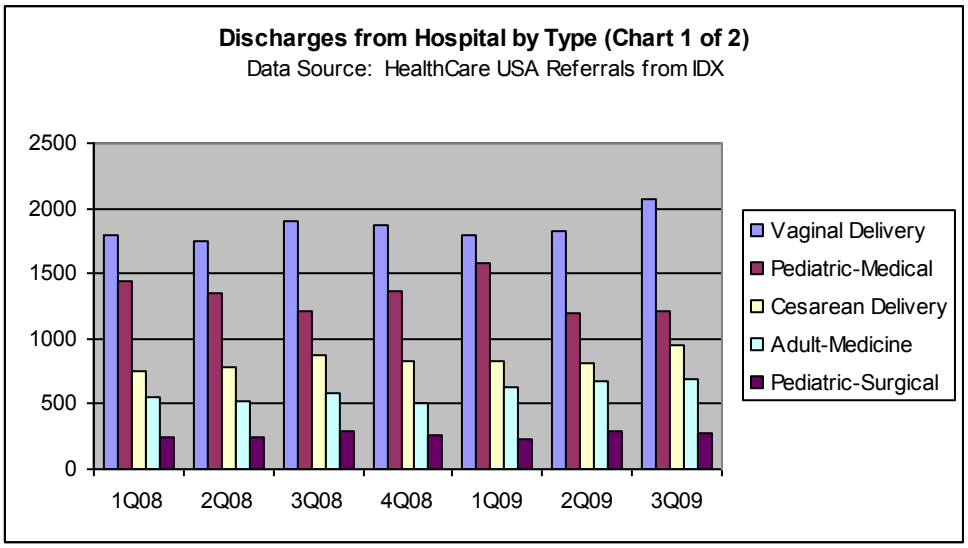
The staff review each using nationally recognized InterQual® criteria and/or Coventry technical specifications and/or community physician developed decision support tools/protocols when InterQual Criteria are not available. Staff are responsible for ensuring consistency of services/procedures with guideline application and referring all cases that do not meet the criteria to a Medical Director for review.

The UM staff are charged with the consistent application of, InterQual® criteria and/or Coventry technical specifications and/or community physician developed decision support tools/protocols when InterQual Criteria are not available, coordination of alternative care arrangements for acute admission and/or observation stays, and arranging referrals to complex case management, disease management, behavioral health and/or social work when appropriate and timely and appropriate discharge planning, when the care and services are in an in-patient setting.

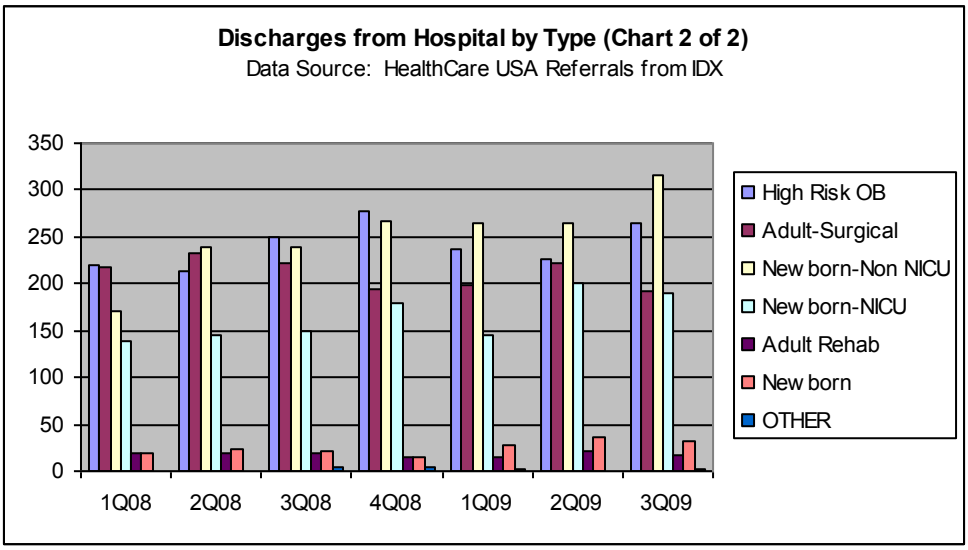
Discharges Per Year



The rate of discharges from inpatient hospitalizations has increased slightly from the beginning of 2008.

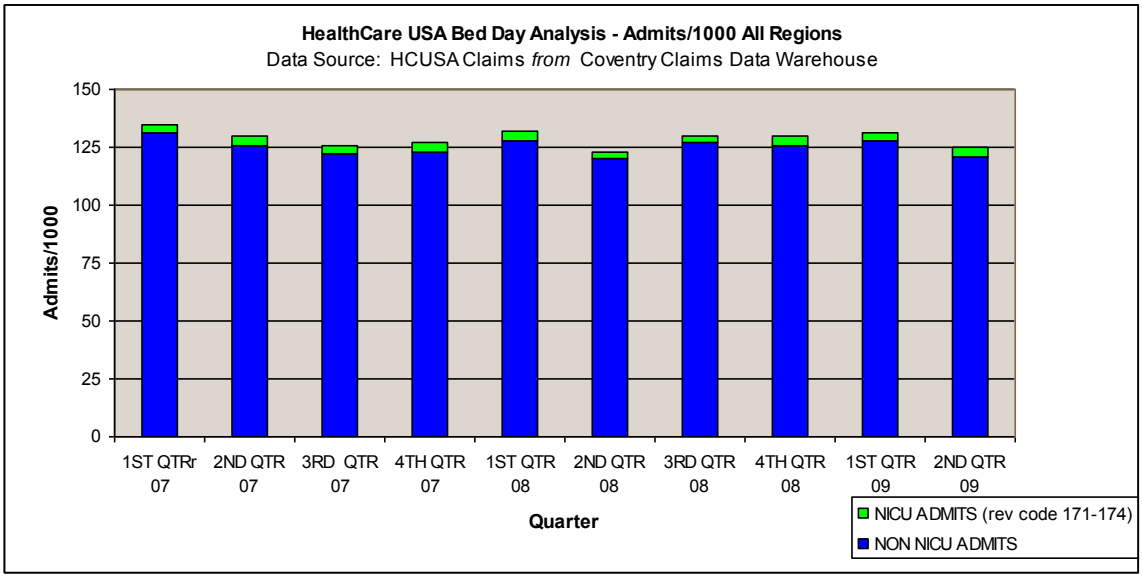


There has been an increase since first quarter 2008 of vaginal and cesarean deliveries. Pediatric and adult medical has varied quarter to quarter, with peaks during first quarter.



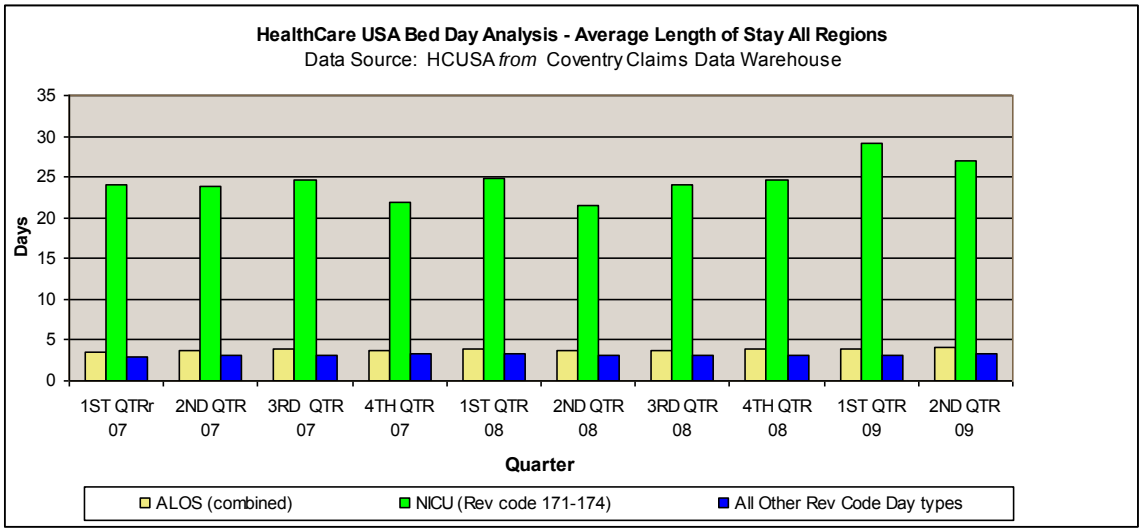
In line with deliveries, newborn non-NICU admissions have increased since first quarter 2008. Newborn NICU is higher overall, but has declined slightly since third quarter 2009. NICU for purposes of this report is related to day type/revenue codes and not just the NICU.

Inpatient Visits



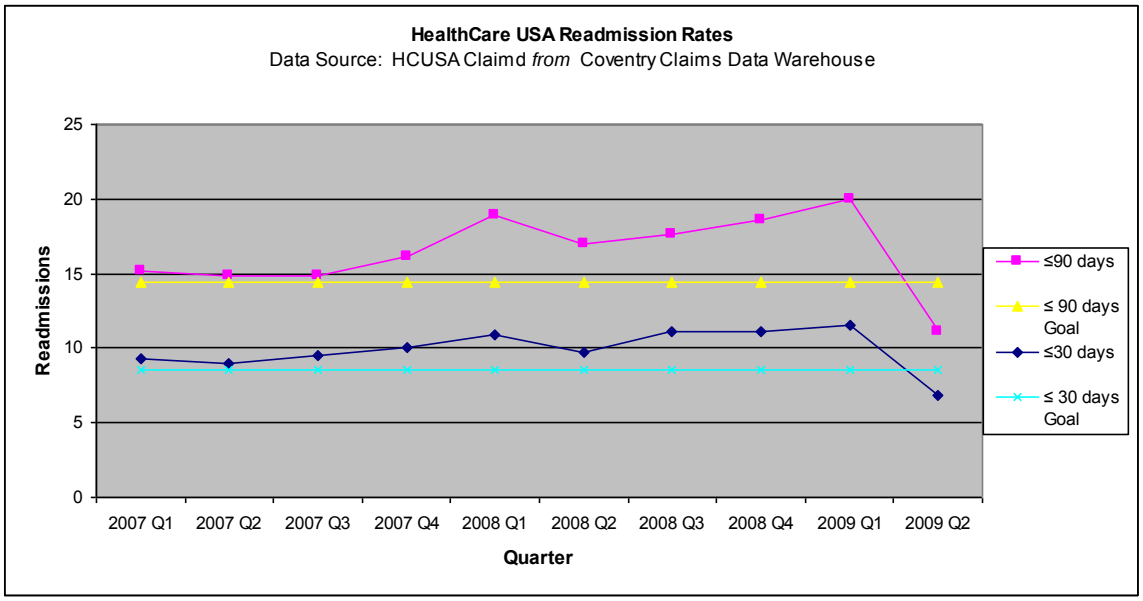
The rate remains essentially unchanged since Q107. NICU for purposes of this report is related to day type/rev codes and not just the Neonatal Intensive Care Unit.

Average Length of Stay



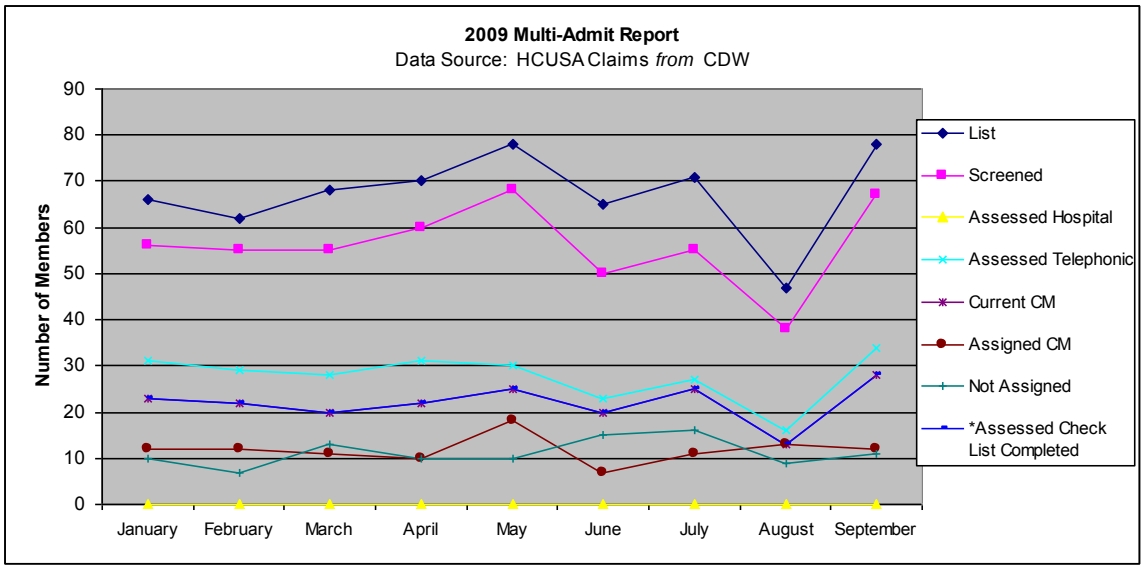
Q209 was the first quarter where the combined average length of stay (ALOS) was 4.0 or greater. Combined admissions decreased, but length of stay was up slightly. NICU ALOS decreased from 29.2 to 27 and non NICU increased slightly to 3.3 from the prior quarter 3.2.

Re-Admissions



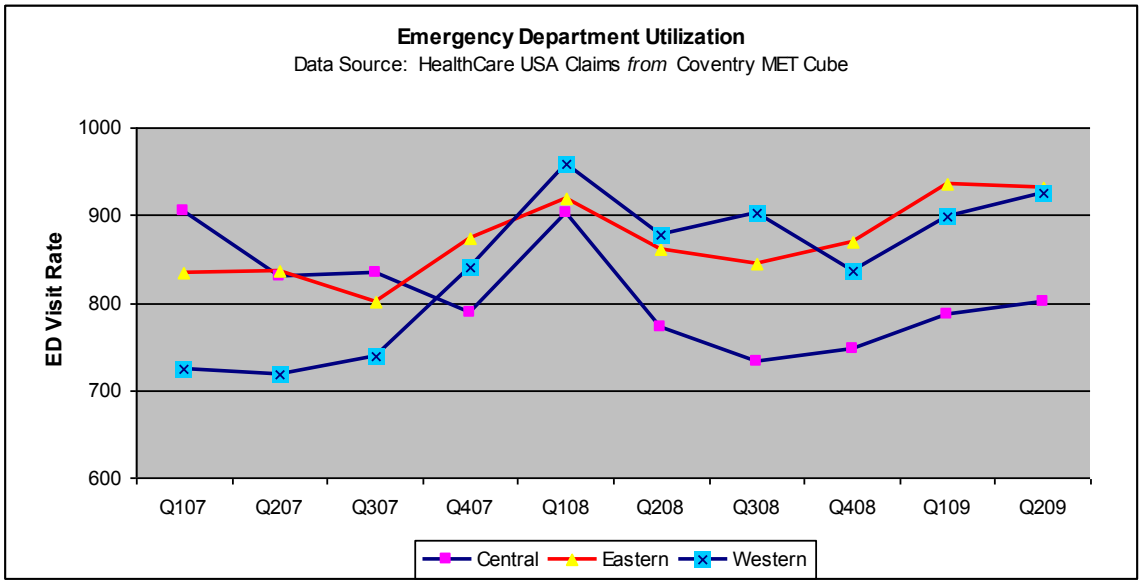
The morbidity assessment tools for case management and disease management have been revised with the goal of better identifying actionable reasons for readmission and implementing strategies to reduce or eliminate these reasons for readmissions. The data currently available is to small to represent anything significant. The readmissions team will continue to review the data.

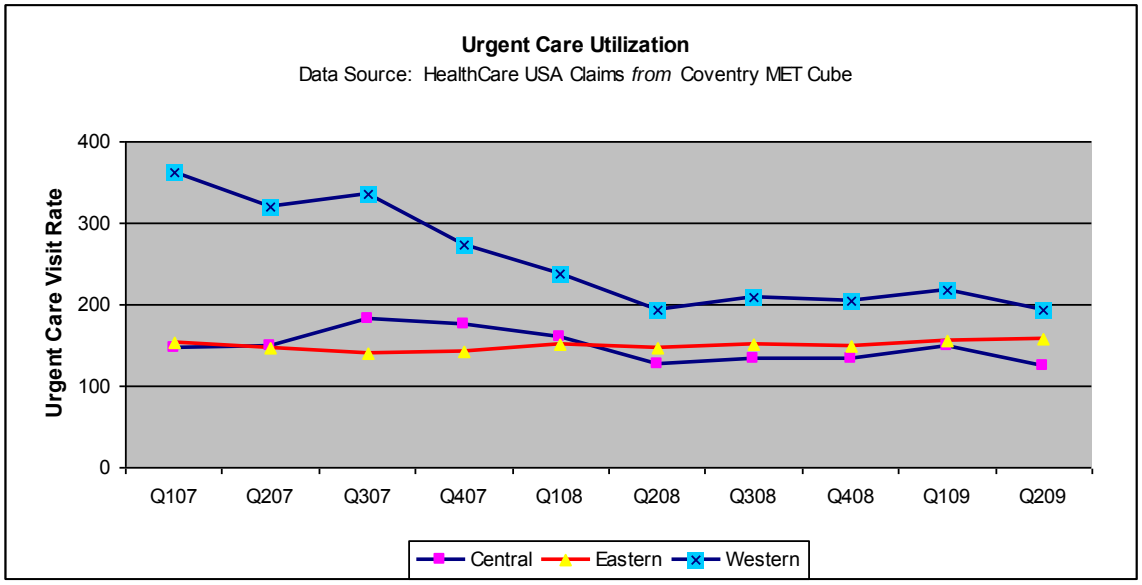
Readmissions had been trending up for the prior four quarters and have remained above the 30 and 90 day goals. In the second quarter of 2009, both rates decreased to better than the goal. This may be a reflection of a decrease in the readmission rates for members enrolled in disease management programs and/or seasonal variation. At this point, it‟s too early to tell for sure.



A review of members who have multiple admissions (3 or more in a year) for missed case or disease management opportunities indicates that less than 10 members per quarter who have multiple admissions have not already been referred to case or disease management. Most of these are members who were not able to be reached and the remaining are members who refused to participate in case or disease management programs, including social work and/or behavioral health services.

Emergency Department Utilization

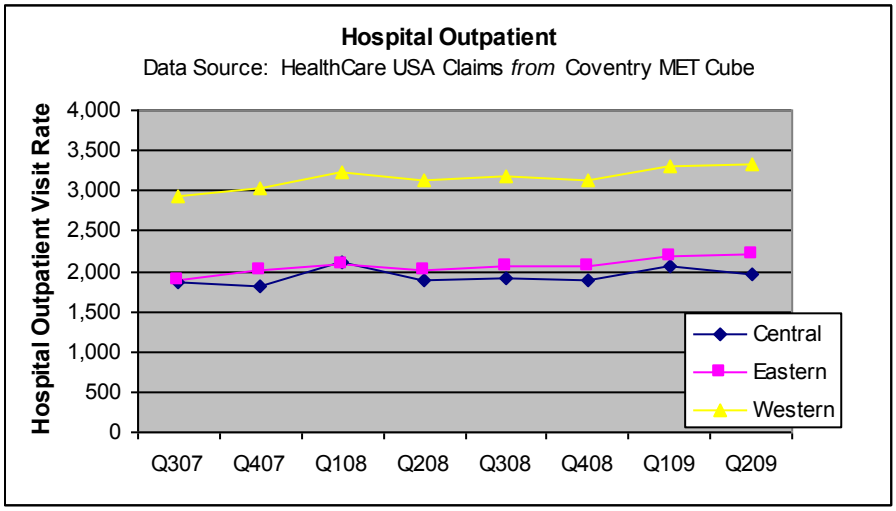




HealthCare USA has an Emergency Department Performance Improvement Project in place (see PIP section) and has an interdepartmental workgroup to evaluate ED utilization, barriers to appropriate care, interventions and effectiveness of interventions, and outcomes. Interventions include member education on appropriate care and urgent care, barrier analysis and interventions by a case manager based on ED logs received from hospital EDs, and on-going aggressive expansion of urgent care centers in network. Some improvement in ED utilization is identified by a decrease in the ED rate in the Central region. The reason for the decrease is unclear. Urgent care hours have expanded with a decrease in ED utilization in one hospital ED per their ED logs. However, there has not been an increase in the urgent care rate that correlates with this. Western region had a peak of urgent care utilization beginning of 2007 after a decline in the 2006 urgent care rate (not depicted on the graph). There was an increase in ED utilization at the same time as the decrease in urgent care utilization. However, the membership is small and has changed during this time period with the acquisition of the First Guard membership.

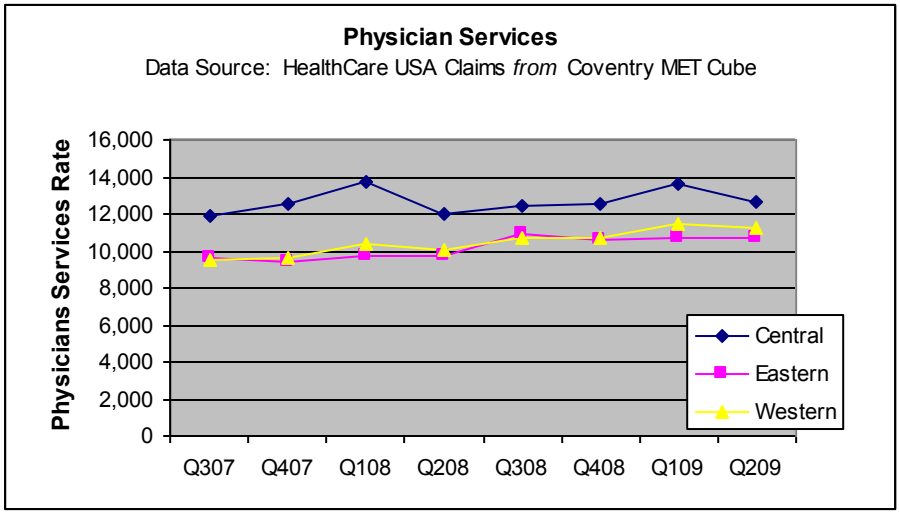
HealthCare USA has noted that members who are on plan 60 days or less have a higher utilization of the ED in the first month or two after enrollment. HealthCare USA CSO staff make outbound calls to new enrollees welcoming them to the plan, ensuring they know who their PCP is and/or changing their PCP if requested, and encouraging them to initiate care with their PCP if needed and offering assistance to set up an appointment and assist with transportation arraignments when applicable.

Outpatient Visits



The rate of hospital outpatient visits has increased slightly for Western and Eastern regions and is fairly stable in the Central region. Western region has the highest rate.

Physician Services



The rate of physician services is higher in Central region, but has increased in Eastern and Western, closing the gap between the three regions.

Over/Under Utilization

HealthCare USA conducts continuous monitoring for over and under utilization of services through the analysis of various sources of information including claims and referral data, review of in-patient admissions and emergency room use and review of pharmacy data. Many opportunities for improvement have been identified. Areas in which HealthCare USA is currently working on improving over utilization include Emergency Department (ED) visits and readmissions. As a part of the ED project, pain management and narcotic abuse are being assessed. The pharmacy has a lock in program for members suspected of or exhibiting drug seeking behaviors or abuse. Areas of improvement for under utilization include well/preventive care visits and screenings prenatal and postpartum care, diabetic care , asthma care, and NICU program and a pilot program to address the needs of those members who have sickle cell disease.

HealthCare USA continues the Beary Important Bundle prenatal visit member incentive program to encourage pregnant members to attend their prenatal visits per their OB healthcare provider‟s instructions. This has proven to be very successful and well received. HealthCare USA continues to share this program with the membership through brochures, the member newsletter and through high volume provider offices. Utilization of this program will continue to be monitored. See Performance Improvement projects – Clinical for more information.

HealthCare USA established an Asthma Around the World member incentive program to encourage members with asthma to attend their visits with their asthma healthcare provider, obtain their asthma medications and identify a rescue person, provide the rescue person with their asthma action plan for daycare, school or work. In addition, a provider education code was established to reimburse those asthma healthcare providers for setting aside time to complete asthma education to members as the provider deems appropriate. Utilization of this program will be tracked through submitted claims. More information on these programs can be found in the Performance Improvement Projects section of this report.

Inter-Rater Reliability

All physicians and nurses involved in utilization of services activities received InterQual® training and participate in routine inter-rater reliability audits. The purpose of Medical Director and nursing peer to peer audits is to improve knowledge of newer/less experienced staff, improve consistency with determinations made and brainstorm ideas to try to resolve difficult and challenging cases.

In addition, all Medical Directors routinely audit a sample of cases with other Medical Directors across Coventry. Medical review determinations are discussed to ensure that they are consistent, meet the plan‟s policies and procedures, and are in compliance with applicable InterQual® criteria or Coventry technical recommendations. The outcomes of the reviews are educational in nature and do not impact decision previously rendered on any case. During FY 2009, each Medical Director reviewed 5 cases every six (6) months. Consensus was achieved on all the cases post-test and the applicable InterQual® criteria and Technology assessments were reviewed and agreed upon. In 2009, the Medical directors began use of a standardized McKesson generated test on InterQual twice per year. Scores are tabulated and individual scores

are shared with the senior medical directors of each plan for discussion. The results are also discussed among the medical directors.

The health services nursing staff are also given a standardized McKesson generated test on InterQual®. Scores are tabulated and reviewed with each staff member. Anytime a score of less than 80% is achieved, individual review with the UM supervisor is completed the staff member is re-tested until a score of 80% or greater is achieved. Nursing staff peer to peer audits are completed on a monthly basis. Five cases are randomly selected for each staff member and reviewed for accuracy, completeness and timeliness of decisions made. Cases are also reviewed to determine if appropriate referrals are made to case managers, disease managers, behavioral health and/or social work. The results of these audits are reviewed in staff meetings.

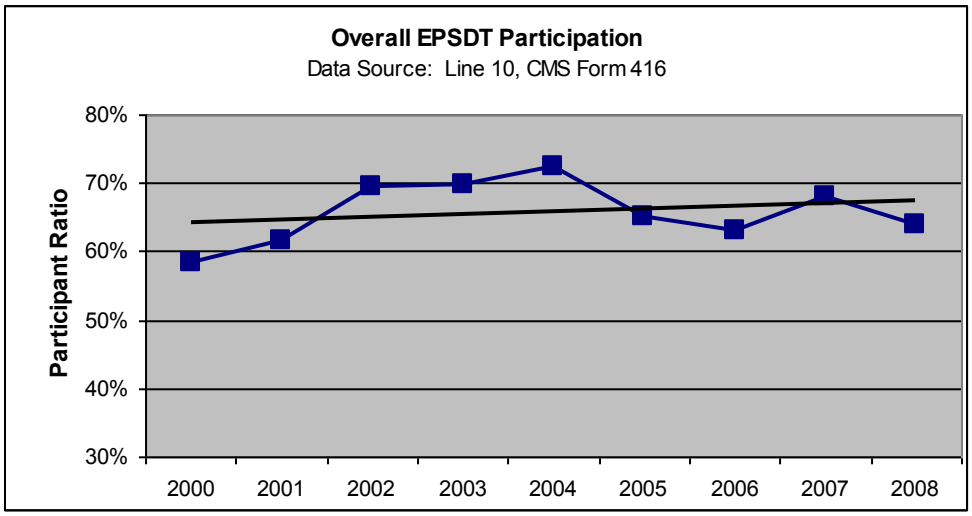
The quality improvement clinical staff conduct peer to peer documentation and inter-rater reliability audits using a tool that is based on NCQA and URAC standards in addition to company policies and state specific contract requirements. Results are reviewed at routine meetings and with the UM Decisions PIP team. If individual scores below an 80% staff review and education is completed followed by on-going monitoring to assure understanding.

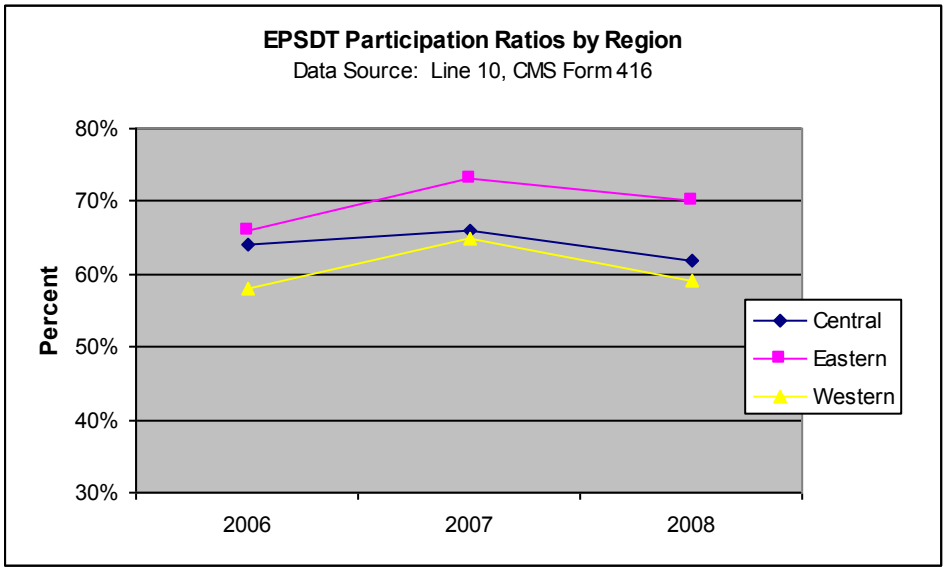
Timeliness of Care Delivery

HealthCare USA has established a Reminder System to notify members who are in need of preventive and well care services. The system generates reminders for members who are in need of receiving necessary preventive services.

The following Preventive and Care Management reminders were sent in FY 2009:

- Childhood immunizations/lead (Coventry Birthday reminders and adherence reminders if no claim for services is identified until September of 2009 when revised HealthCare USA documents were implemented).
- EPSDT (Coventry birthday reminders and adherence reminders if no claim for services is identified through September of 2009, when revised HealthCare USA reminders were implemented).
- Pharmacy claims review by disease management staff and outbound calls to members with asthma or diabetes who have no claims for routine medication refills.
- CSO member reminders about missed visits when the member/caregiver calls the CSO. See the CSO section for details about this program.





HealthCare USA"s EPSDT overall participation ratios have varied but continue an upward trend since 2000. The participant ratio reflects the extent to which members who are eligible for EPSDT services are receiving any initial and periodic screening services through the year. All three regions are combined for the overall ratio.

Concurrent review staff can also increase timeliness. During case reviews, staff determine if care provided in the hospital is delivered in a timely manner. They refer cases to the medical director and the QI staff if there is some concern regarding the care being provided. Staff begin evaluating for discharge needs at the time of the admission. They make arrangements for any home health or DME needs prior to discharge to facilitate the timely delivery of care after discharge.

Timeliness of Prior Authorization/Certification Decision Making

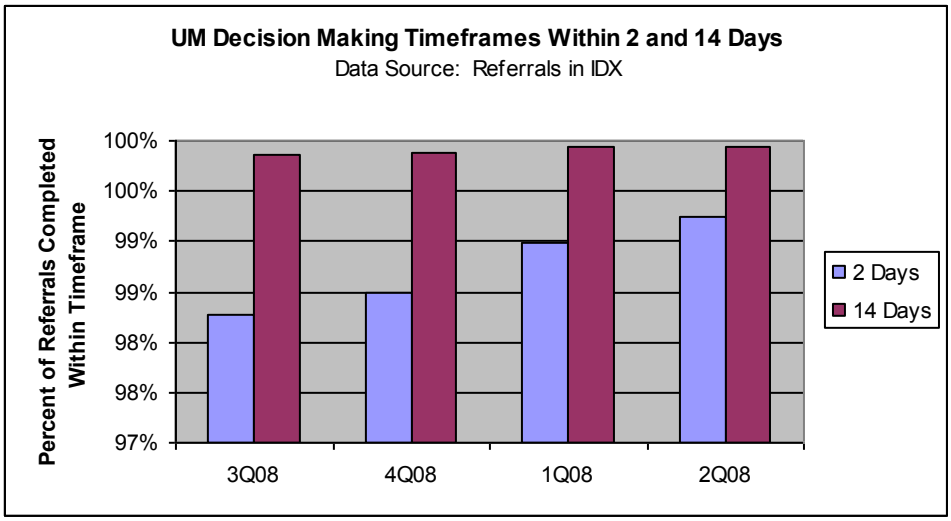
HealthCare USA manages the prior authorization/certification process to guarantee that we follow all time frames required for requests. In all cases, if the determination is not made within the timeframes allowed, automatic approval is given.

For elective requests, the following timeframes are maintained:

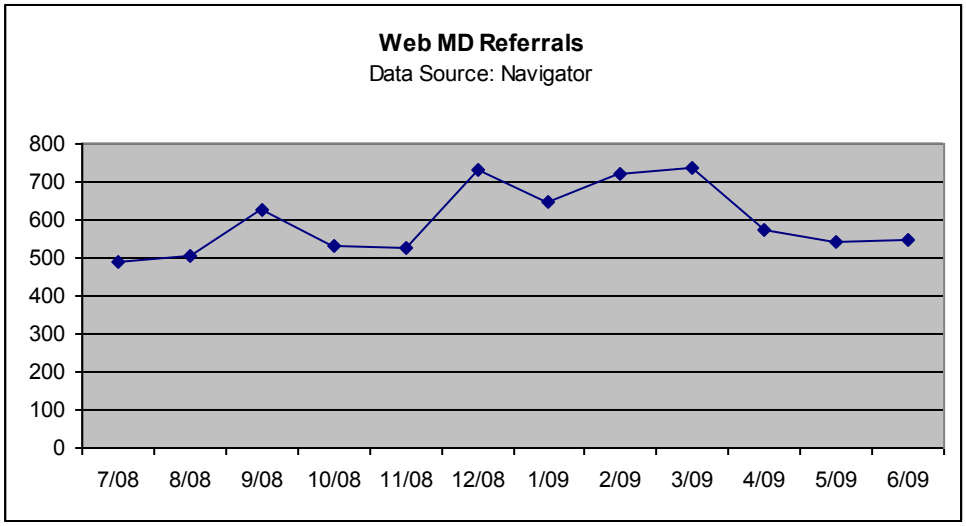
- Approval or denial of non-emergency services, when determined as such by emergency room staff is provided by HealthCare USA within thirty (30) minutes of request. HealthCare USA does not review and/or require pre-authorization or deny payment for emergency room services and emergency room post-stabilization services consistent with the State contract.
- Approval or denial is provided within twenty-four (24) hours of request for services determined to be urgent by the treating provider.
- For requests to extend a current course of urgent care treatment, decisions are issued within twenty-four (24) hours.
- Approval or denial is provided within two (2) business days of obtaining all necessary information for routine services.
- In no case will HealthCare USA exceed fourteen (14) calendar days following the receipt of the request for service to provide approval or denial.

Timeframes for certification review:

- Initial determinations will be provided within two (2) working days of obtaining all necessary information.
- Concurrent review determinations are provided within one (1) working day of obtaining all necessary information.
- When additional information is needed, the provider is notified within two (2) business days following the receipt of the request.
- All requests for services are answered within fourteen (14) calendar days of the receipt of the request for initial or concurrent review determinations.



HealthCare USA continued efforts in educating providers and facilities on the benefits of submitting authorization requests via WebMD. Utilization of WebMD has been instrumental in reducing call volume for the preauthorization department. This project not only reduced call volume, but also improved the rate of calls abandoned and service quality.



UTILIZATION MANAGEMENT IMPROVEMENT PROGRAM SCOPE

Missouri Care's utilization management program has been established to integrate systems for managing, monitoring, evaluating, and improving the utilization of care and services members receive. The program is designed to assist members and providers in the appropriate utilization of care/service delivery systems, assess satisfaction with the processes, and discover opportunities to optimize members' health outcomes and manage costs.

The utilization management program is integrated with the 's quality management program and pursues the plan's common principle of ensuring high quality, cost-effective, outcomes-oriented health care by balancing clinical/medical management, operations, and finance components.

Purpose

The purpose of the Utilization Management program is to ensure that members receive timely, medically necessary health care in the most appropriate setting for a positive health outcome.

Goals and Objectives

Missouri Care has established the following utilization management program goals:

- To monitor the care members receive for timeliness, medical necessity, and appropriate setting
- To monitor and evaluate services for accessibility, continuity of care and over- or underutilization of medical resources
- To identify quality, risk, and utilization issues and develop follow-up measures (including action plans) to resolve the issues
- To promote collaboration among departments and systems in collecting and sharing utilization data and information
- To integrate all utilization processes, such as case management and quality systems, to provide continuity of care
- To identify waste, duplication, delays, and miscommunication in the medical services provided to members
- To improve the clinical and cost-effectiveness of physicians' practice patterns
- To maintain a system for reviewing and resolving reconsiderations, grievances, appeals, and complaints

The utilization management program objectives are:

- To maintain systems for identifying member and health-care professional/provider utilization and/or practice patterns
- To manage referrals for medical services in order to maintain continuity of care and the effective use of medical resources
- To monitor benefit coverage, medical necessity, appropriateness of services and setting, and compliance with regulatory requirements
- To identify members and/or populations whose care may benefit from case management interventions

- To maintain integrated systems and processes for collecting utilization data and disseminating information through the health-care professional/provider network and regulatory agencies, which may require special reports
- To use disease management practice guidelines to improve outcomes for members and special populations, such as the developmentally disabled
- To maintain culturally competent practices throughout the plan and its network of health-care professionals and providers
- To evaluate provider/member satisfaction with the utilization process and develop strategies for improvement
- To work with health care professionals, providers, members, their families and care givers to reduce inappropriate readmissions to hospitals, use of emergency departments or prescription medications and/or health care resources
- To develop utilization benchmarks, initiatives, and target outcomes that reflect the plan's strategic expectations, directions, and goals and comply with federal, state, and local regulations and requirements
- To identify patterns of individual or systemic over- and underutilization and develop ways to address them
- To maximize the utilization of appropriate resources to improve a member's outcome or control a condition

Missouri Care's utilization management program has protocols for denial of services, prior approval, hospital discharge planning, physician profiling, and concurrent, prospective, and retrospective review of claims that comply with federal and state laws and regulations, as amended. The utilization management policies and procedures are clearly specified in provider manuals and are consistently applied in accordance with the established utilization management guidelines. Missouri Care's utilization management program functions to identify both over and under utilization problems for inpatient and outpatient services, undertake corrective action, and follow up. This review must consider the expected utilization of services regarding the characteristics and health care needs of the member population. In addition, Missouri Care case managers use an emergency room log, or equivalent method, to track emergency room services (e.g. daily emergency room report from targeted high volume facilities). Compensation to individuals or entities that conduct utilization management activities shall not be structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member.

Scope

The utilization management plan applies to:

- All Missouri Care members
- All covered services provided to members through contracted or noncontracted health-care professionals and providers
- All contracted or noncontracted health-care professionals and providers who deliver care or services to members
- All sites and facilities in-state and out-of-state (including ancillary providers) at which contracted and/or noncontracted health-care professionals provide care or services to members

- All processes, activities, components, and information sources used to manage and/or make determinations for benefit coverage and medical appropriateness, including:
  - Utilization Management processes and functions: prior authorization, concurrent review, case management, disease management, medical claims review, referral management, discharge management
  - Utilization monitoring processes (e.g., for indicators such as HEDIS measures, or others required by state regulatory or review agencies or the plan; drug utilization reviews; physician profiles)
  - Performance monitoring processes (e.g., inter-rater reliability, telephone answer time, abandonment rates, productivity)
  - Evaluations of outcomes data

Program Accountabilities and Organization

The chief executive officer delegates authority and accountability for implementing and maintaining the utilization management program to the chief medical officer. This includes implementing and overseeing systems and processes to manage, monitor, and evaluate the utilization of services members receive through the health delivery network, carrying out work plan activities, and participating in utilization activities and processes such as, prior authorization reviews, concurrent reviews, case management, and retrospective medical claims reviews.

Working under the direction of the chief medical officer, managers of utilization departments and functional areas (Prior Authorization, Utilization Review, and Case Management, Disease Management, Quality Management) are responsible for day-to-day program operations and activities. Missouri Care's Medical Quality Management (MQM) committee meets regularly under the chief medical officer or a designee to review program activities and provide advice and recommendations. The medical committees report to the Quality Management Oversight Committee (QMOC) through the chief executive officer.

The objectives, scope, organization, and effectiveness of the utilization management program are evaluated and approved annually by the MQM Committee and QMOC. The annual utilization management program evaluation is submitted to applicable regulatory bodies for approval.

DISCHARGES PER YEAR

Discharge planning is an important utilization management tool for maintaining continuity of care and preventing readmissions. Concurrent review nurses are responsible for identifying a member's discharge needs during admission/continued stay reviews and assisting hospital staff to make sure that post-discharge care is available and that the member's discharge plan is implemented.

Missouri Care's nurses assist facilities in meeting discharge planning requirements (e.g., by prior authorization of transfers to a lower level of care, coordinating referrals to ancillary services or to case management). Concurrent review nurses work collaboratively with hospital discharge planning staff, members or their caregivers, and physicians to help coordinate the hospital's discharge planning efforts. The team approach results in better continuity of care in the safest and most cost-effective setting and allows hospital and plan personnel to attend more closely to

special social, economic, cultural, and language needs that will reinforce improved outcomes for the member.

The following metrics are tracked to identify potential areas of over- or under-utilization of inpatient services:

- Admissions per 1000 members
- Days per 1000 members
- Average Length of stay
- Member outcomes (readmissions, discharge plan evaluation)
- Quality and risk management indicators

INPATIENT VISITS AND AVERAGE LENGTH OF STAY

Table 4: Inpatient Utilization by Type of Visit (SFY 09)

Type of Visit	Admits/1000	Days/1000	ALOS
Maternity	63	141	2.2
Newborn	66	111	2.0
NICU	10	106	10.9
High Risk OB	5	26	5.4
Medical/Surgical/ICU	53	125	2.3
Mental Health	16	64	4.1

Table 5: Inpatient Utilization Trends (SF 07 to SF 09)

Indicator	SFY 07	SFY 08	SFY 09
Physical Health			
Admits/1000	203	212	203
Days/1000			
– Maternity	155	159	141
– Newborn	127	130	111
– NICU	87	86	106
– High Risk OB	28	26	26
– Medical/Surgical/ICU	140	143	125
Average Length of Stay	2.9	2.8	2.9
Mental Health			
Discharges/1000	7	12	16
Days/1000	41	47	64
Average Length of Stay	5.8	3.9	4.1

READMISSIONS

Missouri Care works with health care professionals, providers, members, their families and care givers to reduce inappropriate readmissions to hospitals, use of emergency departments or prescription medications and/or health care resources. Missouri Care reports and researches all inpatient readmissions within 30 days of the last admission. The goal is that less than 10% of members with inpatient admissions readmit within 30 days.

EMERGENCY DEPARTMENT UTILIZATION

Missouri Care understands that members with a medical home are less likely to suffer a costly illness and go to the emergency department for care. When members have a medical home they have an improved quality of care and better outcomes. Missouri Care recognizes members have the right to access emergency health care services when and where the need arises, although many ED visits may be prevented with timely access to primary care.

ER Utilization Project

In October 2007 Missouri Care launched a pilot project to reduce unnecessary ER utilization
The goals of the project were to:

1. Reduce number of ER visits by top 2.5% of users.
    - Members with 10 or more ER visits (past 12 months) comprised 2-3% of total ER visits
    - In April 2009, this group was composed of 84 members accounting for 1,138 ER visits in a rolling 12 month period.
2. Reduce percentage of potentially inappropriate (e.g., non-emergent) ER visits as compared to total ER visits.

Interventions included:

1. Individuals with 10 or more ER visits in the past 12 months are enrolled in case management and encouraged to have regularly scheduled visits with their PCP.
    a. Case managers contact members once a month.
    b. The senior medical director sends a letter to the PCP, with a follow up phone call as needed (e.g., for members seeking narcotics through the ER).
2. Members with 2 to 9 inappropriate ER visits within the past 6 months receive a letter and educational flyer on proper ER usage.

Results
Between 2008 and 2009, the percentage of ER visits attributable to Missouri Care's highest utilizing members remained relatively constant, although an upward trend was visible in 2009. In April the rate was 3.4% (Figure 13), demonstrating no reduction in utilization in this group. Weaknesses of this indicator are that it does not take into account the impact of continuous enrollment and member attrition, nor does it effectively assess member-level longitudinal outcomes.

Figure 13. Percent of Total ER Visits Attributable to High Utilizing Members

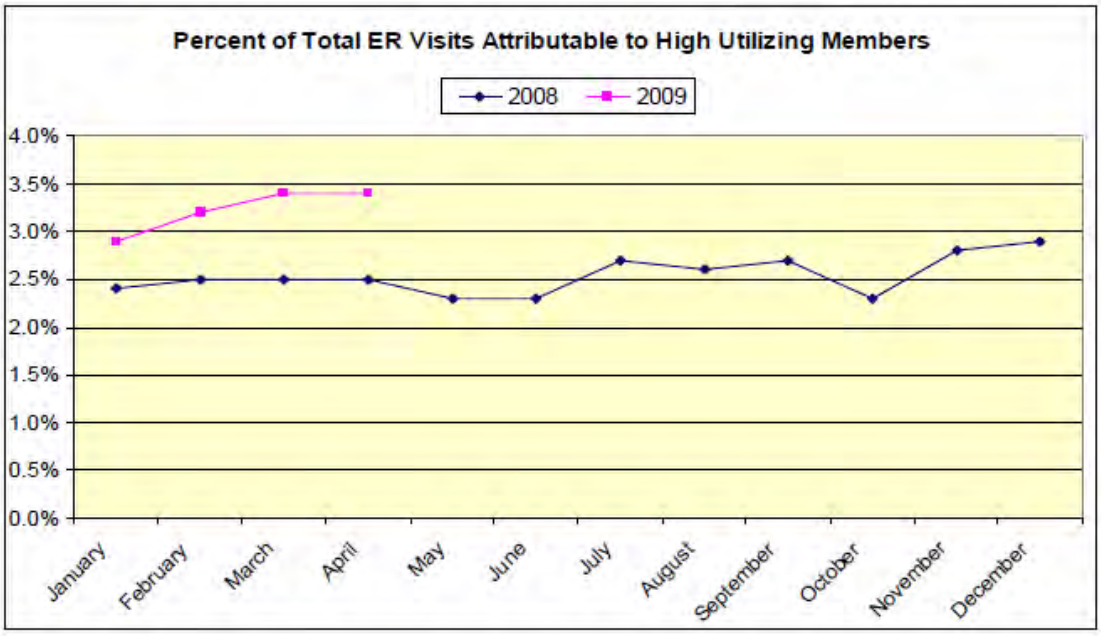
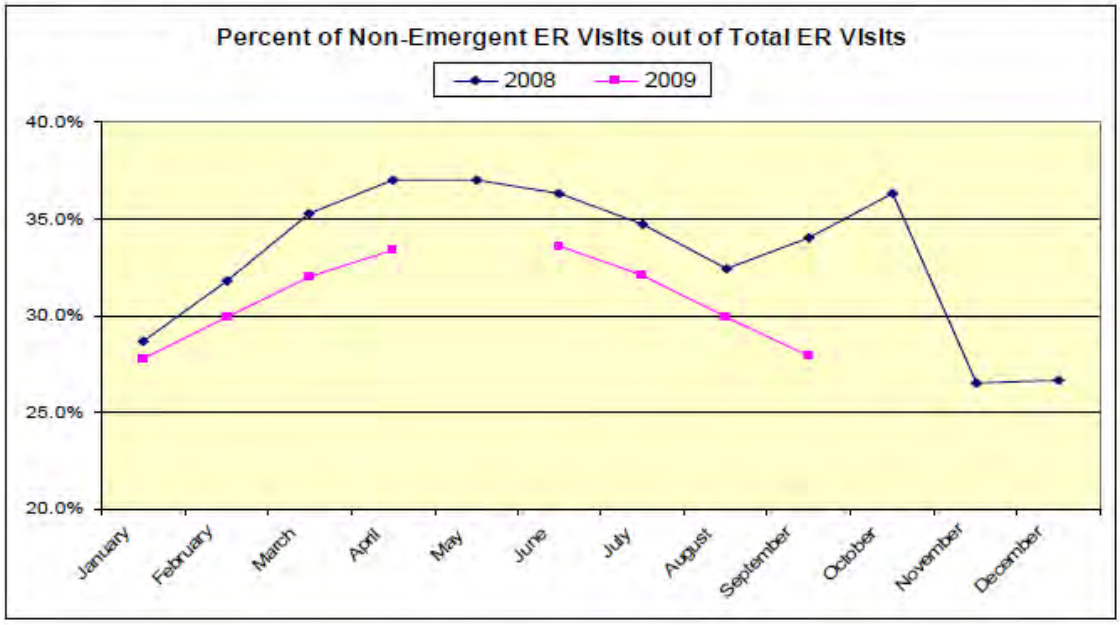


Figure 14 displays Missouri Care's trends in non-emergent ER use between 1/1/08 through 9/30/09. The data reveal a cyclical pattern in ER use, with the highest inappropriate utilization between April and June. Utilization spiked in October 2008, and data are currently being tracked to see if this reoccurs in 2009. The data show a reduction in inappropriate ER use by two to four percentage points between 2008 and 2009.

Figure 14. Percent of "Inappropriate" ER Visits out of Total ER Visits



Impactable Admissions Project (IAP2v2)

Baseline Methodology

To identify and outreach high-utilizing members with BH comorbidities and intervene on them in a way that is likely to change their utilization patterns and lead to improved outcomes. Three health plans (Missouri Care, Maryland Physician's Care, Delaware Physician's Care) and one PCC plan (New Hampshire) will participate in IAP2v2. These plans will be referred to as study plans. Each plan's performance will be measured against a blended comparison group comprised of members who meet eligibility for IAP2v2 against plans that are not participating in IAP2v2 (CHOC, MaineCare, and Mercy Care, acute LOB only); these plans will be referred to as Comparison plans. Quantifiable measures include inpatient admits, inpatient bed days, emergency department visits and PMPM cost.

Eligibility for IAP2v2

1) Length of enrollment: Enrolled a total of at least 10 member months in the most recent 12 months. Operational definition: The member's total days of eligibility must add up to at least 10 member months over the most recent 12 calendar months.
2) BH Criteria: Any inpatient BH admit, OR any pharmacy fill for a psychotropic medication, OR any PPM BH condition during the most recent 12 months.
3) ED Visits: At least 3 ED visits in the previous 3 months OR at least 6 ED visits in the previous 12 months. Operational definition: At least 3 ED visits in the previous 3 months, of which at least 2 must be for PH conditions, or at least 6 ED visits in the previous 12 months, of which at least 3 must be for PH conditions.

Diagnostic exclusions: Members diagnosed with HIV/AIDS, dementia, transplants, cancer, or end-stage renal disease during the most recent 12 months will be excluded.

Performance Accountability

A ramp-up period has been designated from January 8, 2009 through March 31, 2009. Measurement will begin on April 1, 2009. Rates for the quantifiable measures during the measurement period (April 1, 2009 through December 31, 2009) will be compared to rates during the baseline period (April 1, 2008 through December 31, 2008). Analytics will calculate the change between baseline and measurement for each Study plans (individually) and Comparison plans (as a blended whole). Study plans are expected to show a statistically significant rate reduction.

OUTPATIENT VISITS

(See Section IV: Quality Indicators, for a description and analysis of outpatient visits, including HEDIS Use of Services and Access and Availability measures. Included is a discussion of ambulatory care and behavioral health service utilization).

OVER/UNDERUTILIZATION

In addition to the utilization management functions described earlier, Missouri Care utilizes technology to profile primary care practitioners, and other designated specialists for quality of care monitoring. Profiles may be used as an educational tool for health-care professionals. Profiles are comprised of summary data and information related to costs (e.g., of pharmacy

services) and utilization (of outpatient, inpatient, emergency department, and pharmacy services). Compiled electronically from claims, pharmacy, and HEDIS data sources, the profile allows the plan to compare the practices and member health outcomes of individual physicians, physicians' groups, specialists, or geographic regions with utilization benchmarks or with those of similar individuals or groups. The CMO or designee is responsible for reviewing applicable physician profiles on a regular basis to evaluate utilization patterns, trends, and costs. After review, the profiles may be distributed to physicians. The CMO or designee and a physician or physicians' group may discuss profile results for opportunities to improve utilization practices. The chief medical officer may present utilization reports to the MQM Committee, which may advise and/or assist the physician in developing a corrective education plan. Corrective education plans are monitored by the Provider Services department with the assistance of Medical Quality Management.

Profile information is used during quality management reviews as applicable and is consulted during credentialing/recredentialing reviews.

INTER-RATER RELIABILITY

Missouri Care assesses the inter-rater reliability of clinical staff on a regular basis. The inter-rater reliability assessments measure the consistency with which clinical staff apply the criteria used in medical decisions and adhere to plan policies. Whenever performance on the inter-rater reliability assessment does not meet the established standard, a corrective education plan is developed and monitored to improve performance.

TIMELINESS OF CARE DELIVERY: PRIOR AUTHORIZATION/CERTIFICATION DECISION MAKING

Missouri Care adheres to the regulatory requirements for the prior authorization of services. The prior authorization process allows Missouri Care to monitor certain outpatient referrals, services and procedures, as well as non-emergency/elective hospitalizations, before the member receives the service or referral.

Prior Authorization

The prior authorization process allows the plan to monitor certain outpatient referrals, services, and procedures as well as nonemergency/elective hospitalizations before the member receives the service or referral. As the initial step in obtaining medical services, the function is used to confirm that:

- The service is a covered benefit for the member, is appropriate and provided timely and cost-effectively
- The level of care and setting are appropriate
- Necessary services are coordinated with other Medical Management functions (e.g., Quality Management, Case Management, Disease Management) and information is communicated to applicable operations areas (e.g., Finance)

Verification of these elements before the service is provided allows for timely and accurate reimbursement for health-care professional and provider services.

Decisions to require prior authorization for certain services are based on data, such as utilization data that identifies services that are likely to be overutilized or costly; that indicate high-volume use; that show physician utilization trends and referrals; or that may potentially signal conditions (e.g., diabetes) that might require extensive clinical or case management intervention. Prior authorization requirements are communicated to health-care professionals and providers in the Provider Manual, on the plan web site available to the network, in provider newsletter articles, and in health professional and provider contracts. They are also available to network health professionals and providers upon request.

The Prior Authorization and Utilization Review unit is principally responsible for day-to-day prior authorization operations. Requests are evaluated and documented by licensed nurses. The function is available 24 hours a day, seven days a week and maintains a toll-free telephone number for health professionals and providers. Other units approved by the chief medical officer (such as the Member Services transportation unit) may also prior authorize specific services within their area of responsibility.

Staff members who carry out prior authorization duties are responsible for documenting requests and researching the member's files to confirm the member's enrollment and coverage of the service, determine the health professional or provider's network affiliation, identify potential coordination of benefits issues, determining whether the service and setting requested are consistent with criteria for coverage, and coordinating a higher level review of the request if applicable.

Certain services may be authorized by a licensed nurse or under a nurse's supervision if the request is supported by approved review criteria. However, any request that does not clearly meet criteria for coverage as well as any potential denial must be reviewed by the CMO. Only the CMO may decide to deny authorization based on clinical criteria or benefit coverage. If a decision requires specialized judgment, Missouri Care maintains a list of specialist physicians available to participate in utilization reviews.

Criteria

Prior authorization coverage decisions are based on nationally recognized, evidence-based criteria, when available, and are applied on the basis of individual member needs and community requirements. Criteria developed locally by practicing health professionals may be used for decisions on conditions or diagnoses not addressed by the established criteria if applicable state approval requirements are met.

Prior to being used to support utilization decisions, criteria are reviewed by the chief medical officer and approved for use by the MQM committee. Criteria are reviewed annually and updated as necessary.

Documentation

Staff members document certain required information pertaining to the authorization request, including diagnosis including the ICD-9 code, other current applicable codes, member information, primary care or treating health professional and other involved health professionals along with their contact information, the reason for the referral, clinical information applicable to

the request. The staff member is also responsible for documenting the actions taken on the request, date(s), final decision, reason for the decision, and the identification of the staff member and chief medical officer or designee, if applicable.

Decision/Notification Standards

Prior authorization decisions are completed and communicated to the provider in a timely manner, as indicated below, or the denials shall be deemed approved. For the purpose of this section, "necessary information" includes the results of any face-to-face clinical evaluation or second opinion that may be required.

- Approval or denial of non-emergency services when determined as such by emergency room staff shall be provided by Missouri Care within thirty (30) minutes of request.
- Approval or denial shall be provided within twenty-four (24) hours of request for services determined to be urgent by the treating provider.
- Approval or denial shall be provided within two (2) business days of obtaining all necessary information for routine services. Missouri Care shall notify the requesting provider within two business days following the receipt of the request of service regarding any additional information necessary to make a determination. In no case shall a health plan exceed fourteen (14) calendar days following the receipt of the request of service to provide approval or denial.
- Involuntary detentions (96 hour detentions or court ordered detentions) or commitments shall not be prior authorized.

Upon request to a prior authorization nurse/representative, provider representative, or the chief medical officer, a health professional may obtain a copy of the criteria used in making a decision.

Monitoring

Missouri Care monitors prior authorization processes for:

- Timeliness of decisions and notifications to health professionals and members
- Process performance (telephone abandonment rate, average answer time, timeliness, and accuracy of data entry)
- Fax processing rate
- Number of authorization requests approved
- Number of authorization requests denied
- Cost of services authorized (monitored by Finance)
- Inter-rater reliability of clinical staff members and chief medical officer involved in decisions

Integration

Staff members who receive prior authorization requests and notifications of emergency services and admissions play an important role in relaying information received from health professionals and providers to other staff when necessary. Information is routed as necessary to appropriate areas (such as Case Management, Concurrent Review) or operations areas (such as Provider Relations, Member Services, Claims, or Finance). Any use or disclosure of a member's protected health information must be in compliance with federal, state, and local privacy laws.

Concurrent Review

The concurrent review function provides a way to evaluate admissions while a member is hospitalized. Admissions are reviewed for medical necessity and continuing services are reviewed for the appropriate use of inpatient medical resources. Concurrent review activities identify occurrences of over- or underutilization and physician practice patterns, identify ways to improve the member's inpatient care outcomes, and monitor the cost-effectiveness of the services by:

- Assessing the medical necessity of admissions and stays, the medical appropriateness and cost-effectiveness of the setting, level of care, and services, as well as the probable length of stay
- Monitoring services to see that they are appropriate and provided timely and efficiently
- Screening for potential quality, utilization, or risk issues
- Beginning discharge planning early in the member's stay
- Working with hospital discharge planners to identify and recommend alternative care options (e.g., skilled nursing, rehabilitative, or home health services)
- Identifying and referring members who could benefit from case management or disease management program or a community health program
- Identifying clinical issues and referring them to the chief medical officer for discussion with the member's primary care or treating health-care professional
- Identifying other payers responsible for coverage of the member's care
- Communicating as necessary with contracted hospitalists, attending physicians, and others who coordinate members' care

Services subject to concurrent review are those provided in acute and rehabilitation facilities. Licensed nurses working under the direction of the chief medical officer conduct initial reviews of members' admissions within 24 hours of the admission. Subsequent on-site or telephone reviews are conducted on a schedule determined by the kind of facility and its location.

Decision Criteria

Missouri Care ensures that procedures for obtaining initial, concurrent, and retrospective reviews for inpatient admissions meet the following minimum requirements:

- A professional with experience or expertise comparable to the provider requesting the authorization must review all appeals and denials.
- There are standard policies and procedures for inpatient hospital admissions, continued stay reviews, and retrospective reviews and for making determinations on certifications or extensions of stays based on sound medical evidence that are updated regularly and consistently applied, and used for consultations with the requesting provider when appropriate.
    - For inpatient hospital admissions, continued stay reviews, and retrospective reviews to specialty pediatric hospitals, Missouri Care shall use the same criteria as Medicaid fee-for-service.
    - For psychiatric inpatient hospital admissions, continued stay reviews, and retrospective reviews, Missouri Care shall use the same criteria as Medicaid fee-for-service (LOCUS/CALOCUS).
- Reasons for decisions are clearly documented and assigned a certification number, which refers to and documents approvals and denials.

- Documentation shall be maintained on any alternative service approved in lieu of the original request. Standards dictate that:
  - There are fair and unbiased policies and procedures for reconsideration requests when the attending physician, the hospital, or the member disagrees with Missouri Care's determination regarding inpatient hospital admission or continued stays.
  - There are written policies and procedures followed to address the failure or inability of a provider or a member to provide all necessary information for review. In cases where the provider or a member will not release necessary information, Missouri Care may deny certification of an admission.
  - There is a well-publicized review process for both provider and members.
  - To the extent known, inpatient providers are informed of the enrollee's recent health care service history at the time of authorization of a psychiatric inpatient admission. Such information shall include psychiatric inpatient admissions and emergency room visits for the prior year, psychiatric outpatient services for the prior six months, and medications for the prior 90 calendar days. Information about specific episodes of care shall include date, diagnosis, provider, and procedure. Services related to substance abuse or HIV disorders are exempt from this requirement.

Timeliness Criteria

The review process shall be completed and communicated to the provider and member in a timely manner, as indicated below, or the denials shall be deemed approved. For the purpose of this section, "necessary information" includes the results of any face-to-face clinical evaluation or second opinion that may be required.

- Approval or denial for initial determinations shall be provided within two (2) working days of obtaining all necessary information.
- Approval or denial for concurrent review determinations shall be provided within one (1) working day of obtaining all necessary information.
- Approval or denial for retrospective review determinations shall be provided within thirty (30) working days of receiving all necessary information.
- Missouri Care shall notify the requesting provider within two (2) working days following the receipt of the request of service regarding any additional information necessary to make a determination.
- In no case shall Missouri Care exceed fourteen (14) calendar days following the receipt of the request of service to provide approval or denial for an initial or concurrent review.

The Precertification Department documents notifications of members' facility admissions in the business application system prior authorization module when the notification is received. Concurrent review nurses are responsible for seeing that the system record is accurately updated, as applicable, with the results of concurrent reviews and authorization decisions. At a minimum, the following information must be recorded:

- Specific criteria on which the review and decision are based
- Projected stay goals based on the criteria and the member's condition
- Variances (e.g., complications) in the member's condition

- Inpatient procedures and dates
- Denials and/or delay days, including:
  - Reason for denial/delay days
  - Medical director and attending physician who was contacted
  - Facility personnel notified; date and time of notification
- Discharge disposition
- Discharge date with number of days approved at each level of care

Discharge Planning

Discharge planning is an important utilization management tool for maintaining continuity of care and preventing readmissions. Concurrent review nurses are responsible for identifying a member's discharge needs during admission/continued stay reviews and assisting hospital staff to make sure that post-discharge care is available and that the member's discharge plan is implemented.

Missouri Care's nurses assist facilities in meeting discharge planning requirements (e.g., by prior authorizing transfers to a lower level of care, coordinating referrals to ancillary services or to case management). However, they do not assume discharge services that Medicare, Medicaid, and/or the Joint Commission on Accreditation of Healthcare Organizations require hospitals to provide.

Concurrent review nurses work collaboratively with hospital discharge planning staff, members or their caregivers, and physicians to help coordinate the hospital's discharge planning efforts. The team approach results in better continuity of care in the safest and most cost-effective setting and allows hospital and plan personnel to attend more closely to special social, economic, cultural, and language needs that will reinforce improved outcomes for the member.

Retrospective Medical Necessity Review

Under certain circumstances (e.g., if Missouri Care is notified of a hospitalization after the member's discharge), reimbursement for a member's health care may be determined retrospectively upon receipt of the member's records. Retrospective medical necessity reviews are conducted by concurrent review nurses. Potential denials are reviewed and approved or denied by the chief medical officer or a designated medical director. Retrospective review decisions are made and health-care professionals, providers, and, if applicable, members are notified within the following time frames:

- Approval or denial for retrospective review determinations shall be provided by within thirty (30) working days of receiving all necessary information.

Molina Healthcare of Missouri

Utilization Improvement Program Scope

The Medical Management Department is organized into five units which report to the Chief Medical Officer (CMO).

- The Preauthorization Unit is responsible for prospective review of inpatient, ambulatory medical and pharmacy services to ensure that members receive the most medically appropriate services with a quality provider at the appropriate level of care.
- The Utilization Review Unit performs concurrent review, retrospective review and discharge planning.
- The Case Management/Disease Management Unit includes Obstetric (OB) Case Managers who are responsible for education of pregnant members, management of high-risk obstetrical patients, outpatient management and monitoring for women in preterm labor. Case Management Coordinators work in conjunction with the case managers to review requests for durable medical equipment, therapies, Synagis and assist with authorizations. The Complex Case Managers are responsible for the evaluation and management of complicated medical cases, high risk social situations and those members with unique medical needs.
- In the Pharmacy Division, the Director of Pharmacy works closely with the CMO to manage the state-approved formulary and oversee the preauthorization process for medications.
- In the Quality Department, the Director of Quality Improvement (QI) provides oversight of the QI Program, Healthcare Effectiveness Data and Information Set (HEDIS), Credentialing and National Committee for Quality Assurance (NCQA). The Quality Department includes a QI Analyst who is responsible for assessing quality of care issues and a QI Coordinator who is primarily responsible for the credentialing process.

Discharges per Year

Molina Healthcare of Missouri (MHMO) does not have the ability to track this data at this time. MHMO anticipates being able to track the data once integrated onto Molina‟s systems in 2010.

Inpatient Visits

MHMO tracks inpatient visits via the monthly Inpatient Days/1000 Members Report. This report is reviewed by the CMO and analyzed on several levels including Med/Surg Days, Obstetric Days and Newborn days. The data is reviewed by the Utilization Management Committee (UMC) and Quality Improvement Committee (QIC) and analyzed to identify utilization patterns. This information is also presented by the CMO to the Utilization Management Staff.

Inpatient days/1000 Members	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	421.9	501.1	450.3	446.6	414.1	425.1	424.4	434.4	420.7	445.7	418.6	421.9

Average Length of Stay

MHMO‟s Average Length of stay is reflected in the data provided below. MHMO‟s Average Length of Stay is reflected in the data provided below. This data is obtained via the monthly Inpatient Days/1000 Report and reviewed by the CMO, UMC and QIC. The data is analyzed to identify utilization patterns. This information is presented by the CMO at the Utilization Management Staff Meetings.

ALOS	***Jul***	***Aug***	***Sep***	***Oct***	***Nov***	***Dec***	***Jan***	***Feb***	***Mar***	***Apr***	***May***	***Jun***
Medical/Surgical	3.9	3.0	2.7	2.8	3.0	3.0	3.1	3.1	3.2	3.1	2.8	3.0
Obstetrics	2.6	2.7	2.7	2.5	2.6	2.4	2.5	2.6	2.5	2.6	2.6	2.6
Newborn	8.3	6.3	5.7	7.4	5.2	6.5	4.5	6.5	6.1	5.2	9.9	7.9
Total	3.5	3.0	2.9	3.0	3.0	3.0	3.5	3	3.1	2.9	3.5	3.2

Readmissions

MHMO tracks readmissions that occurred within 7 days from discharge as identified through the adverse event process. MHMO tracks readmissions that occurred within 7 days from discharge via Potential Quality of Care reporting. The reports are reviewed by the QI Analyst and presented at the monthly Clinical Quality Improvement Committee (CQIC) meeting. Adverse trends are identified, researched and reported back to the QIC for additional follow up.

Readmissions	**3QFY08**	**4QFY08**	**1QFY09**	**2QFY09**
	29	48	53	36

Emergency Department Utilization

ER Visits/1000 Members	3QFY08	4QFY08	1QFY09	2QFY09
	2,091	2,282	2,260	2,642

Emergency Room Short Interval Overuse (ERSIO)

MHMO monitors and takes action, as necessary, to improve continuity and coordination of medical care when members utilize the Emergency Room (ER) for non-emergent medical needs that can otherwise be met through their primary care provider (PCP) or urgent care facility. One of the principle roles and functions of MHMO‟s CQIC is to review and analyze ER visits per 1000 members per month within MHMO‟s network of members. This measure identifies potential over utilization of the ER. On an average approximately 5,000 members utilize the ER on a monthly based which constitutes 838 ED visits per 1,000 members.

Through analysis of MHMO members ER claims data, it became evident that members would frequent the ER more than once within 1-10 days rather than seeking more appropriate follow-up care from their PCP. Secondly, the majority of ER visits occurred between the hours of 6:00am-6:00pm, a time when accessibility to a PCP or urgent care facility for non emergent medical needs should not be an issue. A breakdown of ER visits by diagnosis group was also analyzed per claims data to better understand and manage a member‟s transition in care and identify their healthcare needs. It became evident that non-emergent medically related diagnoses of

gastrointestinal illness, upper respiratory infection, asthma, fever and dehydration were the leading sources of ER utilization and therefore, would benefit the most from case management intervention.

Improvement strategies and interventions implemented by MHMO"s Medical Management are:

- Coordination through facilities with high ER utilized by MHMO members and obtains a census report within 24 hours.
- Analysis of ER census to identify members with the potential for SIO, based on age, diagnosis and ER Claim history.
- Verification of Emergent versus non-emergent needs by Case Management.
- Identify language barriers and provide translation when needed for members seeking medical care.
- Provide the member with their assigned Primary Care Physician"s (PCP) phone number, address and encourage the member to contact the PCP for appropriate follow-up.
- Inform the member about transportation services available to them.
- Provide the member with MHMO"s after hours Nurse Advice Line phone number
- Encourage the member/parent to obtain all prescription medications and use according to provider instructions as well as following discharge instructions
- Offer to help the member secure a timely follow-up appointment with their PCP or MHMO specialist, as is appropriate.
- Offer information about Urgent Care Centers that are located near the member including phone numbers and addresses.
- If the Clinical Case Manager (CCM) is unable to contact the member, a letter will be sent to the member outlining the information above that would have been provided in the telephone call and a copy sent to the member"s PCP.
- A MHMO "Quick Relief for Common Illnesses Guide" educational material is sent to members to provide helpful hints on how to treat the common cold, ear discomfort, fever, sore throat, vomiting, diarrhea, stomach ache and constipation. This material also educates members on signs and symptoms as well as instructions on when to contact a PCP.
- When a member meets MHMO criteria for Case Management enrollment, the CCM will assist the member by correlating care with the member"s provider and enroll the member in case management.

ER censuses were derived from two (2) high-volume ER"s identified within MHMO"s health plan. Diagnosis related groups populated from the census reports that case management intervened on are: gastrointestinal illness, upper respiratory infection, asthma, fever and dehydration. This constituted a total of 571 ER visit during the time frame of 2/1/2009-6/30/2009.

Members Unable to Contact	Members contacted	Repeat ER Visit Member Not Reached	Repeat ER visit Member Reached
489	82	24	2
85.6%	14.4%	4.2%	2.4%

It can be ascertained, that when case management is able to contact and assist a member with their transition of care to an outpatient setting, the repeat return rate to the ER decreases. This method directs the health plan focus on patient safety by increasing communication between the member, case management and providers thus, improving the continuity of care and better management of their health.

Outpatient Visits
MHMO does not have the ability to track this data at this time. MHMO anticipates being able to track the data once integrated onto Molina‟s systems in 2010.

Over/Under Utilization
MHMO does not have the ability to track this data at this time. MHMO anticipates being able to track the data once integrated onto Molina‟s systems in 2010.

Inter-Rater Reliability
The purpose of Inter-Rater Reliability (IRR) testing is to provide a mechanism for evaluating the consistency with which health care professionals involved in Utilization Management decisions apply criteria and identify opportunities to improve consistency. All physicians and clinical staff who participate in the review of medically necessary requests or retrospective review of claims and issue a coverage determination will be tested semi-annually. MHMO initiated IRR testing in June 2009. All Utilization Management staff was tested and received a passing score. The test results were reviewed by the UMC and the QIC. Testing will be repeated at the end of 2009 and then twice annually going forward.

June 2009 IRR Test Results

Complex Case Managers
InterQual Level of Care Rehabilitation Criteria (Adult & Pediatric)

Number of tests completed	4 out of 4
Range of scores	81 to 95%
Average score	87%

OB Case Managers/Utilization Management Specialists
InterQual Level of Care Homecare Criteria

Number of tests completed	6 out of 6
Range of scores	86 to 100%
Average score	92%

Pre-Authorization Staff –
InterQual Level of Care Planning Imaging Criteria

Number of tests completed	5 out of 5
Range of scores	88 to 100%
Average score	92.8%

Clinical Case Managers/CMO/UTILIZATION MANAGEMENT Director –
InterQual Level of Care Criteria Acute Criteria

Number of tests completed	9 out of 9
Range of scores	82 to100%
Average score	90.3%

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Performance Improvement Projects (PIP)

The following information contains titles of each MO HealthNet Managed Care health plan's PIP's. Full text of the individual PIP's can be found in their SFY 2009 Annual Evaluations.

Blue Advantage Plus of Kansas City

Clinical
PIP Title: Improving Ambulatory Follow-Up and Patient Safety

Non-Clinical
PIP Title: Adolescent Well Care (AWC) Performance Improvement Project
Appeals Process Compliance

Children's Mercy Family Health Partners

Clinical
PIP Title: Improving Dental Utilization Rates

Non-Clinical
PIP Title: Adolescent Well Care (AWC) Performance Improvement Project

Harmony Health Plan of Missouri

Clinical
PIP Title: Lead Screening
Perinatal Activities 2008- 2009
Adolescent Well Care (AWC) Performance Improvement Project

Non-Clinical
PIP Title:
Medical Record Documentation by Primary Care Physicians (PCP's) and their Staff, Interventions and their Efficacy

HealthCare USA

Clinical
PIP Title(s): Readmissions
Synagis
Asthma Around the World Member Incentive
Statewide Adolescent Well Care
Chlamydia Screening

Non-Clinical
PIP Title: Utilization Management Decisions

Missouri Care

Clinical
PIP Title: Increase Use of Controller Medication for Members with Asthma
WIC Partnership to Increase Well Child Checkup Compliance
Increase Compliance with Chlamydia Screening Recommendations (CHL)
Increasing the Number of Lead Screening Tests for Children

Non-Clinical

PIP Title: Adolescent Well Care – State-Wide PIP
Follow-Up After Hospitalization for Mental Health (FUH, 7- and 30-day)

Molina Healthcare of Missouri

Clinical

PIP Title: Members at High Risk for Cesarean Section Wound Infections
Early Intervention in Prenatal Case Management and the Relationship to Very Low birth Weight Babies PIP

Non-Clinical

PIP Title: Primary Care Provider (PCP) Change
Adolescent Well Care

Work Plan For Next Year (SFY 2010)

The following information was taken from the MO HealthNet Managed Care health plans' SFY 2008 Annual Evaluations:

Blue Advantage Plus of Kansas City

BA+ 2009 Work Plan: See Attachment 14

Children's Mercy Family Health Partners

CMFHP 2009 Work Plan: See Attachment 15

Harmony Health Plan of Missouri

Harmony 2009 Work Plan: See Attachment 16

HealthCare USA

HealthCare USA 2009 Work Plan: See Attachment 17

Missouri Care

Missouri Care 2009 Work Plan: See Attachment 18

Molina Healthcare of Missouri

Molina 2009 Work Plan: See Attachment 19

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MO HealthNet Managed Care Health Plan Best Practices

For the 2008 Missouri External Quality Review Report of Findings, Behavioral Health Concepts was requested 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
Immunization Initiative

Blue-Advantage Plus of Kansas City, Inc. (BA+) understands the importance of immunizations. They have a goal to provide as much education to members about going to the doctor and obtaining all required immunizations. In 2008 BA+ initiated an immunization initiative. The details are as follows:

Members indicating a need for information on vaccines on their Health Risk Assessment Form received a letter and educational materials on vaccinations. Educational materials included:

- Vaccination Initiative Letter -- Information on the importance of receiving all required immunizations
- Shots for Tots brochure – A brochure that provides information on immunizations and the diseases immunizations protect against
- Elliot"s Book about Shots (activity book) – Information about immunizations with fun activities for children
- Protect Your Preteen or Teen with Shots: They"re not just for Babies! – Information about immunizations that preteens and teenagers may need, and where they can go to obtain them
- Older Adults Need Shots brochure – Information for older adults on the importance of flu shots
- Moms and Dads! Elliot Says, don"t Forget Your Child"s Shots! – Information about the importance of immunizations and the periodicity schedule
- Shots For Your Child"s Health – General information about immunizations

Other materials included are:
- Don"t Lose Your Healthcare Coverage – Flyer encouraging members to take an active step in preventing loss of healthcare coverage, including information on the Family Support Division Offices
- Urgent Care List – Information for urgent care centers and on the most common non-emergency conditions that can be treated there

Through 2008 BA+ reached out to sixty-three (63) members with this initiative. In addition, the Health Information Coordinators create a case in the Health Plan"s FACETS system, assign the case to a case manager, and save the information as a potential initial referral to Case Management for any member indicating that they need assistance in obtaining immunizations.

Children's Mercy Family Health Partners
Wellness and Prevention

CMFHP has implemented a number of initiatives to increase member awareness in the areas of Prevention and Wellness. They have synchronized the distribution of information to members in order to coordinate with local and national recognition months for health screenings and disease management awareness. An example is the month of February, which is Children"s Dental Month. CMFHP provides information on dental screenings through member postcards, the member newsletter, on-hold recordings, and the post customer call Hot Topic, as well as information posted on the Health Plan website.

CMFHP has also focused on well-care exams, lead screening and immunizations through a birthday card program. All members ages 1 – 11 receive a birthday card from CMFHP which contains the periodicity schedule appropriate for their age. The Health Plan sends a congratulatory card for all newborns with a periodicity schedule for the first year of life.

In order to provide a targeted information campaign focused on Teens, CMFHP has developed a Teen Newsletter, "Your Space," printed semi-annually. The Health Plan also has a dedicated page on their website that highlights issues relevant to teens. They develop these topics in conjunction with their Teen Advisory Board from Children"s Mercy Hospital to ensure that the message reaches their target audience.

The Health Plan strives to assist members to make the most of their health care benefits. One of the methods of communication regarding the myriad resources that are available through the Health Plan and community is their Quick Resource Guide. CMFHP developed a one-page guide for members who may need assistance in obtaining services, equipment or assistance in managing a chronic disease. The recently implemented Quick Resource Guide is being placed in the New Member Packet, on the website, and in the member newsletter. In the future this publication will be part of the Member Handbook.

Currently CMFHP provides a key fob and magnet for members with a periodicity schedule for distribution with all new enrollment packets. They key fobs contain key phone numbers, such as that of the transportation provider, Customer Services number, and a place to enter PCP information, or other important numbers.

The following postcards are used throughout the year by CMFHP to keep members informed regarding needed and available services:

- Annual Dental Visits – Combined Rate/annually
- Birthday Card – Well Man/annually
- Birthday Cards – WCV/ annually
- Anniversary Cards & Teen Magazines – Adolescents WCV/annually
- Cervical Cancer Screening/2 times each year
- Chlamydia Screening/annually
- Diabetes/annually
- Follow-up after Hospitalization for Mental Illness/annually
- Lead/2 times each year

- Mammogram/2 times per year
- No PCP visit in last year/2 times each year
- Postpartum Care/annually
- Timeliness of Prenatal Care/annually
- Well Woman/annually

Harmony Health Plan
Pay for Quality Program (2008 PFQ)

As part of Harmony Health Plan"s commitment to improving access to care and delivery of quality services to members, the Health Plan has implemented a Pay for Quality Program. The Health Plan identified barriers to achieving quality service provision. These included lack of member education, lack of provider education, and lack of member and provider incentives. Harmony Health Plan has implemented several interventions to address these barriers. The provider focused incentive is a new program, based on improved HEDIS measures, beginning with reports based on the 2008 data. The program description includes:

Goals of the program:
- Pay for financial incentives to physicians and groups to provide needed preventive and other disease-specific services to Harmony Members.
- Improve the accuracy and completeness of encounter and claims data submission from providers.
- With additional PFQ dollars, enable physicians and groups to implement their own member outreach programs.
- Encourage a friendly competition among providers toward improving quality by sharing best PFQ results and practices.

Brief Description of the Program:
- All PCPs with 50 or more members qualify for the program.
- Ten (10) HEDIS measures, including Adolescent Well Care (AWC) are included.
- Based on Quality Compass Medicaid rates, three specific targets are set at 50^{th}, 75^{th}, and 90^{th} percentiles.
- On achieving the target the plan is to pay approximately $40 to $80 per measure.
- Harmony Health Plan staff periodically share the PFQ data and the non-compliant member lists with the physicians and groups throughout the year as part of one-on-one meetings.

Results and Future Plans:
- Since 2008 CY is the first year this program is implemented in Missouri, Harmony Health Plan is currently analyzing the HEDIS 2009 and CY 2008 PFQ data.
- By September 2009 the final results will be available and the incentive checks will be distributed.
- Based on the results and feedback from providers, Harmony Health Plan will modify the program to increase its effectiveness and efficacy.
- Harmony Health Plan is considering implementing a "Star System" to recognize high performing physicians and groups.

HealthCare USA
Cultural Competency Program

HealthCare USA strives to ensure that members receive appropriate care in a culturally-sensitive manner. They do so by maintaining a focus on cultural competency at all levels. They provide education to staff and providers, address language access issues, and include cultural competency in their outcome-based measures. The Health Plan uses the Offices of Minority Health's Culturally and Linguistically Appropriate Services (CLAS) as models for improving policy and practice related to cultural competence. During the past year HCUSA began a program to develop and implement interventions that serve as a foundation for responding to the needs of minority members and eliminating health disparities in historically underserved populations. This program focused on members, providers, and employees and the organization. The over-arching goal is to reduce racial and ethnic health care disparities to improve health status of all members. To achieve this goal the Health Plan implemented the following interventions:

For members in all three MO HealthNet Managed Care Regions:

- Utilize member education materials in other languages
- Print the Member Handbook in Braille and make audio versions available upon request
- Make verbal interpretation or written translation available in preferred language to members upon request
- Make a new Language Service Brochure for LEP members available
- Participate in various ethnic-sponsored events and organizations

For providers and other stakeholders the following interventions occurred:

- Completed a survey of PCPs and other providers in all regions through the credentialing process to determine the languages spoken in each office. This information is made available in HCUSA provider directories and on the on-line provider search.
- Create new provider handouts "Find Your Language," which is a tool that allows for identification of over 20 languages with instructions on accessing language services.
- Participated in the St. Louis Health Care Call to Action Initiative. This symposium focused on establishing meaningful community dialogue on the best methods to achieve 100% access to health care and zero disparities in the St. Louis' health care system.

For members of the HCUSA organization the following interventions occurred:

- Completed organization-wide and individual cultural competency surveys during 2008
- Implemented a multi-disciplinary, intra-departmental team to establish and implement an organization-wide cultural competency program consistent with the CLAS standards in 2008
- Providing three organization-wide all-staff cultural competency trainings presented by Language Access Metro Project (LAMP) to be completed in 2009 that focus on the specific ethnic populations across the state of Missouri
- Continued partnership with BJC Health System's Center for Cultural Diversity in the on-going deployment of HCUSA's cultural competency program
- Participation by 35 management and staff employees in the Poverty Simulation exercise. The exercise was conducted by the Community Action Agency of St. Louis County

(CAASTLC). Additional sessions will be held in the Central and Western Regions throughout 2009

- Produced educational materials in the member‟s preferred language or provided translation services upon request
- Provided all new employees diversity training through a program entitled "Footprints," an online program, which provides education about respecting the differences of others in the workplace. The focus is challenging and enhancing employees‟ understanding of the importance of valuing and respecting co-workers‟ differences
- Hired bilingual member services and member outreach staff
- Conducted behavioral health educational seminars at the International Institute regarding mental health issues facing immigrants and refugees. This will occur in all three regions
- Investigated the "undetermined" language category on the State data file. They sent surveys to 144 member households who selected "other" on their State-provided file. The returned surveys reported that 41% reported Bosnian as their primary language. The Health Plan continues to track various languages in the member population using LAMP, BJC Center for Diversity and Cultural Competency, and other translation services used in all three MO HealthNet Managed Care regions. This process will be repeated annually

The Health Plan has experienced remarkable outcomes as the result of this initiative. The have built a significant network of community partnerships in order to reach out to members. Through partnerships with local hospitals, physicians, health centers, community agencies, and community organizations they have been able to consistently improve well-child visits as reported through HEDIS, and through the results of the CAHPS survey. HCUSA has recruited a culturally-diverse workforce that reflects the diversity of their membership. The staff reflects of the diversity experienced in all three MO HealthNet Managed Care Regions. The Health Plan has developed a culturally diverse provider network in all three Regions as well. The Provider Survey reflects that over 200 PCPs and over 500 specialists speak 69 languages other than English. And finally, in serving non-English speaking members, the Health Plan has learned that over 69% were aware of translation services and interpreter services. From 2006 through 2008 the number of members that use language services, in the Eastern Region alone, has increased by 142%.

Missouri Care Health Plan
"I CAN…Help My Child Stay Healthy" Project

Missouri Care, an Aetna Health Plan, is partnering with the Central Missouri Community Action (CMCA) center in support of the "I CAN Help My Child Stay Healthy" project. "I CAN" is a collaboration between CMCA and the UCLA/Johnson & Johnson Health Care Institute in providing Head Start and Early Head Start program training tools to deliver health literacy training to Head Start families across America.

Studies show that 90 million Americans lack the necessary health literacy skills to effectively utilize the healthcare system. The inappropriate use of emergency rooms has been identified as a major contributor to increased health care costs. The UCLA/Johnson & Johnson project trains Head Start families, who are predominately uninsured or on Medicaid, how to treat minor childhood illnesses. Tracking 9240 Head Start families enrolled in the health literacy program – and impacting nearly 20,000 children in 35 states – researchers found that visits to a hospital ER

or clinic dropped by 58 percent and 42 percent, respectively, as parents opted to treat their children‟s fevers, colds, and earaches at home. This added up to a potential annual savings to Medicaid of $554 per family in direct costs associated with such visits or about $1.5 million annually.[1]

In early 2008 Missouri Care initiated a partnership with the CMCA center in providing "I CAN" training for Head Start parents in Central Missouri. Training includes use of "I CAN‟s" easy-to-read medical reference guide, group classes, and follow-up home sessions. The goals of the partnership are to decrease ER visits and improve parent health literacy. Class participants who are Missouri Care members are asked to participate in a follow-up evaluation of subsequent ER utilization and well-child visits, using claims data. Only aggregate outcomes will be reported.

Missouri Care has been a co-sponsor with CMCA on two class training events in Columbia and Sedalia, drawing 250 and 80 families, respectively. Most recently, Missouri Care was a co-sponsor with CMCA and the UCLA/Johnson & Johnson Health Care Institute in a „night on the town‟ for parents of Head Start children. Parents were provided with gift bags with the medical reference guide, literature and a digital thermometer with Missouri Care‟s logo. The parents were able to take their temperature using the digital thermometer as well as review the medical reference book. Dinner and door prizes were provided.

Missouri Care will conduct follow-up claims data analysis for participating families in the future.

Molina HealthCare of Missouri
Case Management for Pregnant Women
Beginning **A**nother **B**eautiful **Y**ou through **C**oordination of care, **A**ssessment, **R**eferral and **E**ducation (B.A.B.Y. C.A.R.E.) has been implemented to improve obstetrical outcomes, reduce obstetrical-related hospital admissions and decrease the incidence of pre-term deliveries by identifying, educating and managing members with risk factors throughout their pregnancy. This program provides early identification of pregnancies and intervention for all members. Based on the Pregnancy Risk Screening assessment, Molina HealthCare of Missouri‟s Obstetrical Case Managers formulate an individualized plan of management to accomplish and meet the B.A.B.Y.C.A.R.E. Program‟s objectives. Case management services include identifying, tracking and monitoring all pregnant members through prenatal and postpartum care.

Molina HealthCare of Missouri identified low birth weight (LBW), very low birth weight (VLBW), and extremely low birth weight (ELBW) infants as a problem for the health plan and its members. The cost of care of these infants was problematic. More of an issue was the quality of life for the infants and their families when future physical, mental, emotional, and socio-economic problems occurred as the result of issues associated with their premature birth. As a result the Health Plan hypothesized that early identification of risk factors in pregnant women, and implementation of an OB Case Management program for all pregnant Health Plan members, would positively impact these individuals create an atmosphere for healthier and more successful birth outcomes.

[1] Empowering Parents, Benefiting Children: A Study of the Impact of Health Literacy Training on Head Start Parents and the Healthcare System. UCLA/Johnson & Johnson Health Care Institute for Head Start.

The project started as a Performance Improvement Project (PIP) in January 2005 and continued through November 2008. The interventions included risk assessment screenings for all pregnant Health Plan members. All members would receive some case management services which increased with the level of risk assessed. The risk levels are defined as:

- Level 1: No Risk – The member entered into prenatal care in the first 12 – 14 weeks of pregnancy; had longer than 18 months between pregnancies; and reported no previous pregnancy complications.
- Level 2: Low Risk – The member had a pre-pregnancy weight of less than 100 pounds, or greater than 200 pounds; has or had a sexually transmitted disease; had a previous "C" section; entered prenatal care after 12 weeks gestation; is non-compliant with prenatal care; interconceptual spacing of less than 18 months; has a history of medical conditions; has severe social stressors; is a teenager at the time of conception; is a smoker; has a history of previous fetal or infant death; or has had seven or more pregnancies.
- Level 3: High Risk – The member has a chronic or exacerbated medical condition; is currently a drug or alcohol abuser; advanced maternal age of greater than 35 years; has intrauterine growth retardation or fetal anomalies; is 16 years or less at time of conception; is identified with lead toxicity; has chronic or recent mental illness; reports multiple gestations; has current or history of preterm labor; has a history of low or very-low birth weight infants; has gestational diabetes; has pregnancy induced hypertension; or hyperemesis.

The amount of case management services increases with the level of risk assessed as follows:

Level 1 – Information packets are sent to all pregnant women. An ante-partum home visit is made and the member is found stable. A letter is sent each trimester and the case managers tracks the women to ensure that birth notification is received. The member receives a post partum home visit, which may include additional visits as needed or ordered by the member"s obstetrician. The case is closed after six weeks.
Level 2 – Information packets are sent to all pregnant women. The member receives a home visit, and through the assessment process is determined to need additional interventions. Closer tracking occurs, with trimester letters delivered, and additional home visit scheduled as needed. The case manager is notified of the birth and arranges a post partum visit. Additional assessment occurs and the case manager remains involved as necessary.
Level 3 – Information packets are sent to all pregnant women. The member receives a home visit and further assessment occurs. Letters are sent each trimester. The case manager maintains at least monthly telephone contact with the member. Additional services are arranged, as needed, by the mother. After the notification of delivery, the case manager makes a post-partum visit. They authorize additional visits or services as needed, or as authorized by the physician.

The conclusion at the completion of this PIP is that increased rates of Obstetrical Case Management correspond to decreased rates of low birth weight, very low birth weight, and extremely low birth weight babies born during the periods 2005 through 2008. These outcomes are based on yearly reports.

The process of providing some level of case management to all pregnant women has been incorporated into Molina HealthCare of Missouri‟s normal plan operations as the result of the PIP and its findings. While all cases of prematurity are not avoidable, managing the at-risk members with intensive case management appears to lead to a significant decrease in the rates of VLBW and ELBW babies. The Obstetrical Case Managers report that member satisfaction, as well as the positive supporting data, has greatly improved birth outcomes. The positive effect on member health is creating well being in both the long and short term. This is now a part of the routine for OB Case Management at Molina HealthCare of Missouri.

Marketing

MO HealthNet Managed Care health plans must submit their proposed marketing plan, all marketing materials and member education materials to MHD for written approval prior to use. Below is the total of marketing and member education materials for FY2009 for each managed care health plan as well as for Affiliated Computer Services, Inc., (ACS), Missouri Primary Association and Enrollment Broker materials. This report does not include Pharmacy submissions.

Blue –Advantage Plus of Kansas City

Total Marketing Submitted	95
Total Approved	94
Total Denied	00
Total Submitted then Withdrawn	01
Total Other	00

Children's Mercy Family Health Partners

Total Marketing Submitted	276
Total Approved	255
Total Denied	03
Total Submitted then Withdrawn	14
Total Other	04

HealthCare USA

Total Marketing Submitted	168
Total Approved	134
Total Denied	00
Total Submitted then Withdrawn	28
Total Other	06

Harmony Health Plan of Missouri

Total Marketing Submitted	52
Total Approved	47
Total Denied	04
Total Submitted then Withdrawn	01
Total Other	00

Mercy CarePlus

Total Marketing Submitted	66
Total Approved	65
Total Denied	01
Total Submitted then Withdrawn	00
Total Other	00

Molina Healthcare of Missouri

Total Marketing Submitted	175
Total Approved	156
Total Denied	00
Total Submitted then Withdrawn	13
Total Other	06

Missouri Care

Total Marketing Submitted	108
Total Approved	97
Total Denied	03
Total Submitted then Withdrawn	07
Total Other	01

Missouri Primary Association

Total Marketing Submitted	01
Total Approved	01
Total Denied	00
Total Submitted then Withdrawn	00
Total Other	00

Affiliated Computer Services, Inc. (ACS)

Total Marketing Submitted	15
Total Approved	13
Total Denied	00
Total Submitted then Withdrawn	01
Other	01

Enrollment Broker

Total Marketing Submitted	04
Total Approved	04
Total Denied	00
Total Submitted then Withdrawn	00
Total Other	00

After review of the marketing and member education materials by MHD if changes are needed the managed care health plans are required to correct problems and/or errors as identified by MHD. MO HealthNet managed care health plans shall return the corrected marketing plan or revised material within ten (10) business days of the receipt date of the written notice from MHD.

Marketing/Member Education Materials

MO HealthNet Managed Care health plan marketing and member education materials shall include but are not limited to a listing of in-network providers, member's rights and

responsibilities, general MO HealthNet Managed Care eligibility information, member education on how to use a health plan and how to assert certain rights with their health plan member benefits, new member orientation, member handbook, disease management information, and provider directory.

Below is a sampling of marketing and member education materials submitted by the MO HealthNet Managed Care health plans in SFY2009. Some of the materials were also submitted in Spanish, Bosnian, and Serbo-Croatian.

Member Handbooks/Provider Directory
Marketing Plan
Happy Birthday Mailings
Member Newsletters
Well Women Mailings
Men's Health Mailings
Member Identification Cards
Open Enrollment Letters, Flyers, Billboards, Mailers
Educational Materials/Brochures for asthma, dental, diabetes, ADHD, ADD, smoking cessation, obesity, emergency room usage, lead, prenatal, post-partum, heart health, flu, cancer awareness, swine flu, plus many more.
Grievance and Appeals Letters/Flyers
Pharmacy Lock-In Letters
Immunizations (Shots)
Early Periodic Screening, Diagnosis and Treatment (EPSDT)
Case Management Letters
Health Plan Website Information
Community Activities
Radio Scripts
TV Ads
Health Assessments
Satisfaction Surveys
Audio Member Handbook
Health Information via Audio
Non Emergency Medical Transportation

MO HealthNet Managed Care health plan marketing and member education submissions for FY2009 totaled 940*.

There was an increase of 224 submissions from the SFY2008 (716) submissions to SFY2009 (940) submissions.

**Total does not include Missouri Primary Association, ACS and Enrollment Broker submissions*.

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MO HealthNet Managed Care
Western Region Annual HEDIS Comparison

Measure	Data Year	Blue Advantage Plus	Children's Mercy Family Health Partners	FirstGuard* (Contract Terminated 01/31/2007)	Healthcare USA	Molina** (Contract Began 07/01/2006)	Statewide Average of All MC+ Plans	NCQA National Average
Adolescent Immunizations	2005	0.00%	68.86%	17.03%	18.59%	**	27.55%	
	2006	16.79%	36.50%	*	26.42%	**	39.83%	
	2007	DHSS suspended this measure as it was retired by NCQA						
Adolescent Well-Care Visits	2005	32.65%	33.09%	28.64%	23.67%	**	32.68%	
	2006	32.65%	42.82%	*	24.35%	**	35.68%	43.66%
	2007	34.79%	41.61%	*	32.56%	17.83%	33.41%	41.88%
	2008	35.32%	39.42%	*	30.32%	30.82%	35.82%	45.85%
Annual Dental Visit Age 2-3	2005	13.37%	15.84%	13.03%	8.98%	**	10.82%	
	2006	12.23%	15.80%	*	8.94%	**	11.61%	23.60%
	2007	11.24%	15.01%	*	11.39%	16.67%	12.29%	25.87%
	2008	11.27%	15.08%	*	13.05%	13.03%	12.92%	27.60%
Annual Dental Visit Age 4-6	2005	36.12%	41.34%	36.31%	27.11%	**	32.69%	
	2006	36.95%	40.66%	*	26.82%	**	34.73%	49.96%
	2007	33.46%	41.43%	*	34.20%	14.08%	31.42%	52.02%
	2008	35.86%	41.79%	*	37.12%	35.97%	34.90%	52.40%
Annual Dental Visit Age 7-10	2005	41.27%	45.37%	41.91%	31.73%	**	37.41%	
	2006	44.52%	46.85%	*	35.40%	**	40.54%	51.92%
	2007	42.60%	48.87%	*	38.00%	19.10%	37.49%	54.01%
	2008	42.38%	48.10%	*	42.14%	39.27%	41.85%	55.67%
Annual Dental Visit Age 11 - 14	2005	36.24%	40.85%	35.91%	25.37%	**	32.78%	
	2006	36.94%	40.95%	*	28.36%	**	34.56%	46.64%
	2007	37.64%	42.62%	*	34.07%	13.83%	32.14%	48.21%
	2008	37.38%	43.95%	*	37.32%	28.73%	35.59%	49.98%
Annual Dental Visit Age 15 - 18	2005	31.64%	34.79%	32.34%	20.14%	**	27.65%	
	2006	31.33%	34.30%	*	28.31%	**	29.81%	39.59%
	2007	30.95%	34.93%	*	29.85%	14.29%	27.02%	40.76%
	2008	31.16%	36.83%	*	32.51%	24.78%	30.74%	42.18%
Annual Dental Visit Age 19 - 21	2005	15.32%	16.60%	15.88%	15.45%	**	16.15%	
	2006	17.38%	25.19%	*	11.70%	**	18.36%	30.40%
	2007	16.89%	26.27%	*	15.02%	NA	17.16%	31.09%
	2008	9.22%	26.39%	*	15.03%	13.04%	17.55%	31.38%
Annual Dental Visit Combined Rate	2005	32.82%	37.07%	32.60%	23.19%	**	29.34%	
	2006	33.72%	37.49%	*	25.46%	**	31.45%	42.48%
	2007	32.54%	38.59%	*	30.29%	15.16%	27.54%	43.55%
	2008	32.73%	38.99%	*	33.42%	29.32%	32.29%	44.17%
Asthma Age 5 - 9	2005	93.48%	92.83%	88.41%	NA	**	87.94%	
	2006	91.88%	90.06%	*	NA	**	88.72%	89.62%
	2007	93.57%	92.38%	*	94.87%	NA	90.23%	89.29%
	2008	0.00%	93.17%	*	92.11%	NA	90.40%	92.02%
Asthma Age 10 - 17	2005	87.50%	91.91%	95.83%	NA	**	85.61%	
	2006	91.36%	92.58%	*	NA	**	87.68%	87.03%
	2007	86.14%	90.29%	*	81.25%	NA	87.32%	86.85%
	2008	0.00%	91.29%	*	92.90%	NA	87.82%	89.05%
Asthma Age 18 - 56	2005	74.23%	70.48%	85.29%	NA	**	75.35%	
	2006	83.33%	85.32%	*	NA	**	78.53%	84.73%
	2007	80.00%	78.41%	*	NA	NA	77.11%	84.41%
	2008	0.00%	85.19%	*	80.00%	NA	78.95%	85.18%
Asthma Combined	2005	87.12%	89.34%	90.07%	86.79%	**	84.58%	
	2006	90.43%	90.57%	*	80.28%	**	85.97%	87.14%
	2007	88.63%	89.73%	*	85.37%	NA	87.01%	86.91%
	2008	0.00%	91.37%	*	90.64%	NA	87.42%	88.66%
Cervical Cancer Screening	2005	66.39%	66.69%	67.40%	55.96%	**	66.33%	
	2006	68.23%	63.78%	*	53.74%	**	65.77%	65.69%
	2007	65.21%	66.84%	*	55.22%	25.45%	56.78%	64.75%
	2008	69.11%	62.53%	*	59.93%	32.19%	56.47%	66.02%
Childhood Immunization	2005	47.65%	66.00%	49.64%	59.79%	**	59.77%	
	2006	60.83%	67.15%	*	53.94%	**	60.01%	
	2007	54.43%	56.79%	*	55.56%	NA	55.73%	
	2008	52.08%	51.11%	*	52.31%	40.00%	53.58%	

Measure	Data Year	Blue Advantage Plus	Children's Mercy Family Health Partners	FirstGuard* (Contract Terminated 01/31/2007)	Healthcare USA	Molina** (Contract Began 07/01/2006)	Statewide Average of All MC+ Plans	NCQA National Average
Chlamydia Screening Age 16 - 20	2005	42.54%	58.46%	60.63%	55.84%	**	55.88%	
	2006	49.14%	55.82%	*	66.47%	**	58.14%	50.54%
	2007	41.95%	50.06%	*	54.81%	NA	51.91%	48.56%
	2008	55.59%	54.31%	*	62.31%	40.94%	54.38%	52.67%
Chlamydia Screening Age 21 - 26	2005	46.38%	60.22%	62.76%	52.86%	**	58.38%	
	2006	65.00%	66.67%	*	52.88%	**	62.70%	54.98%
	2007	64.80%	61.32%	*	63.77%	NA	60.91%	53.95%
	2008	62.85%	65.37%	*	69.98%	44.23%	59.06%	59.39%
Chlamydia Screening Combined Rate	2005	44.43%	59.23%	61.75%	54.07%	**	57.02%	
	2006	55.79%	59.54%	*	59.22%	**	59.60%	52.41%
	2007	50.52%	53.80%	*	59.10%	NA	55.27%	50.68%
	2008	57.97%	57.21%	*	65.21%	41.90%	55.79%	54.88%
Well Child Visits in the First 15 Months of Life: 0 Visits	2005	2.78%	2.80%	3.89%	4.82%	**	2.93%	
	2006	2.78%	1.74%	*	2.79%	**	3.06%	3.79%
	2007	2.69%	2.06%	*	2.08%	NA	3.76%	5.68%
	2008	3.67%	2.70%	*	3.91%	18.95%	5.63%	2.66%
Well Child Visits in the First 15 Months of Life: 1 Visit	2005	4.63%	4.34%	4.62%	7.11%	**	3.63%	
	2006	4.63%	2.73%	*	5.35%	**	3.63%	2.60%
	2007	4.30%	1.03%	*	1.85%	NA	3.67%	3.30%
	2008	4.17%	0.54%	*	3.71%	12.63%	3.07%	2.42%
Well Child Visits in the First 15 Months of Life: 2 Visits	2005	5.86%	6.68%	4.14%	7.34%	**	5.24%	
	2006	5.86%	2.23%	*	6.05%	**	4.26%	3.60%
	2007	6.09%	3.61%	*	7.41%	NA	5.22%	3.92%
	2008	6.68%	4.58%	*	7.49%	4.21%	4.55%	3.43%
Well Child Visits in the First 15 Months of Life: 3 Visits	2005	8.79%	9.14%	9.00%	10.55%	**	7.95%	
	2006	8.79%	6.20%	*	8.14%	**	7.02%	6.09%
	2007	9.13%	3.35%	*	8.80%	NA	7.70%	6.20%
	2008	9.68%	5.66%	*	9.38%	6.32%	6.20%	5.70%
Well Child Visits in the First 15 Months of Life: 4 Visits	2005	15.57%	16.50%	9.49%	17.66%	**	12.42%	
	2006	15.57%	8.44%	*	16.05%	**	12.25%	11%
	2007	14.68%	9.54%	*	13.19%	NA	11.21%	10.84%
	2008	8.63%	13.61%	*	13.77%	16.84%	13.20%	10.33%
Well Child Visits in the First 15 Months of Life: 5 Visits	2005	23.36%	25.81%	12.65%	20.41%	**	18.14%	
	2006	23.36%	16.63%	*	17.91%	**	18.04%	17.30%
	2007	23.10%	13.66%	*	20.60%	NA	17.19%	17.12%
	2008	22.79%	11.86%	*	20.51%	14.74%	17.10%	16.64%
Well Child Visits in the First 15 Months of Life: 6+ Visits	2005	39.01%	34.72%	56.20%	32.11%	**	49.69%	
	2006	39.01%	62.03%	*	43.72%	**	51.74%	55.61%
	2007	40.02%	66.75%	*	46.06%	NA	51.24%	52.95%
	2008	39.23%	66.04%	*	41.41%	26.32%	50.26%	58.77%
Well Child Visits in the Third through Sixth Year of Life	2005	55.70%	72.75%	50.99%	47.50%	**	58.07%	
	2006	55.70%	66.27%	*	49.79%	**	57.81%	66.81%
	2007	55.43%	62.53%	*	60.42%	34.04%	53.69%	65.11%
	2008	55.56%	65.21%	*	61.57%	42.22%	56.91%	69.68%
Postpartum Care	2005	56.05%	56.69%	43.31%	34.42%	**	50.15%	
	2006	56.34%	57.28%	*	65.05%	**	61.69%	59.08%
	2007	54.88%	52.11%	*	61.34%	51.09%	58.68%	58.60%
	2008	56.22%	60.24%	*	67.29%	59.29%	63.08%	62.65%
Timeliness of Prenatal Care	2005	39.96%	75.43%	49.15%	40.58%	**	56.28%	
	2006	39.54%	79.51%	*	90.74%	**	79.88%	81.24%
	2007	43.87%	80.89%	*	86.11%	59.78%	77.95%	81.37%
	2008	43.34%	83.90%	*	90.26%	79.20%	80.84%	81.94%
Follow-Up After Hospitalization for Mental Illness Within 7 Days of Discharge	2005	50.17%	45.15%	35.34%	20.83%	**	31.46%	
	2006	58.67%	48.51%	*	28.21%	**	36.99%	39.13%
	2007	51.39%	34.42%	*	35.53%	NA	36.52%	42.50%
	2008	52.03%	40.20%	*	44.85%	36.11%	38.24%	42.62%
Follow-Up After Hospitalization for Mental Illness Within 30 Days of Discharge	2005	72.76%	71.52%	59.40%	41.67%	**	55.92%	
	2006	76.00%	88.37%	*	53.85%	**	61.85%	57.67%
	2007	75.00%	69.85%	*	57.51%	NA	64.50%	60.99%
	2008	73.31%	68.70%	*	66.54%	58.33%	62.06%	61.67%

NA=Statewide average excludes n<30.

MO HealthNet Managed Care
Eastern Region Annual HEDIS Comparison

Measure	Data Year	Harmony* (Contract Began 07/01/2006)	Healthcare USA	Mercy MC+** (Contract Terminated 06/30/2006)	Molina (Contract Began 07/01/2006)	Statewide Average of All Health Plans	NCQA National Average
Adolescent Immunizations	2005	*	43.52%	24.57%	25.79%	27.55%	
	2006	*	57.64%	**	72.51%	39.83%	
	2007	DHSS suspended this measure as it was retired by NCQA					
Adolescent Well-Care Visits	2005	*	35.55%	30.90%	28.92%	32.68%	
	2006	*	36.49%	**	29.49%	35.68%	43.66%
	2007	25.06%	40.35%	**	43.55%	33.41%	41.88%
	2008	28.71%	45.14%	**	33.85%	35.82%	45.85%
Annual Dental Visit Age 2-3	2005	*	10.00%	7.83%	9.04%	10.82%	
	2006	*	11.23%	**	9.12%	11.61%	23.60%
	2007	3.69%	12.40%	**	9.01%	12.29%	25.87%
	2008	6.99%	14.05%	**	10.58%	12.92%	27.60%
Annual Dental Visit Age 4-7	2005	*	34.78%	29.77%	31.73%	32.69%	
	2006	*	37.19%	**	33.64%	34.73%	49.96%
	2007	19.93%	39.42%	**	33.76%	31.42%	52.02%
	2008	18.82%	41.13%	**	36.42%	34.90%	52.40%
Annual Dental Visit Age 7-10	2005	*	37.96%	36.73%	38.14%	37.41%	
	2006	*	42.19%	**	40.59%	40.54%	51.92%
	2007	25.93%	46.04%	**	41.74%	37.49%	54.01%
	2008	30.31%	48.42%	**	46.24%	41.85%	55.67%
Annual Dental Visit Age 11 - 14	2005	*	32.32%	32.22%	32.34%	32.78%	
	2006	*	35.44%	**	34.07%	34.56%	46.64%
	2007	16.55%	37.41%	**	35.97%	32.14%	48.21%
	2008	25.19%	40.62%	**	40.12%	35.59%	49.98%
Annual Dental Visit Age 15 - 18	2005	*	26.34%	27.41%	26.62%	27.65%	
	2006	*	27.92%	**	27.18%	29.81%	39.59%
	2007	16.67%	29.25%	**	28.44%	27.02%	40.76%
	2008	20.92%	32.80%	**	31.33%	30.74%	42.18%
Annual Dental Visit Age 19 - 21	2005	*	17.18%	17.60%	18.45%	16.15%	
	2006	*	19.30%	**	20.00%	18.36%	30.40%
	2007	9.41%	16.82%	**	15.11%	17.16%	31.09%
	2008	9.90%	21.18%	**	15.95%	17.55%	31.38%
Annual Dental Visit Combined Rate	2005	*	29.81%	27.71%	29.08%	29.34%	
	2006	*	32.52%	**	30.45%	31.45%	42.48%
	2007	16.94%	34.61%	**	30.75%	27.54%	43.55%
	2008	20.68%	37.16%	**	33.97%	32.29%	44.17%
Asthma Age 5 - 9	2005	*	88.46%	88.12%	79.31%	87.94%	
	2006	*	86.29%	**	86.02%	88.72%	89.62%
	2007	NA	87.75%	**	85.07%	90.23%	89.29%
	2008	NA	88.35%	**	86.18%	90.40%	92.02%
Asthma Age 10 - 17	2005	*	85.79%	87.62%	83.94%	85.61%	
	2006	*	87.51%	**	89.84%	87.68%	87.03%
	2007	NA	86.88%	**	84.51%	87.32%	86.85%
	2008	NA	86.67%	**	88.65%	87.82%	89.05%
Asthma Age 18 - 56	2005	*	77.52%	84.48%	66.24%	75.35%	
	2006	*	82.28%	**	71.60%	78.53%	84.73%
	2007	NA	83.46%	**	80.95%	77.11%	84.41%
	2008	NA	81.31%	**	78.86%	78.95%	85.18%
Asthma Combined	2005	*	85.51%	87.12%	78.08%	84.58%	
	2006	*	86.43%	**	85.66%	85.97%	87.14%
	2007	NA	86.87%	**	84.16%	87.01%	86.91%
	2008	NA	86.75%	**	86.34%	87.42%	88.66%
Cervical Cancer Screening	2005	*	71.43%	65.94%	59.53%	66.33%	
	2006	*	70.79%	**	61.25%	65.77%	65.69%
	2007	40.20%	68.36%	**	46.57%	56.78%	64.75%
	2008	45.01%	67.75%	**	61.04%	56.47%	66.02%

Measure	Data Year	Harmony* (Contract Began 07/01/2006)	Healthcare USA	Mercy MC+** (Contract Terminated 06/30/2006)	Molina (Contract Began 07/01/2006)	Statewide Average of All Health Plans	NCQA National Average
Childhood Immunization	2005	*	62.65%	43.07%	61.31%	59.77%	
	2006	*	55.79%	**	52.55%	60.01%	
	2007	27.27%	57.41%	**	54.01%	55.73%	
	2008	42.86%	52.55%	**	53.42%	53.58%	
Chlamydia Screening Age 16 - 20	2005	*	61.07%	50.91%	83.19%	55.88%	
	2006	*	67.52%	**	63.33%	58.14%	50.54%
	2007	57.28%	62.68%	**	47.86%	51.91%	48.56%
	2008	57.49%	66.81%	**	55.49%	54.38%	52.67%
Chlamydia Screening Age 21 - 26	2005	*	64.42%	51.42%	88.67%	58.38%	
	2006	*	71.32%	**	65.22%	62.70%	54.98%
	2007	57.43%	70.65%	**	52.71%	60.91%	53.95%
	2008	62.59%	73.32%	**	62.21%	59.06%	59.39%
Chlamydia Screening Combined Rate	2005	*	62.70%	51.17%	85.67%	57.02%	
	2006	*	69.14%	**	64.09%	59.60%	52.41%
	2007	57.35%	65.81%	**	49.80%	55.27%	50.68%
	2008	59.80%	68.83%	**	57.71%	55.79%	54.88%
Well Child Visits in the First 15 Months of Life: 0 Visits	2005	*	2.77%	2.43%	3.09%	2.93%	
	2006	*	4.63%	**	6.93%	3.06%	3.79%
	2007	11.63%	5.13%	**	4.38%	3.76%	5.68%
	2008	5.99%	2.31%	**	10.62%	5.63%	2.66%
Well Child Visits in the First 15 Months of Life: 1 Visit	2005	*	3.42%	1.46%	4.26%	3.63%	
	2006	*	3.14%	**	4.52%	3.63%	2.60%
	2007	8.14%	3.63%	**	7.79%	3.67%	3.30%
	2008	2.34%	2.08%	**	2.88%	3.07%	2.42%
Well Child Visits in the First 15 Months of Life: 2 Visits	2005	*	6.27%	4.14%	5.78%	5.24%	
	2006	*	5.11%	**	5.37%	4.26%	3.60%
	2007	2.33%	5.13%	**	10.95%	5.22%	3.92%
	2008	5.99%	3.24%	**	5.75%	4.55%	3.43%
Well Child Visits in the First 15 Months of Life: 3 Visits	2005	*	9.28%	6.57%	8.73%	7.95%	
	2006	*	8.59%	**	9.82%	7.02%	6.09%
	2007	9.30%	8.90%	**	11.68%	7.70%	6.20%
	2008	8.07%	8.10%	**	4.42%	6.20%	5.70%
Well Child Visits in the First 15 Months of Life: 4 Visits	2005	*	15.74%	11.44%	14.24%	12.42%	
	2006	*	14.14%	**	14.77%	12.25%	11%
	2007	10.47%	13.37%	**	14.60%	11.21%	10.84%
	2008	9.73%	14.12%	**	17.97%	13.20%	10.33%
Well Child Visits in the First 15 Months of Life: 5 Visits	2005	*	21.76%	15.57%	18.84%	18.14%	
	2006	*	20.63%	**	19.86%	18.04%	17.30%
	2007	16.28%	20.94%	**	18.25%	17.19%	17.12%
	2008	15.89%	20.60%	**	18.14%	17.10%	16.64%
Well Child Visits in the First 15 Months of Life: 6+ Visits	2005	*	40.76%	58.39%	45.05%	49.69%	
	2006	*	43.76%	**	38.73%	51.74%	55.61%
	2007	41.86%	42.90%	**	32.36%	51.24%	52.95%
	2008	43.75%	49.54%	**	48.45%	50.26%	58.77%
Well Child Visits in the Third through Sixth Year of Life	2005	*	58.84%	52.07%	55.81%	58.07%	
	2006	*	59.78%	**	52.83%	57.81%	66.81%
	2007	48.18%	62.27%	**	50.94%	53.69%	65.11%
	2008	53.53%	68.52%	**	51.88%	56.91%	69.68%
Postpartum Care	2005	*	37.00%	53.77%	52.07%	50.15%	
	2006	*	52.78%	**	59.85%	61.69%	59.08%
	2007	55.56%	54.76%	**	54.74%	58.68%	58.60%
	2008	57.66%	59.16%	**	59.38%	63.08%	62.65%
Timeliness of Prenatal Care	2005	*	52.66%	41.12%	64.72%	56.28%	
	2006	*	80.09%	**	83.94%	79.88%	81.24%
	2007	86.51%	83.53%	**	78.35%	77.95%	81.37%
	2008	78.83%	83.76%	**	80.13%	80.84%	81.94%
Follow-Up After Hospitalization for Mental Illness Within 7 Days of Discharge	2005	*	28.28%	25.78%	25.26%	31.46%	
	2006	*	26.75%	**	24.68%	36.99%	39.13%
	2007	NA	30.59%	**	31.05%	36.52%	42.50%
	2008	24.66%	42.79%	**	38.89%	38.24%	42.62%
Follow-Up After Hospitalization for Mental Illness Within 30 Days of Discharge	2005	*	49.25%	51.27%	49.12%	55.92%	
	2006	*	48.89%	**	46.31%	61.85%	57.67%
	2007	NA	57.45%	**	52.62%	64.50%	60.99%
	2008	39.73%	70.68%	**	63.52%	62.06%	61.67%

NA=Statewide average excludes n<30.

MO HealthNet Managed Care
Central Region Annual HEDIS Comparison

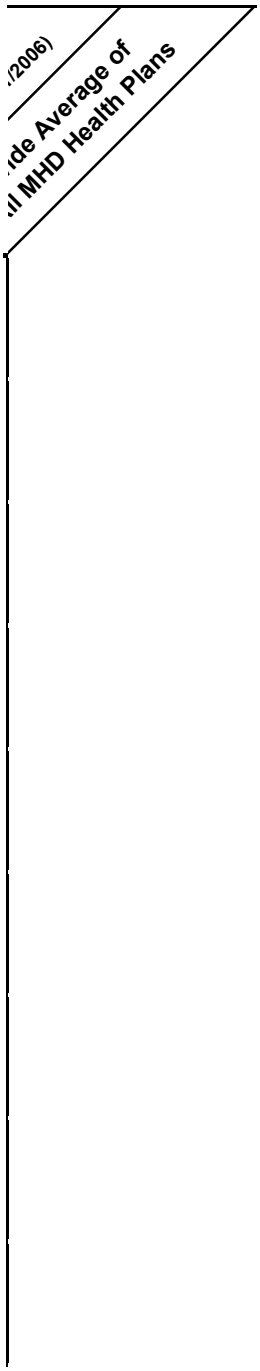
Measure	Data Year	HCUSA	Missouri Care	Molina** (Contract Began 07/01/2006)	Statewide Average of All MC+ Plans	NCQA National Average
Adolescent Immunizations	2005	19.21%	30.41%	**	27.55%	
	2006	28.01%	40.97%	**	39.83%	
	2007	DHSS suspended this measure as it was retired by NCQA				
Adolescent Well-Care Visits	2005	36.19%	44.53%	**	32.68%	
	2006	39.06%	44.91%	**	35.68%	43.66%
	2007	40.19%	49.54%	8.57%	33.41%	41.88%
	2008	39.12%	43.06%	32.44%	35.82%	45.85%
Annual Dental Visit Age 2-3	2005	9.65%	9.65%	**	10.82%	
	2006	13.72%	10.24%	**	11.61%	23.60%
	2007	19.60%	11.62%	NA	12.29%	25.87%
	2008	20.10%	10.70%	14.36%	12.92%	27.60%
Annual Dental Visit Age 4-7	2005	28.20%	28.85%	**	32.69%	
	2006	38.09%	29.77%	**	34.73%	49.96%
	2007	39.75%	26.75%	NA	31.42%	52.02%
	2008	43.95%	27.98%	30.00%	34.90%	52.40%
Annual Dental Visit Age 7-10	2005	32.09%	31.52%	**	37.41%	
	2006	40.47%	33.74%	**	40.54%	51.92%
	2007	42.07%	33.04%	NA	37.49%	54.01%
	2008	48.85%	33.84%	38.99%	41.85%	55.67%
Annual Dental Visit Age 11 - 14	2005	29.12%	30.66%	**	32.78%	
	2006	34.73%	31.42%	**	34.56%	46.64%
	2007	38.59%	32.61%	NA	32.14%	48.21%
	2008	42.92%	30.25%	29.45%	35.59%	49.98%
Annual Dental Visit Age 15 - 18	2005	21.55%	27.99%	**	27.65%	
	2006	30.74%	28.92%	**	29.81%	39.59%
	2007	30.17%	28.66%	NA	27.02%	40.76%
	2008	37.76%	29.75%	29.52%	30.74%	42.18%
Annual Dental Visit Age 19 - 21	2005	8.65%	20.22%	**	16.15%	
	2006	16.22%	18.71%	**	18.36%	30.40%
	2007	10.81%	26.97%	NA	17.16%	31.09%
	2008	26.55%	28.21%	10.00%	17.55%	31.38%
Annual Dental Visit Combined Rate	2005	25.05%	26.76%	**	29.34%	
	2006	32.73%	27.76%	**	31.45%	42.48%
	2007	35.08%	27.50%	13.93%	27.54%	43.55%
	2008	40.33%	27.41%	28.86%	32.29%	44.17%
Asthma Age 5 - 9	2005	89.22%	83.67%	**	87.94%	
	2006	91.07%	90.40%	**	88.72%	89.62%
	2007	89.41%	88.57%	NA	90.23%	89.29%
	2008	95.88%	86.73%	NA	90.40%	92.02%
Asthma Age 10 - 17	2005	84.50%	67.76%	**	85.61%	
	2006	84.62%	80.16%	**	87.68%	87.03%
	2007	91.67%	90.48%	NA	87.32%	86.85%
	2008	84.83%	82.56%	NA	87.82%	89.05%
Asthma Age 18 - 56	2005	84.71%	59.86%	**	75.35%	
	2006	76.09%	72.58%	**	78.53%	84.73%
	2007	67.50%	72.34%	NA	77.11%	84.41%
	2008	73.81%	74.55%	NA	78.95%	85.18%
Asthma Combined	2005	86.08%	71.09%	**	84.58%	
	2006	85.67%	82.75%	**	85.97%	87.14%
	2007	87.36%	86.96%	NA	87.01%	86.91%
	2008	86.97%	82.46%	NA	87.42%	88.66%
Cervical Cancer Screening	2005	70.34%	73.32%	**	66.33%	
	2006	68.01%	74.59%	**	65.77%	65.69%
	2007	66.85%	76.35%	NA	56.78%	64.75%
	2008	63.72%	70.25%	33.13%	56.74%	66.02%
Childhood Immunization	2005	72.69%	75.18%	**	59.77%	
	2006	64.97%	64.81%	**	60.01%	
	2007	72.45%	67.92%	NA	55.73%	
	2008	65.28%	66.23%	60.00%	53.58%	

Measure	Data Year	HCUSA	Missouri Care	Molina** (Contract Began 07/01/2006)	Statewide Average of All MC+ Plans	NCQA National Average
Chlamydia Screening Age 16 - 20	2005	43.22%	47.03%	**	55.88%	
	2006	54.07%	50.64%	**	58.14%	50.54%
	2007	50.80%	49.86%	NA	51.91%	48.56%
	2008	53.03%	48.45%	49.40%	54.38%	52.67%
Chlamydia Screening Age 21 - 26	2005	46.39%	52.28%	**	58.38%	
	2006	57.14%	60.69%	**	62.70%	54.98%
	2007	54.55%	62.06%	NA	60.91%	53.95%
	2008	58.59%	58.17%	33.33%	59.06%	59.39%
Chlamydia Screening Combined Rate	2005	44.75%	49.44%	**	57.02%	
	2006	55.20%	54.24%	**	59.60%	52.41%
	2007	51.98%	53.76%	NA	55.27%	50.68%
	2008	54.36%	51.16%	43.75%	55.79%	54.88%
Well Child Visits in the First 15 Months of Life: 0 Visits	2005	1.49%	2.30%	**	2.93%	
	2006	0.70%	1.85%	**	3.06%	3.79%
	2007	1.42%	0.74%	NA	3.76%	5.68%
	2008	0.65%	0.79%	6.67%	5.63%	2.66%
Well Child Visits in the First 15 Months of Life: 1 Visit	2005	1.86%	0.98%	**	3.63%	
	2006	2.51%	2.55%	**	3.63%	2.60%
	2007	2.13%	0.49%	NA	3.67%	3.30%
	2008	1.03%	1.32%	0.00%	3.07%	2.42%
Well Child Visits in the First 15 Months of Life: 2 Visits	2005	2.98%	3.93%	**	5.24%	
	2006	2.20%	3.01%	**	4.26%	3.60%
	2007	2.37%	3.92%	NA	5.22%	3.92%
	2008	1.81%	2.38%	3.33%	4.55%	3.43%
Well Child Visits in the First 15 Months of Life: 3 Visits	2005	5.59%	3.93%	**	7.95%	
	2006	4.11%	3.47%	**	7.02%	6.09%
	2007	3.79%	6.62%	NA	7.70%	6.20%
	2008	5.05%	5.29%	0.00%	6.20%	5.70%
Well Child Visits in the First 15 Months of Life: 4 Visits	2005	5.87%	5.25%	**	12.42%	
	2006	7.31%	9.49%	**	12.25%	11%
	2007	6.75%	7.11%	NA	11.21%	10.84%
	2008	6.34%	7.67%	23.33%	13.20%	10.33%
Well Child Visits in the First 15 Months of Life: 5 Visits	2005	13.69%	11.15%	**	18.14%	
	2006	10.52%	17.36%	**	18.04%	17.30%
	2007	12.19%	12.50%	NA	17.19%	17.12%
	2008	14.23%	15.61%	16.67%	17.10%	16.64%
Well Child Visits in the First 15 Months of Life: 6+ Visits	2005	68.53%	72.46%	**	49.69%	
	2006	72.65%	62.27%	**	51.74%	55.61%
	2007	71.36%	68.63%	NA	51.24%	52.95%
	2008	70.89%	66.93%	50.00%	50.26%	58.77%
Well Child Visits in the Third through Sixth Year of Life	2005	61.59%	67.37%	**	58.07%	
	2006	61.34%	58.97%	**	57.81%	66.81%
	2007	62.32%	58.22%	42.55%	53.69%	65.11%
	2008	63.66%	57.87%	49.12%	56.91%	69.68%
Postpartum Care	2005	51.11%	66.91%	**	50.15%	
	2006	69.00%	71.56%	**	61.69%	59.08%
	2007	72.79%	70.83%	NA	58.68%	58.60%
	2008	76.98%	67.21%	67.32%	63.08%	62.65%
Timeliness of Prenatal Care	2005	53.82%	89.05%	**	56.28%	
	2006	92.07%	93.24%	**	79.88%	81.24%
	2007	91.40%	91.11%	NA	77.95%	81.37%
	2008	95.81%	92.08%	81.05%	80.84%	81.94%
Follow-Up After Hospitalization for Mental Illness Within 7 Days of Discharge	2005	34.69%	17.65%	**	31.46%	
	2006	29.53%	42.58%	**	36.99%	39.13%
	2007	42.65%	30.00%	NA	36.52%	42.50%
	2008	45.88%	39.34%	17.65%	38.24%	42.62%
Follow-Up After Hospitalization for Mental Illness Within 30 Days of Discharge	2005	60.54%	47.79%	**	55.92%	
	2006	56.38%	63.16%	**	61.85%	57.67%
	2007	71.32%	67.78%	NA	64.50%	60.99%
	2008	70.59%	62.13%	47.06%	62.06%	61.67%

NA=Statewide average excludes n<30.

MO HealthNet Managed Care
Western Region Annual CAHPS Comparison

Measure	Data Year	Blue Advantage Plus	Children's Mercy Family Health Partners	FirstGuard* (Contract Terminated 01/31/2007)	Healthcare USA	Molina** (Contract Began 07/01	Statew A
Getting Needed Care (% Not a Problem)	2005	81.34%	82.01%	80.49%	79.17%		80.16%
	2006	80.07%	83.24%		73.38%		80.07%
	2007	81.61%	80.15%		80.42%	64.61%	77.38%
	2008	75.20%	77.77%		76.57%	70.60%	75.83%
Getting Care Quickly (% Always/Usually)	2005	79.50%	80.38%	78.88%	76.14%		79.02%
	2006	77.74%	78.01%		75.14%		79.42%
	2007	79.43%	80.87%		77.81%	67.88%	77.19%
	2008	90.30%	88.70%		91.04%	89.28%	89.62%
Courteous and Helpful Staff (% Always/Usually)	2005	92.18%	90.54%	91.24%	90.35%		92.00%
	2006	89.90%	95.55%		87.93%		91.38%
	2007	90.50%	91.88%		90.38%	91.06%	91.09%
	2008	Discontinued by NCQA					
How Well Doctors Communicate (% Always/Usually)	2005	91.98%	92.73%	90.98%	87.61%		91.24%
	2006	88.95%	93.93%		86.91%		90.45%
	2007	89.84%	91.88%		92.65%	84.89%	90.04%
	2008	90.01%	90.51%		90.72%	95.12%	92.24%
Customer Service (% Not a Problem)	2005	77.02%	80.37%	78.78%	71.20%		74.86%
	2006	63.97%	86.09%		67.22%		73.46%
	2007	73.69%	74.04%		73.94%	59.83%	71.78%
	2008	84.44%	84.80%		86.02%		80.18%
Rating of Doctor (% 8, 9, 10)	2005	78.27%	82.22%	78.59%	75.69%		80.23%
	2006	79.24%	81.19%		73.72%		79.40%
	2007	82.50%	84.50%		77.65%	71.67%	80.12%
	2008	79.05%	82.18%		83.47%	85.29%	83.80%
Rating of Specialist (% 8, 9, 10)	2005	76.54%	82.93%	70.24%	78.38%		76.79%
	2006	79.38%	79.03%		70.73%		75.46%
	2007	80.68%	80.88%		80.49%	76.92%	79.82%
	2008	77.88%	82.67%		82.35%	na	78.38%
Rating of Health Care (% 8, 9, 10)	2005	79.83%	83.50%	78.35%	73.65%		80.92%
	2006	82.37%	69.31%		72.00%		78.81%
	2007	83.48%	84.13%		83.02%	69.86%	79.07%
	2008	74.21%	80.23%		78.96%	72.85%	77.71%
Rating of Plan (% 8, 9, 10)	2005	81.21%	82.20%	78.77%	76.63%		79.94%
	2006	81.95%	83.46%		78.52%		79.96%
	2007	79.63%	84.55%		78.90%	62.89%	77.59%
	2008	76.31%	83.47%		79.90%	64.61%	76.39%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MO HealthNet Managed Care
Eastern Region Annual CAHPS Comparison

Measure	Data Year	Harmony* (Contract Began 07/01/2006)	Healthcare USA	Mercy MC+** (Contract Terminated 06/30/2006)	Molina (Contract Began 07/01/2006)	Statewide Average of All MHD Health Plans
Getting Needed Care (% Not a Problem)	2005		80.17%	79.86%	80.09%	80.16%
	2006		78.69%		81.11%	80.07%
	2007	67.47%	81.56%		79.70%	77.38%
	2008	64.53%	81.03%		75.51%	75.83%
Getting Care Quickly (% Always/Usually)	2005		78.40%	83.52%	75.03%	79.02%
	2006		78.56%		81.00%	79.42%
	2007	68.88%	76.99%		77.66%	77.19%
	2008	84.04%	89.94%		87.13%	89.62%
Courteous and Helpful Staff (% Always/Usually)	2005		91.30%	93.68%	90.93%	92.00%
	2006		89.72%		91.13%	91.38%
	2007	85.10%	92.45%		91.98%	91.09%
	2008	Discontinued by NCQA				
How Well Doctors Communicate (% Always/Usually)	2005		91.37%	92.68%	89.69%	91.24%
	2006		89.07%		90.54%	90.45%
	2007	86.14%	90.62%		90.03%	90.04%
	2008	90.36%	92.18%		92.10%	92.24%
Customer Service (% Not a Problem)	2005		77.45%	74.97%	72.12%	74.86%
	2006		75.64%		72.75%	73.46%
	2007	61.14%	77.59%		75.46%	71.78%
	2008	76.92%	75.30%		81.26%	80.18%
Rating of Doctor (% 8, 9, 10)	2005		83.53%	85.05%	81.23%	80.23%
	2006		78.67%		81.38%	79.40%
	2007	72.97%	84.16%		84.52%	80.12%
	2008	79.90%	84.60%		83.52%	83.80%
Rating of Specialist (% 8, 9, 10)	2005		78.45%	75.45%	82.43%	76.79%
	2006		70.69%		73.40%	75.46%
	2007	75.86%	84.11%		88.16%	79.82%
	2008	72.97%	80.39%		80.53%	78.38%
Rating of Health Care (% 8, 9, 10)	2005		85.58%	84.51%	81.76%	80.92%
	2006		79.51%		82.00%	78.81%
	2007	67.59%	81.87%		80.78%	79.07%
	2008	71.98%	79.12%		79.43%	77.71%
Rating of Plan (% 8, 9, 10)	2005		85.52%	83.37%	79.32%	79.94%
	2006		81.54%		78.03%	79.96%
	2007	71.22%	83.51%		78.48%	77.59%
	2008	65.50%	83.14%		77.58%	76.39%

MO HealthNet Managed Care
Central Region Annual CAHPS Comparison

Measure	Data Year	HCUSA	Missouri Care	Molina** (Contract Began 07/01/2006)	Statewide Average of All MHD Health Plans
Getting Needed Care (% Not a Problem)	2005	78.95%	79.35%		80.16%
	2006	81.60%	81.36%		80.07%
	2007	80.82%	80.09%		77.38%
	2008	82.78%	79.35%	74.99%	75.83%
Getting Care Quickly (% Always/Usually)	2005	82.59%	76.74%		79.02%
	2006	82.61%	81.27%		79.42%
	2007	83.85%	81.37%		77.19%
	2008	93.39%	91.13%	91.28%	89.62%
Courteous and Helpful Staff (% Always/Usually)	2005	92.91%	94.88%		92.00%
	2006	93.71%	92.00%		91.38%
	2007	93.99%	92.49%		91.09%
	2008	Discontinued by NCQA			
How Well Doctors Communicate (% Always/Usually)	2005	93.20%	90.94%		91.24%
	2006	91.77%	91.90%		90.45%
	2007	92.69%	91.67%		90.04%
	2008	94.13%	93.14%	94.09%	92.24%
Customer Service (% Not a Problem)	2005	70.92%	70.95%		74.86%
	2006	69.89%	79.34%		73.46%
	2007	80.88%	69.46%		71.78%
	2008	83.33%	71.77%	82.56%	80.18%
Rating of Doctor (% 8, 9, 10)	2005	80.83%	76.69%		80.23%
	2006	81.15%	78.44%		79.40%
	2007	83.27%	79.89%		80.12%
	2008	85.43%	85.91%	88.61%	83.80%
Rating of Specialist (% 8, 9, 10)	2005	77.42%	69.23%		76.79%
	2006	80.67%	76.36%		75.46%
	2007	75.21%	76.09%		79.82%
	2008	79.26%	75.00%	NA	78.38%
Rating of Health Care (% 8, 9, 10)	2005	82.75%	78.31%		80.92%
	2006	83.71%	79.58%		78.81%
	2007	83.22%	77.65%		79.07%
	2008	81.36%	79.08%	79.91%	77.71%
Rating of Plan (% 8, 9, 10)	2005	79.30%	73.13%		79.94%
	2006	80.61%	77.51%		79.96%
	2007	83.63%	75.47%		77.59%
	2008	82.73%	78.06%	72.56%	76.39%

MANAGED CARE

2009 Dentist/Enrollee Ratios

EAST	Dentists	Enrollees	Dentist/Enrollee Ratio
Harmony	60	13,809	1 / 230
Healthcare USA(1)	146	116,742	1 / 800
Molina Healthcare(2)	242	61,478	1 / 254

CENTRAL	Dentists	Enrollees	Dentist/Enrollee Ratio
Healthcare USA(3)	88	28,589	1 / 325
Missouri Care	116	39,928	1 / 344
Molina Healthcare(4)	89	6,644	1 / 75

WEST	Dentists	Enrollees	Dentist/Enrollee Ratio
Blue Advantage Plus	80	28,229	1 / 353
Childrens Mercy Family Health Partners	146	49,726	1 / 341
Healthcare USA(5)	128	36,347	1 / 284
Molina Healthcare(6)	204	9,484	1 / 46

(1) thru (6): Providers located in a managed care county are counted in the appropriate region only.

Providers located in non-managed care counties that happen to border two managed care regions are counted in both regions. Examples: Providers located in Crawford county will be included in the Central and East region provider counts. Providers located in Carroll county will be included in the Central and West region provider counts.

Providers located in other non-managed care counties will be included in the region that is closest to them.

SOURCES:

Dentists: Provider data submitted by the MCO's to the Missouri Department of Insurance, Financial Institutions and Professional Registration (DIFP).

(Provider networks as of January 1, 2009)

Enrollees: January 30, 2009 enrollment data from MHD's Managed Care Operations Unit.

One state (New Jersey) requires a dentist/enrollee ratio of no greater than 1/1500.

Five states (Maryland, New York, Oklahoma, Rhode Island, Virginia) require a dentist/enrollee ratio of no greater than 1/2000.

Source:

http://www.gwumc.edu/sphhs/healthpolicy/nnhs4/GSA/Subheads/gsa140.html

MANAGED CARE

2009 Mental Health Provider/Enrollee Ratios

EAST	MH Providers	Enrollees	MH Provider/ Enrollee ratio
Harmony	275	13,809	1 / 50
Healthcare USA(1)	952	116,742	1 / 123
Molina Healthcare(2)	962	61,478	1 / 64

CENTRAL	MH Providers	Enrollees	MH Provider/ Enrollee ratio
Healthcare USA(3)	317	28,589	1 / 90
Missouri Care	611	39,928	1 / 65
Molina Healthcare(4)	316	6,644	1 / 21

WEST	MH Providers	Enrollees	MH Provider/ Enrollee ratio
Blue Advantage Plus	675	28,229	1 / 42
Childrens Mercy Family Health Partners	568	49,726	1 / 88
Healthcare USA(5)	710	36,347	1 / 51
Molina Healthcare(6)	710	9,484	1 / 13

(1) thru (6): Providers located in a managed care county are counted in the appropriate region only.

Providers located in non-managed care counties that happen to border two managed care regions are counted in both regions. Examples: Providers located in Crawford county will be included in the Central and East region provider counts. Providers located in Carroll county will be included in the Central and West region provider counts.

Providers located in other non-managed care counties will be included in the region that is closest to them.

SOURCES:

MH Providers: Provider data submitted by the MCO's to the Missouri Department of Insurance, Financial Institutions and Professional Registration (DIFP).

Includes Adult/General Psychiatrists, Child/Adolescent Psychiatrists, and Psychologists/Other.

(Provider networks as of January 1, 2009)

Enrollees: January 30, 2009 enrollment data from MHD's Managed Care Operations Unit.

MANAGED CARE

2009 PCP/Enrollee Ratios

EAST	PCPs	Enrollees	PCP/Enrollee Ratio
Harmony	485	13,809	1 / 28
Healthcare USA(1)	694	116,742	1 / 168
Molina Healthcare(2)	729	61,478	1 / 84

CENTRAL	PCPs	Enrollees	PCP/Enrollee Ratio
Healthcare USA(3)	481	28,589	1 / 59
Missouri Care	684	39,928	1 / 58
Molina Healthcare(4)	467	6,644	1 / 14

WEST	PCPs	Enrollees	PCP/Enrollee Ratio
Blue Advantage Plus	355	28,229	1 / 80
Childrens Mercy Family Health Partners	505	49,726	1 / 98
Healthcare USA(5)	724	36,347	1 / 50
Molina Healthcare(6)	679	9,484	1 / 14

(1) thru (6): Providers located in a managed care county are counted in the appropriate region only.

Providers located in non-managed care counties that happen to border two managed care regions are counted in both regions. Examples: Providers located in Crawford county will be included in the Central and East region provider counts. Providers located in Carroll county will be included in the Central and West region provider counts.

Providers located in other non-managed care counties will be included in the region that is closest to them.

SOURCES:

PCPs: Provider data submitted by the MCO's to the Missouri Department of Insurance, Financial Institutions, and Professional Registration (DIFP). (Provider networks as of January 1, 2009)

Enrollees: January 30, 2009 enrollment data from MHD's Managed Care Operations Unit

NOTE: PCP/Enrollee ratios in the range of 1/1500 to 1/2500 have been used to represent adequate staffing levels both in federal health programs, and in individual states: http://www.gencmh.org/documents/42CFR.pdf

2009 Average Distance to PCP (as calculated by GeoNetworks™)

Central Region			Healthcare USA - Central		Molina - Central	
County	**MC+ Eligibles**	**Distance Standard (for PCP)**	**PCPs**	**Average distance to PCP (miles)**	**PCPs**	**Average distance to PCP (miles)**
Audrain	2,866	30 miles	32	2.6	25	4.6
Benton	2,239	30 miles	13	5.6	21	5.9
Boone	11,235	20 miles	69	2.8	29	4.4
Callaway	3,531	30 miles	12	4.2	8	5.1
Camden	3,576	30 miles	33	3.8	22	4.3
Chariton	833	30 miles	18	2.8	14	2.4
Cole	5,622	20 miles	35	3.1	43	3.2
Cooper	1,499	30 miles	3	4.2	10	4.4
Gasconade	1,259	30 miles	16	3.3	11	3.7
Howard	1,056	30 miles	1	6.2	0	11.2
Laclede	4,653	30 miles	28	4.9	31	5.4
Linn	985	30 miles	8	3.5	9	4.7
Macon	1,443	30 miles	11	4.1	6	6.5
Maries	739	30 miles	8	3.6	6	5.8
Marion	3,518	30 miles	23	2.5	29	2.5
Miller	3,334	30 miles	27	3.9	20	3.6
Moniteau	1,217	30 miles	4	9.3	4	3.4
Monroe	396	30 miles	1	5.8	2	6.0
Montgomery	1,289	30 miles	10	4.9	14	4.9
Morgan	2,566	30 miles	10	5.1	11	5.1
Osage	602	30 miles	11	4.6	13	5.2
Pettis	4,929	30 miles	24	2.2	13	2.7
Phelps	4,601	30 miles	41	3.4	31	3.8
Pulaski	3,680	30 miles	24	3.5	22	3.8
Ralls	827	30 miles	5	4.2	10	4.2
Randolph	2,933	30 miles	25	2.3	3	3.0
Saline	2,557	30 miles	16	1.8	5	2.9
Shelby	678	30 miles	2	3.2	3	5.8
Totals:	74,663		510		415	

2009 Average Distance to PCP (as calculated by GeoNetworks™)

Central Region (continued)

County	MC+ Eligibles	Distance Standard (for PCP)	Missouri Care PCPs	Missouri Care Average distance to PCP (miles)
Audrain	2,866	30 miles	15	2.6
Benton	2,239	30 miles	6	4.7
Boone	11,235	20 miles	148	2.4
Callaway	3,531	30 miles	20	4.2
Camden	3,576	30 miles	19	3.9
Chariton	833	30 miles	5	2.9
Cole	5,622	20 miles	32	3.6
Cooper	1,499	30 miles	7	3.8
Gasconade	1,259	30 miles	8	4.1
Howard	1,056	30 miles	7	6.1
Laclede	4,653	30 miles	23	5.3
Linn	985	30 miles	8	4.6
Macon	1,443	30 miles	8	4.4
Maries	739	30 miles	2	8.1
Marion	3,518	30 miles	20	2.5
Miller	3,334	30 miles	10	5.2
Moniteau	1,217	30 miles	3	5.8
Monroe	396	30 miles	1	5.8
Montgomery	1,289	30 miles	6	5.3
Morgan	2,566	30 miles	6	4.7
Osage	602	30 miles	2	6.2
Pettis	4,929	30 miles	24	2.5
Phelps	4,601	30 miles	29	3.6
Pulaski	3,680	30 miles	16	4.1
Ralls	827	30 miles	4	4.2
Randolph	2,933	30 miles	18	2.4
Saline	2,557	30 miles	12	2.8
Shelby	678	30 miles	1	8.6
Totals:	74,663		460	

2009 Average Distance to PCP (as calculated by GeoNetworks™)

Eastern Region

County	MC+ Eligibles	Distance Standard (for PCP)	Harmony Health Plan PCPs	Harmony Health Plan Average distance to PCP (miles)	Healthcare USA - East PCPs	Healthcare USA - East Average distance to PCP (miles)
Franklin	7,427	20 miles	4	4.9	77	3.1
Jefferson	13,345	10 miles	11	2.9	24	2.7
Lincoln	4,739	30 miles	10	7.0	17	4.0
Madison	1,611	30 miles	12	4.3	n/a*	n/a*
Perry	1,589	30 miles	8	4.5	n/a*	n/a*
Pike	1,448	30 miles	14	3.3	18	2.4
St. Charles	12,654	10 miles	49	2.1	96	1.5
St. Francois	7,152	20 miles	17	2.7	48	2.8
St. Louis	74,394	10 miles	214	1.4	344	0.9
St. Louis city	57,122	10 miles	313	0.5	281	0.5
Ste. Genevieve	1,293	30 miles	13	4.5	10	4.5
Warren	2,990	30 miles	4	4.6	26	4.1
Washington	3,775	30 miles	19	4.2	20	4.8
Totals:	189,539		688		961	

County	MC+ Eligibles	Distance Standard (for PCP)	Molina - East PCPs	Molina - East Average distance to PCP (miles)
Franklin	7,427	20 miles	37	4.1
Jefferson	13,345	10 miles	36	2.3
Lincoln	4,739	30 miles	20	5.1
Madison	1,611	30 miles	13	4.4
Perry	1,589	30 miles	19	4.4
Pike	1,448	30 miles	21	3.0
St. Charles	12,654	10 miles	85	1.5
St. Francois	7,152	20 miles	48	2.8
St. Louis	74,394	10 miles	323	1.0
St. Louis city	57,122	10 miles	262	0.5
Ste. Genevieve	1,293	30 miles	14	4.5
Warren	2,990	30 miles	11	4.5
Washington	3,775	30 miles	19	4.4
Totals:	189,539		908	

*Healthcare USA was not contracted to serve Madison county or Perry county in 2009.

2009 Average Distance to PCP (as calculated by GeoNetworks™)

Western Region			Blue Advantage Plus		Childrens Mercy Family Health Partners	
County	**MC+ Eligibles**	**Distance Standard (for PCP)**	**PCPs**	**Average distance to PCP (miles)**	**PCPs**	**Average distance to PCP (miles)**
Bates	1,533	30 miles	n/a*	n/a*	8	3.7
Cass	7,348	20 miles	26	2.6	21	2.8
Cedar	2,075	30 miles	n/a*	n/a*	2	4.0
Clay	13,517	10 miles	29	2.6	35	1.9
Henry	2,435	30 miles	15	3.4	15	3.5
Jackson	76,905	10 miles	239	1.4	294	1.4
Johnson	3,725	30 miles	14	3.7	24	4.3
Lafayette	3,097	30 miles	30	2.8	68	2.8
Platte	3,615	20 miles	17	2.2	19	2.0
Polk	3,556	30 miles	n/a*	n/a*	16	4.4
Ray	1,712	30 miles	4	3.8	6	3.7
St. Clair	1,024	30 miles	6	5.9	12	5.7
Vernon	2,452	30 miles	n/a*	n/a*	6	3.9
Totals:	122,994		380		526	

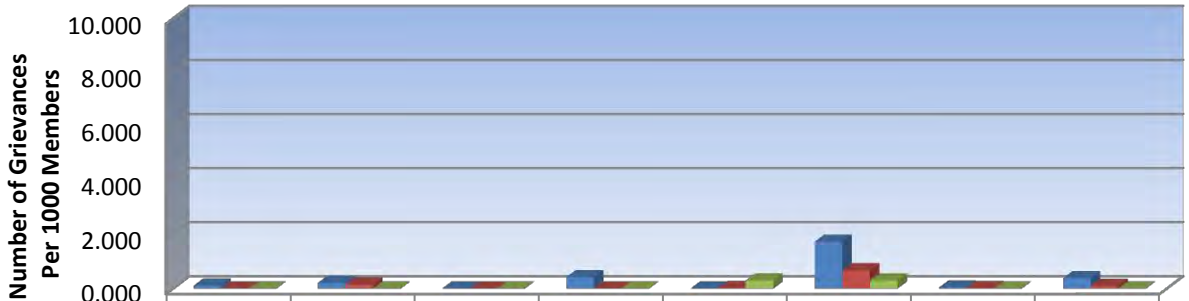
			Healthcare USA - West		Molina - West	
County	**MC+ Eligibles**	**Distance Standard (for PCP)**	**PCPs**	**Average distance to PCP (miles)**	**PCPs**	**Average distance to PCP (miles)**
Bates	1,533	30 miles	14	1.5	20	1.6
Cass	7,348	30 miles	28	2.3	25	2.6
Cedar	2,075	30 miles	15	3.2	12	3.7
Clay	13,517	10 miles	41	2.0	9	4.5
Henry	2,435	30 miles	25	3.4	24	3.9
Jackson	76,905	10 miles	335	1.4	244	1.6
Johnson	3,725	30 miles	31	4.3	20	3.8
Lafayette	3,097	30 miles	73	2.8	37	2.9
Platte	3,615	20 miles	34	1.9	16	2.8
Polk	3,556	30 miles	29	2.9	35	3.0
Ray	1,712	30 miles	2	4.6	3	5.3
St. Clair	1,024	30 miles	15	4.9	17	4.9
Vernon	2,452	30 miles	22	2.9	20	2.9
Totals:	122,994		664		482	

*Blue Advantage Plus was not contracted to serve Bates, Cedar, Polk, or Vernon counties in 2009.

2009 GeoAccess Summary

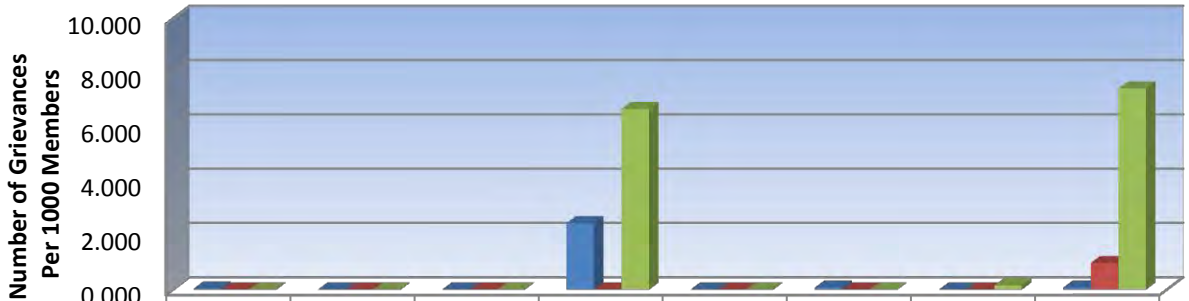
Health Plan	PCPs	Specialists	Facilities	Ancillary	Overall network score	Status	Date Approved
Blue Advantage Plus	100%	99%	91%	96%	**97%**	Approved	07/16/2009
CMFHP	100%	100%	100%	99%	**100%**	Approved	06/18/2009
Harmony	100%	97%	99%	100%	**99%**	Approved	06/18/2009
Healthcare USA - Central	100%	100%	99%	100%	**100%**	Approved	06/18/2009
Healthcare USA - East	100%	99%	100%	100%	**100%**	Approved	06/18/2009
Healthcare USA - West	100%	100%	98%	100%	**100%**	Approved	06/18/2009
Missouri Care	100%	99%	100%	100%	**100%**	Approved	06/18/2009
Molina - Central	100%	100%	94%	100%	**98%**	Approved	06/18/2009
Molina - East	100%	100%	100%	100%	**100%**	Approved	06/18/2009
Molina - West	99%	100%	92%	100%	**98%**	Approved	06/18/2009

Central Region
Member Grievances SFY 2009 Annual Analysis



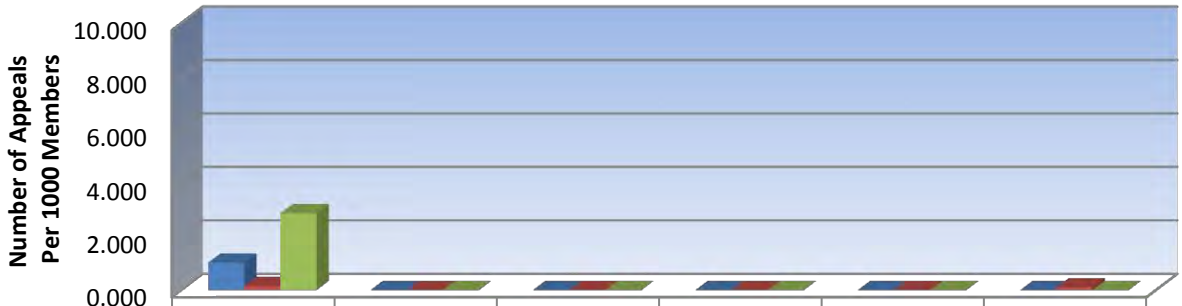
	Health Plan/ Provider Policy	Provider Staff Behavior	Health Plan Staff Behavior	Appoint-ment Availability	Network Adequacy /Availability	*Wait Time (Office, Trans.)	Condition of Office/ Trans.	Treatment Plan/ Diagnosis
HCUSA	0.106	0.213	0.000	0.425	0.000	1.736	0.035	0.390
Mo Care	0.000	0.151	0.000	0.000	0.025	0.680	0.025	0.101
Molina	0.000	0.000	0.000	0.000	0.303	0.303	0.000	0.000

Central Region
Member Grievances SFY 2009 Annual Analysis



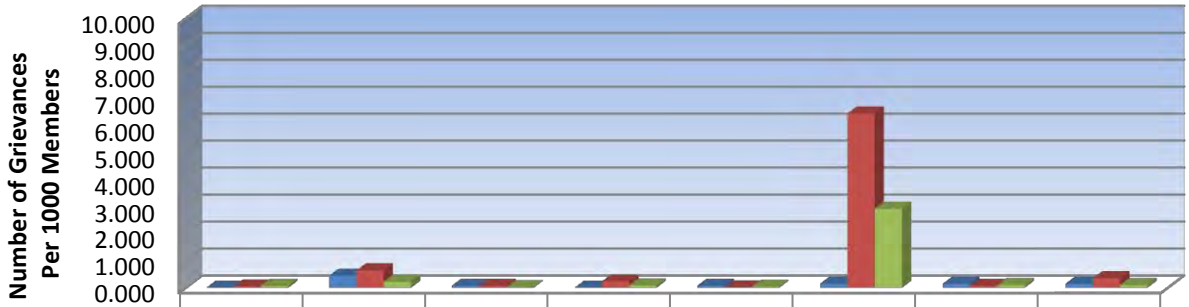
	Provider Competency	Interpreter Services	Fraud and Abuse of Services	Recipient Receiving Bills (etc.)	Health Plan Information	Provider Communi-cation	Member Rights	Other
HCUSA	0.035	0.000	0.000	2.445	0.000	0.071	0.000	0.071
Mo Care	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.982
Molina	0.000	0.000	0.000	6.658	0.000	0.000	0.151	7.414

Central Region
Member Appeals SFY 2009 Annual Analysis



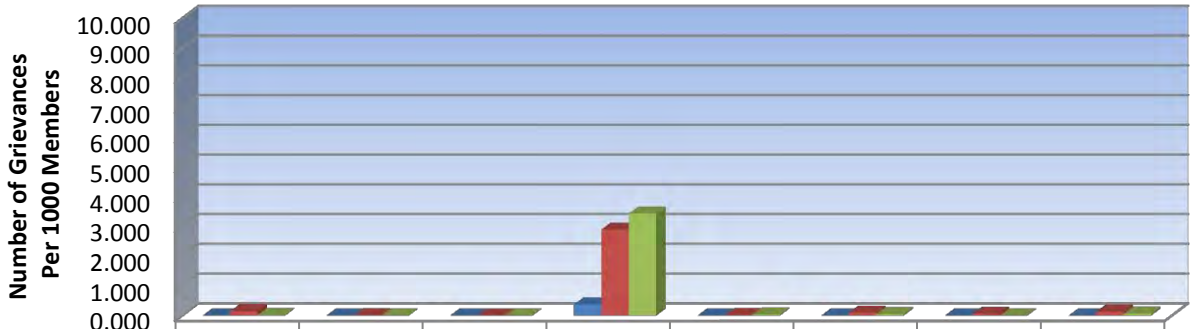
	Service Denial	Service Reduction, Sus- pension (etc.)	Payment Denial	Timeliness of Service	Prior Authorization Timeliness	Other
HCUSA	1.028	0.000	0.000	0.000	0.000	0.000
Mo Care	0.151	0.000	0.000	0.000	0.000	0.101
Molina	2.875	0.000	0.000	0.000	0.000	0.000

Eastern Region
Member Grievances SFY 2009 Annual Analysis



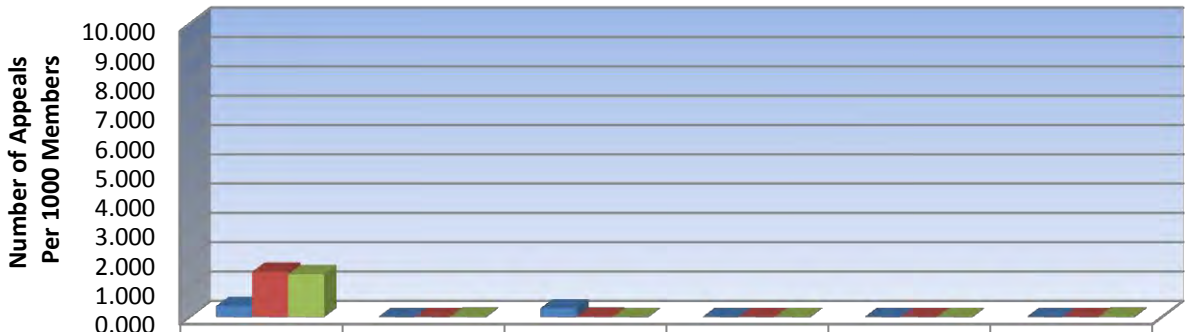
	Health Plan/ Provider Policy	Provider Staff Behavior	Health Plan Staff Behavior	Appoint- ment Availability	Network Adequacy /Availability	*Wait Time (Office, Trans.)	Condition of Office/ Trans.	Treatment Plan/ Diagnosis
HARMONY	0.000	0.447	0.074	0.000	0.074	0.149	0.149	0.149
HCUSA	0.043	0.648	0.069	0.233	0.009	6.462	0.069	0.354
MOLINA	0.065	0.228	0.016	0.081	0.033	2.930	0.098	0.098

Eastern Region
Member Grievances SFY 2009 Annual Analysis



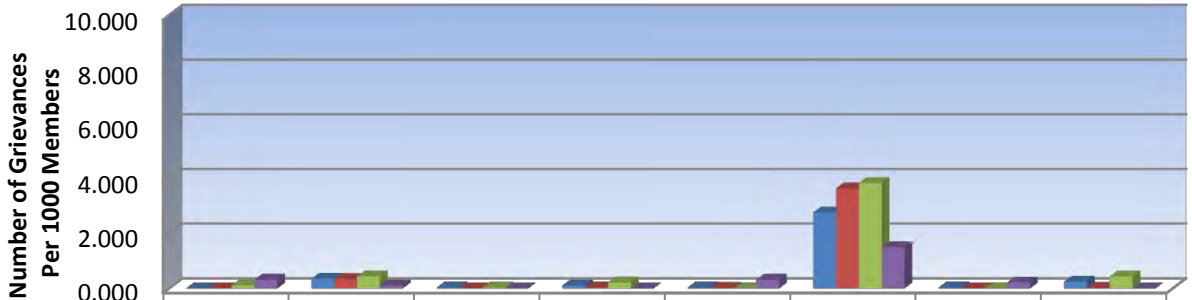
	Provider Competency	Interpreter Services	Fraud and Abuse of Services	Recipient Receiving Bills (etc.)	Health Plan Information	Provider Communi-cation	Member Rights	Other
HARMONY	0.000	0.000	0.000	0.372	0.000	0.000	0.000	0.000
HCUSA	0.147	0.009	0.000	2.894	0.017	0.095	0.060	0.130
MOLINA	0.016	0.000	0.000	3.434	0.033	0.049	0.000	0.065

Eastern Region
Member Appeals SFY 2009 Annual Analysis



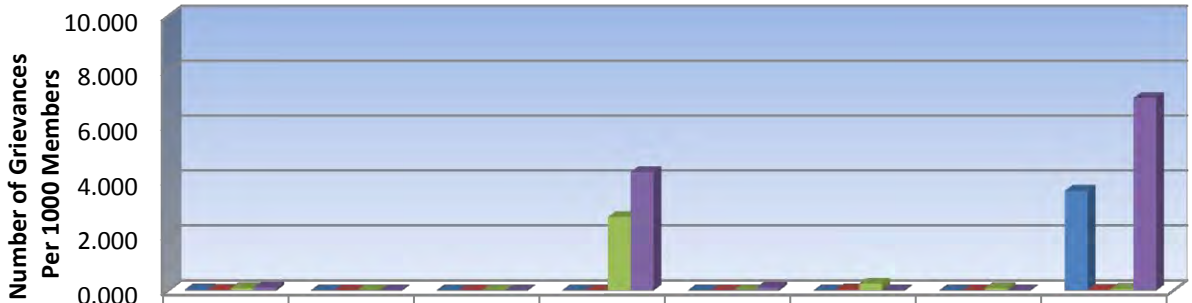
	Service Denial	Service Reduction, Sus-pension (etc.)	Payment Denial	Timeliness of Service	Prior Authorization Timeliness	Other
HARMONY	0.372	0.000	0.298	0.000	0.000	0.000
HCUSA	1.546	0.000	0.017	0.000	0.000	0.000
MOLINA	1.465	0.016	0.000	0.000	0.000	0.016

Western Region
Member Grievances SFY 2009 Annual Analysis

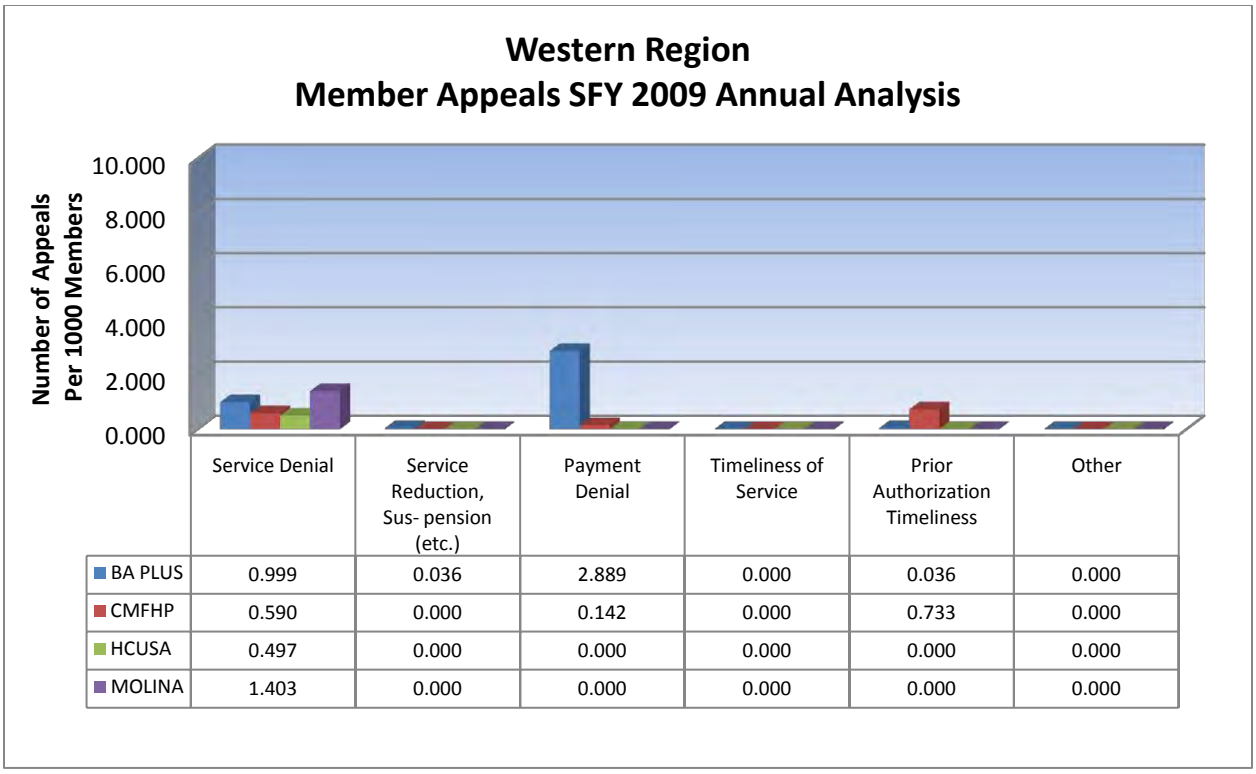


	Health Plan/ Provider Policy	Provider Staff Behavior	Health Plan Staff Behavior	Appoint-ment Availability	Network Adequacy /Availabilit y	*Wait Time (Office, Trans.)	Condition of Office/ Trans.	Treatment Plan/ Diagnosis
BA PLUS	0.000	0.357	0.036	0.107	0.036	2.782	0.036	0.250
CMFHP	0.000	0.346	0.000	0.041	0.020	3.664	0.000	0.020
HCUSA	0.110	0.442	0.028	0.221	0.000	3.864	0.000	0.442
MOLINA	0.324	0.108	0.000	0.000	0.324	1.511	0.216	0.000

Western Region
Member Grievances SFY 2009 Annual Analysis



	Provider Competen cy	Interpreter Services	Fraud and Abuse of Services	Recipient Receiving Bills (etc.)	Health Plan Informatio n	Provider Communi-cation	Member Rights	Other
BA PLUS	0.036	0.000	0.000	0.000	0.000	0.000	0.000	3.637
CMFHP	0.020	0.000	0.000	0.000	0.000	0.041	0.000	0.020
HCUSA	0.083	0.000	0.000	2.677	0.000	0.248	0.083	0.055
MOLINA	0.108	0.000	0.000	4.318	0.108	0.000	0.000	7.017



	Service Denial	Service Reduction, Sus- pension (etc.)	Payment Denial	Timeliness of Service	Prior Authorization Timeliness	Other
BA PLUS	0.999	0.036	2.889	0.000	0.036	0.000
CMFHP	0.590	0.000	0.142	0.000	0.733	0.000
HCUSA	0.497	0.000	0.000	0.000	0.000	0.000
MOLINA	1.403	0.000	0.000	0.000	0.000	0.000

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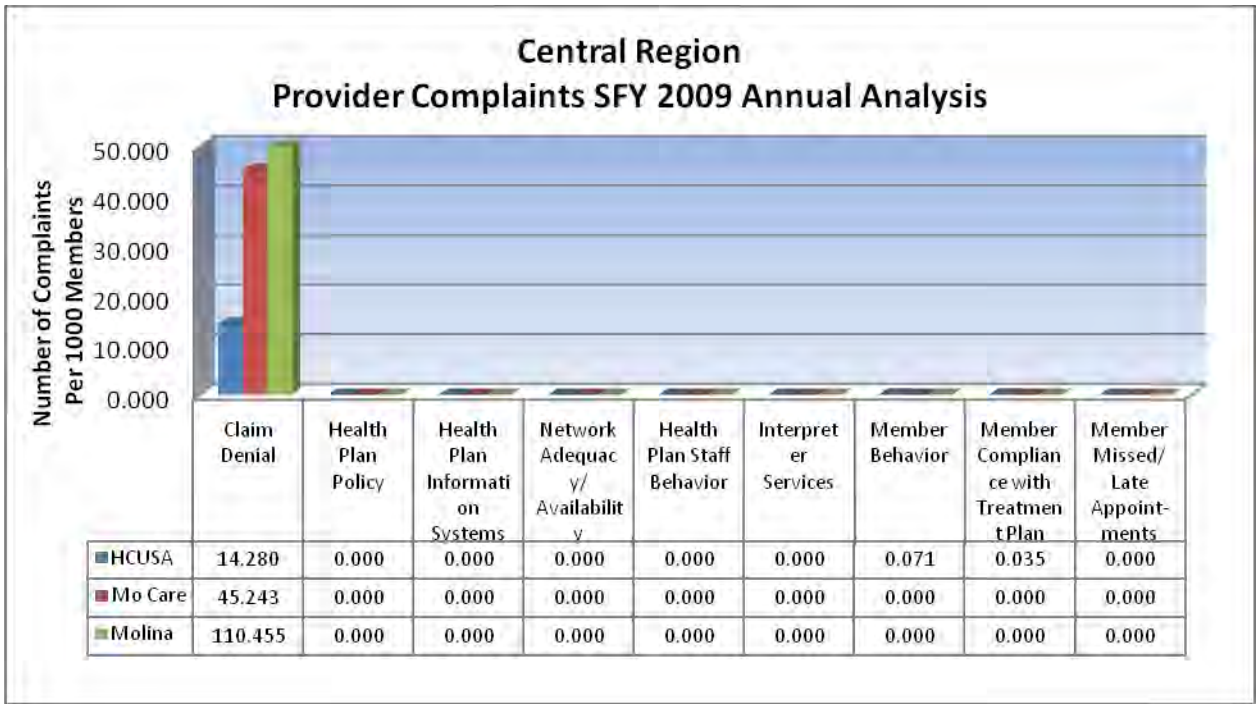
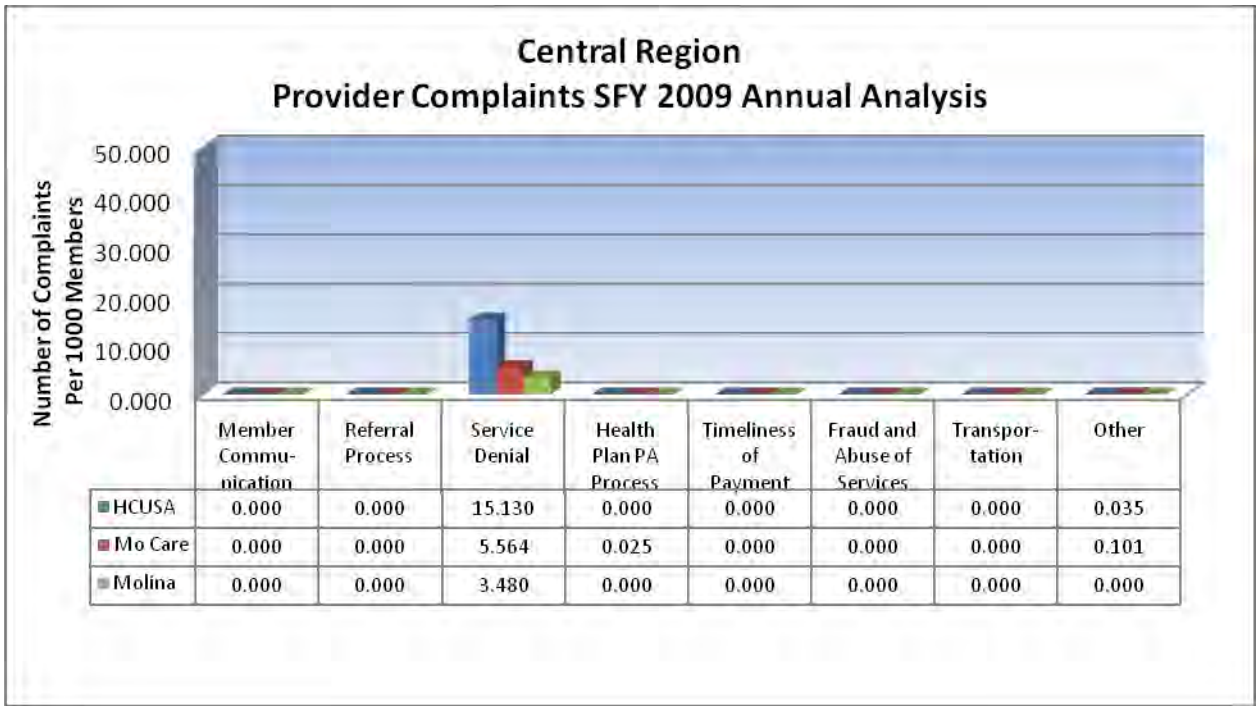
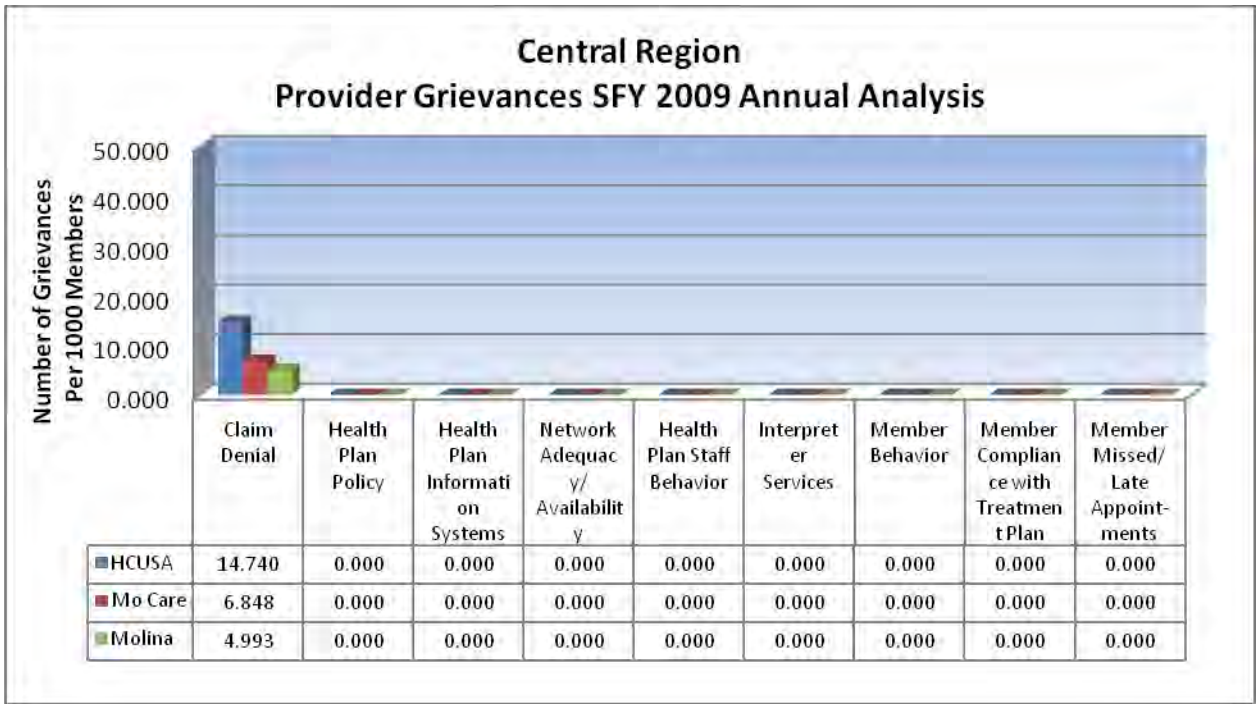


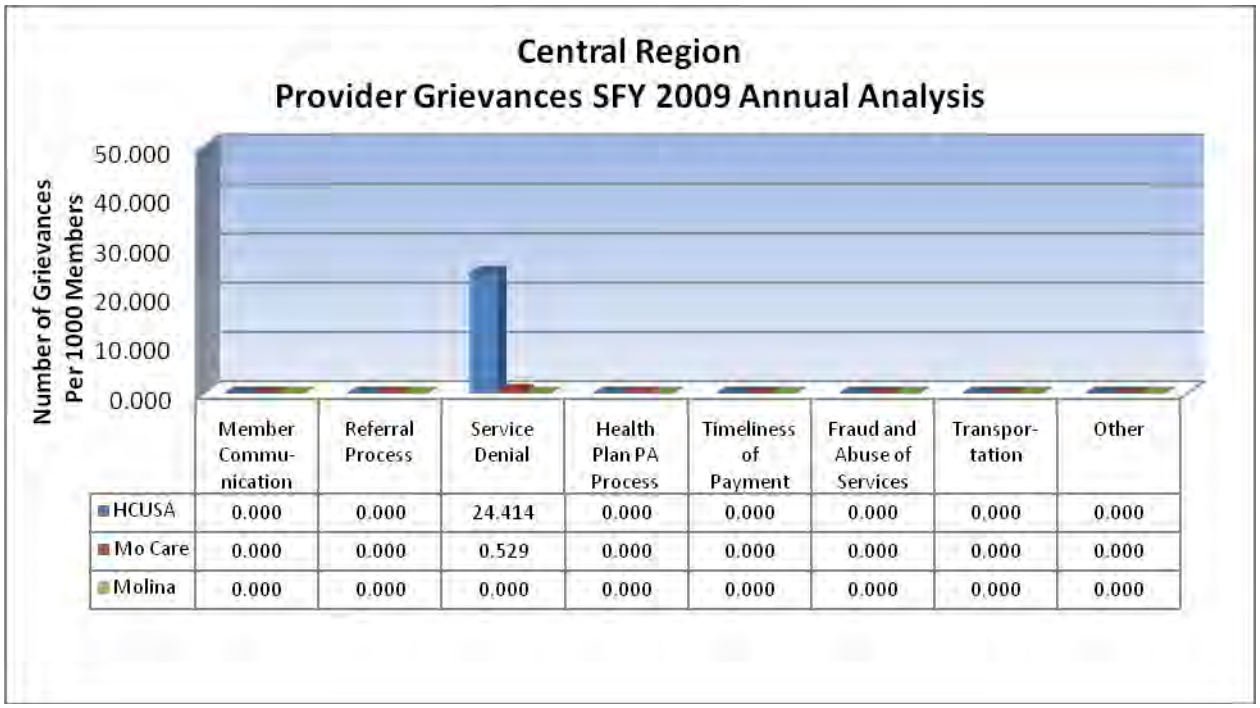
	Claim Denial	Health Plan Policy	Health Plan Information Systems	Network Adequacy/ Availability	Health Plan Staff Behavior	Interpreter Services	Member Behavior	Member Compliance with Treatment Plan	Member Missed/ Late Appoint-ments
HCUSA	14.280	0.000	0.000	0.000	0.000	0.000	0.071	0.035	0.000
Mo Care	45.243	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
Molina	110.455	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000



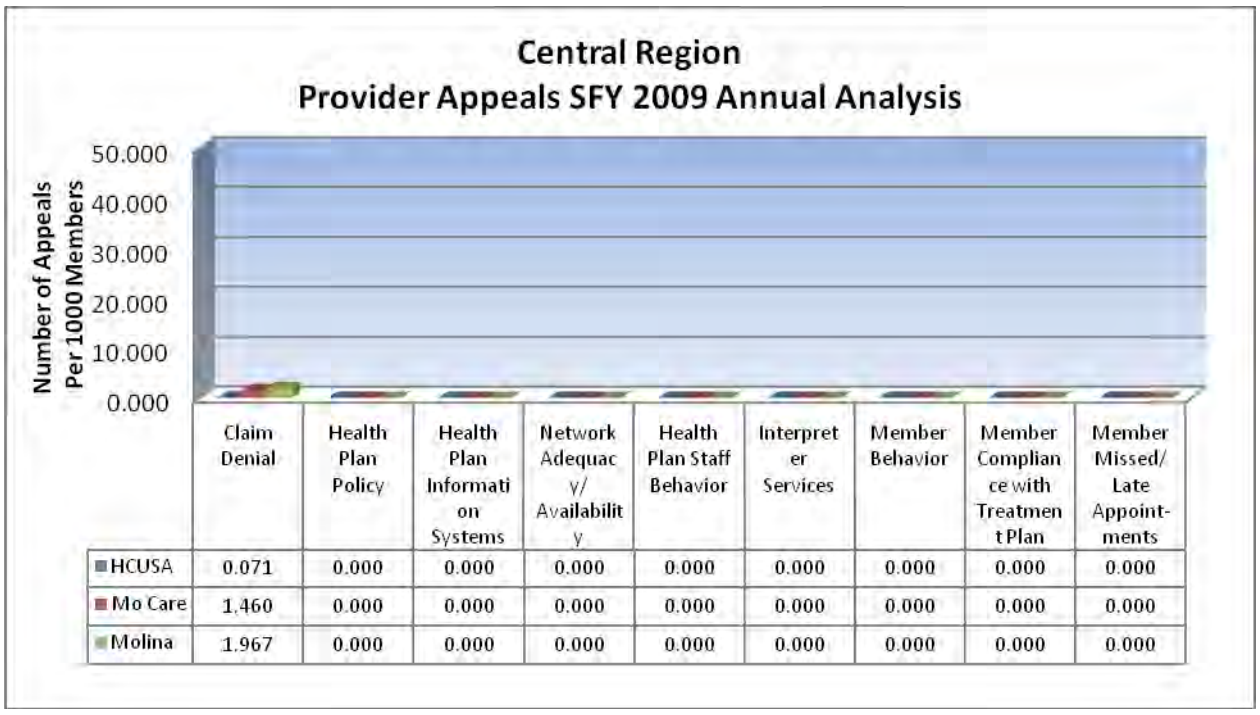
	Member Communication	Referral Process	Service Denial	Health Plan PA Process	Timeliness of Payment	Fraud and Abuse of Services	Transportation	Other
HCUSA	0.000	0.000	15.130	0.000	0.000	0.000	0.000	0.035
Mo Care	0.000	0.000	5.564	0.025	0.000	0.000	0.000	0.101
Molina	0.000	0.000	3.480	0.000	0.000	0.000	0.000	0.000



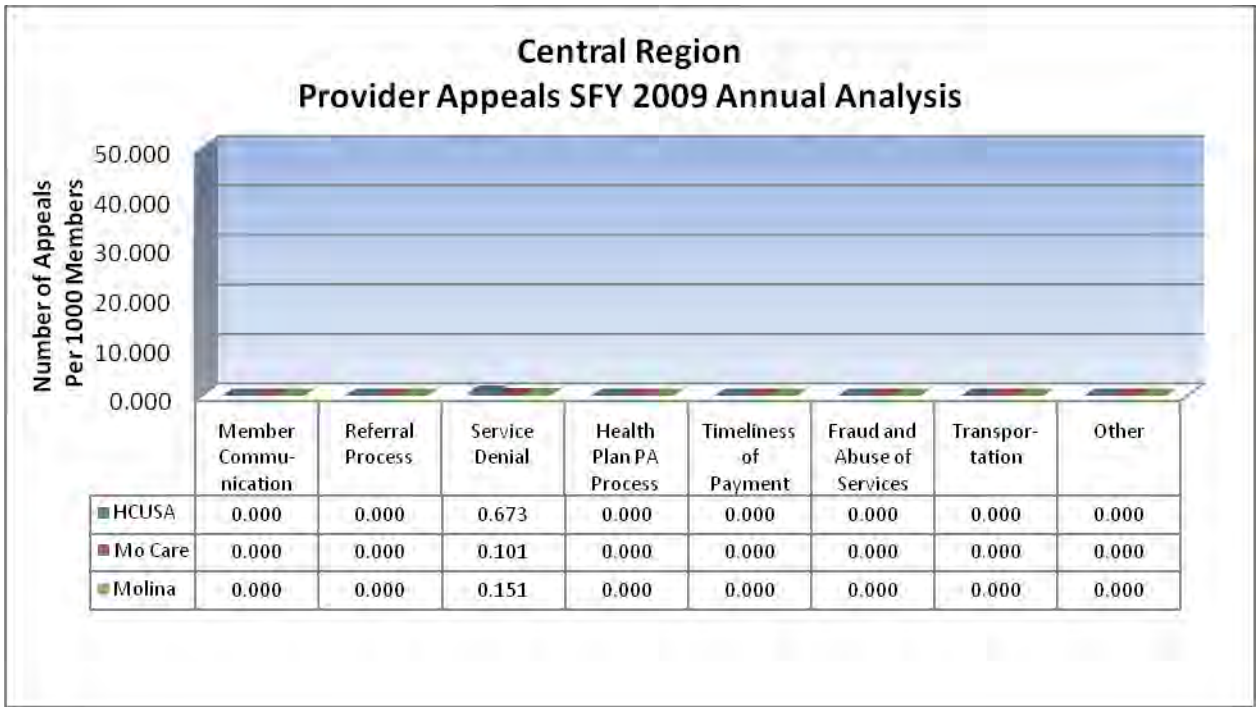
	Claim Denial	Health Plan Policy	Health Plan Information Systems	Network Adequacy/ Availability	Health Plan Staff Behavior	Interpreter Services	Member Behavior	Member Compliance with Treatment Plan	Member Missed/ Late Appoint-ments
HCUSA	14.740	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
Mo Care	6.848	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
Molina	4.993	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000



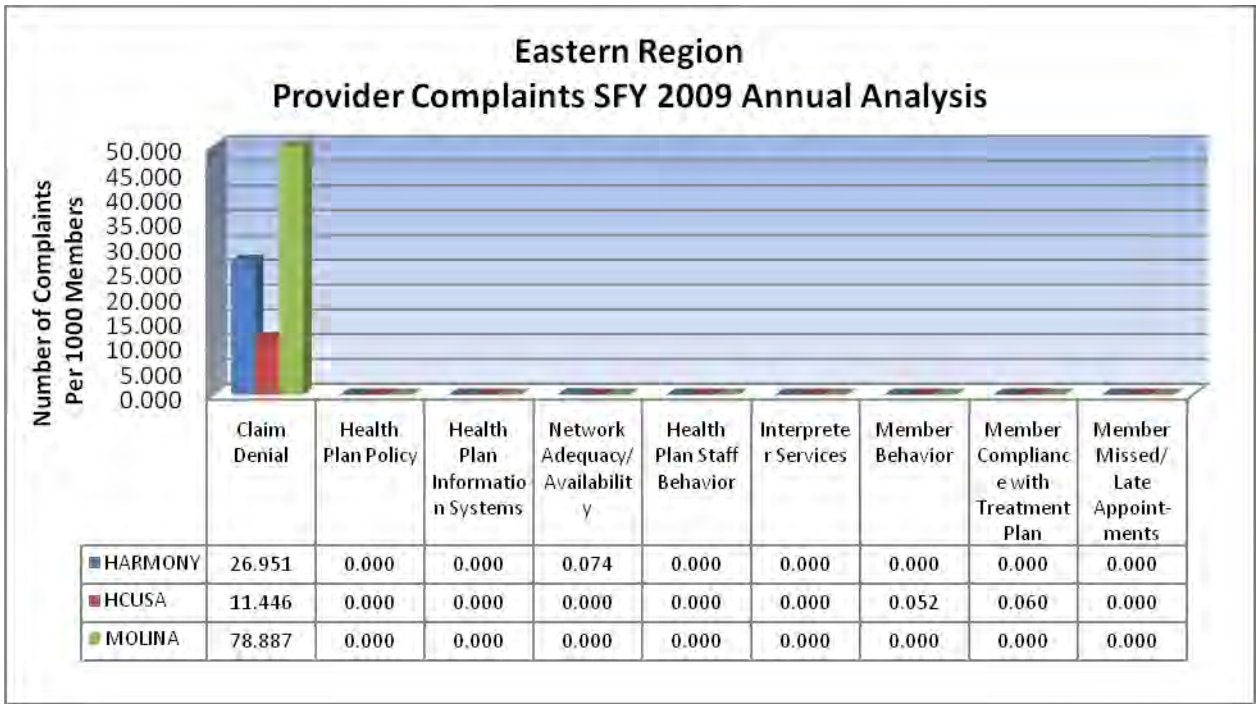
	Member Commu-nication	Referral Process	Service Denial	Health Plan PA Process	Timeliness of Payment	Fraud and Abuse of Services	Transpor-tation	Other
HCUSA	0.000	0.000	24.414	0.000	0.000	0.000	0.000	0.000
Mo Care	0.000	0.000	0.529	0.000	0.000	0.000	0.000	0.000
Molina	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000



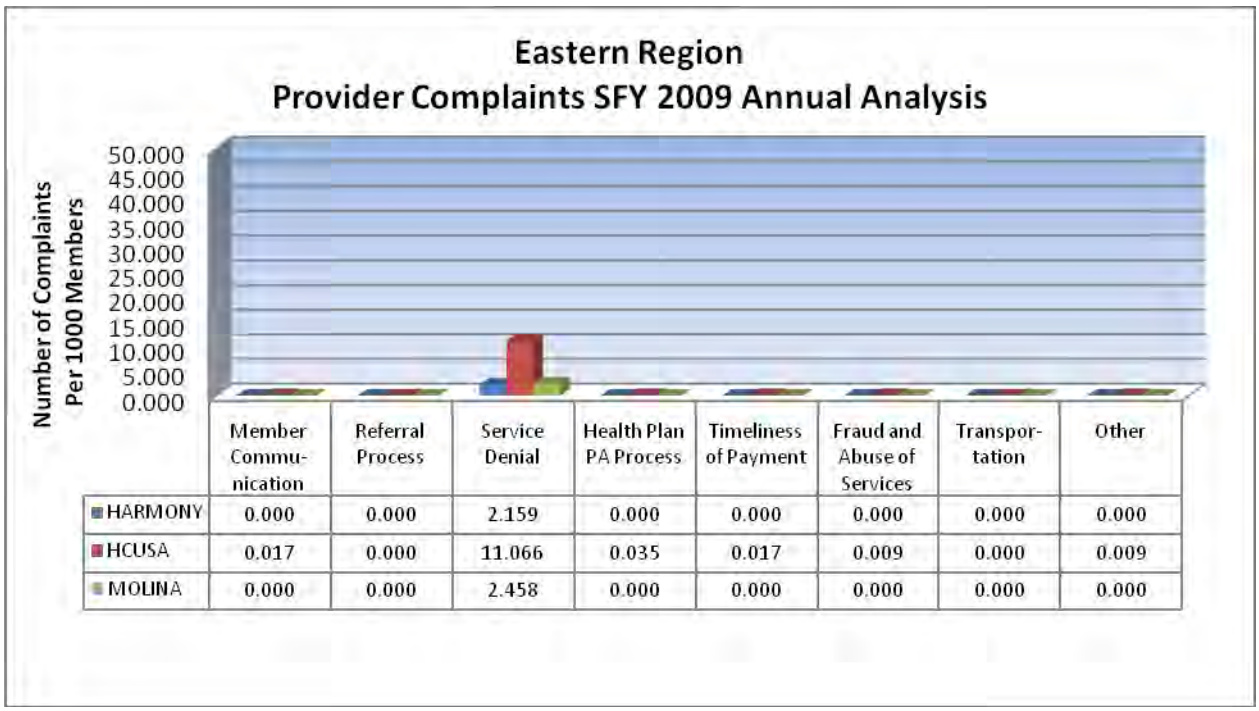
	Claim Denial	Health Plan Policy	Health Plan Information Systems	Network Adequacy/ Availability	Health Plan Staff Behavior	Interpreter Services	Member Behavior	Member Compliance with Treatment Plan	Member Missed/ Late Appoint-ments
HCUSA	0.071	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
Mo Care	1.460	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
Molina	1.967	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000



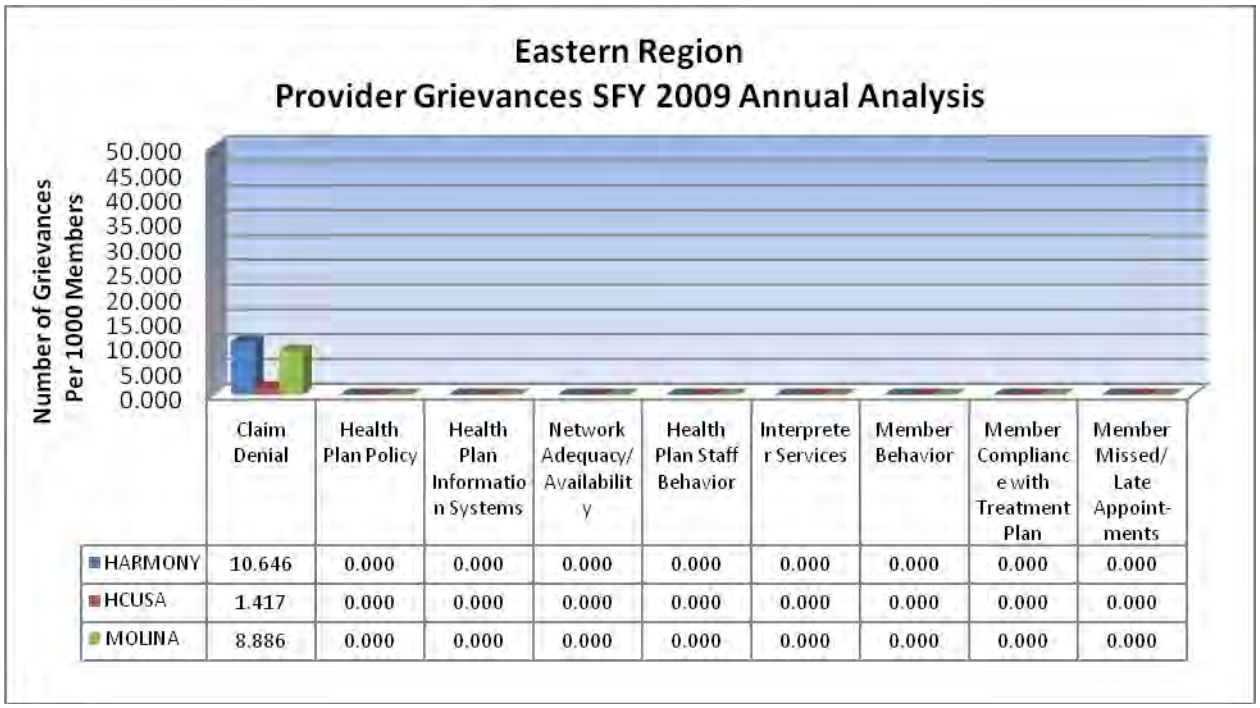
	Member Commu-nication	Referral Process	Service Denial	Health Plan PA Process	Timeliness of Payment	Fraud and Abuse of Services	Transpor-tation	Other
HCUSA	0.000	0.000	0.673	0.000	0.000	0.000	0.000	0.000
Mo Care	0.000	0.000	0.101	0.000	0.000	0.000	0.000	0.000
Molina	0.000	0.000	0.151	0.000	0.000	0.000	0.000	0.000



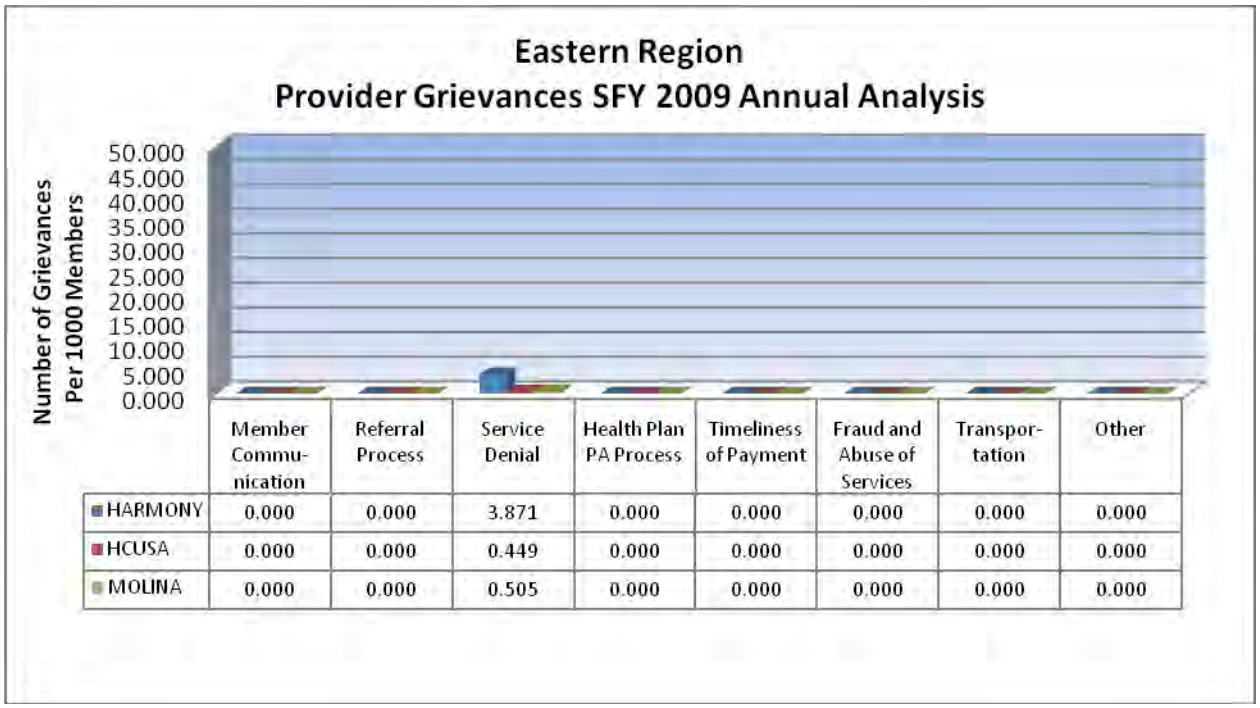
	Claim Denial	Health Plan Policy	Health Plan Information Systems	Network Adequacy/ Availability	Health Plan Staff Behavior	Interpreter Services	Member Behavior	Member Compliance with Treatment Plan	Member Missed/ Late Appoint-ments
HARMONY	26.951	0.000	0.000	0.074	0.000	0.000	0.000	0.000	0.000
HCUSA	11.446	0.000	0.000	0.000	0.000	0.000	0.052	0.060	0.000
MOLINA	78.887	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000



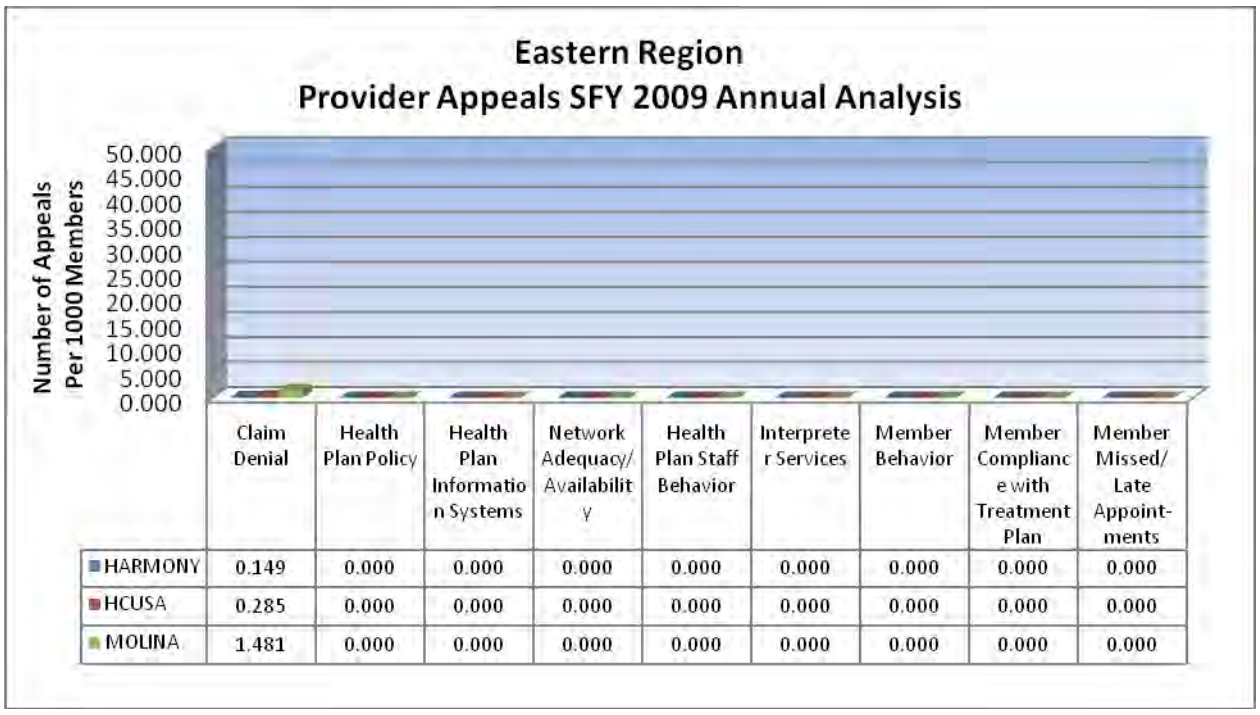
	Member Commu-nication	Referral Process	Service Denial	Health Plan PA Process	Timeliness of Payment	Fraud and Abuse of Services	Transpor-tation	Other
HARMONY	0.000	0.000	2.159	0.000	0.000	0.000	0.000	0.000
HCUSA	0.017	0.000	11.066	0.035	0.017	0.009	0.000	0.009
MOLINA	0.000	0.000	2.458	0.000	0.000	0.000	0.000	0.000



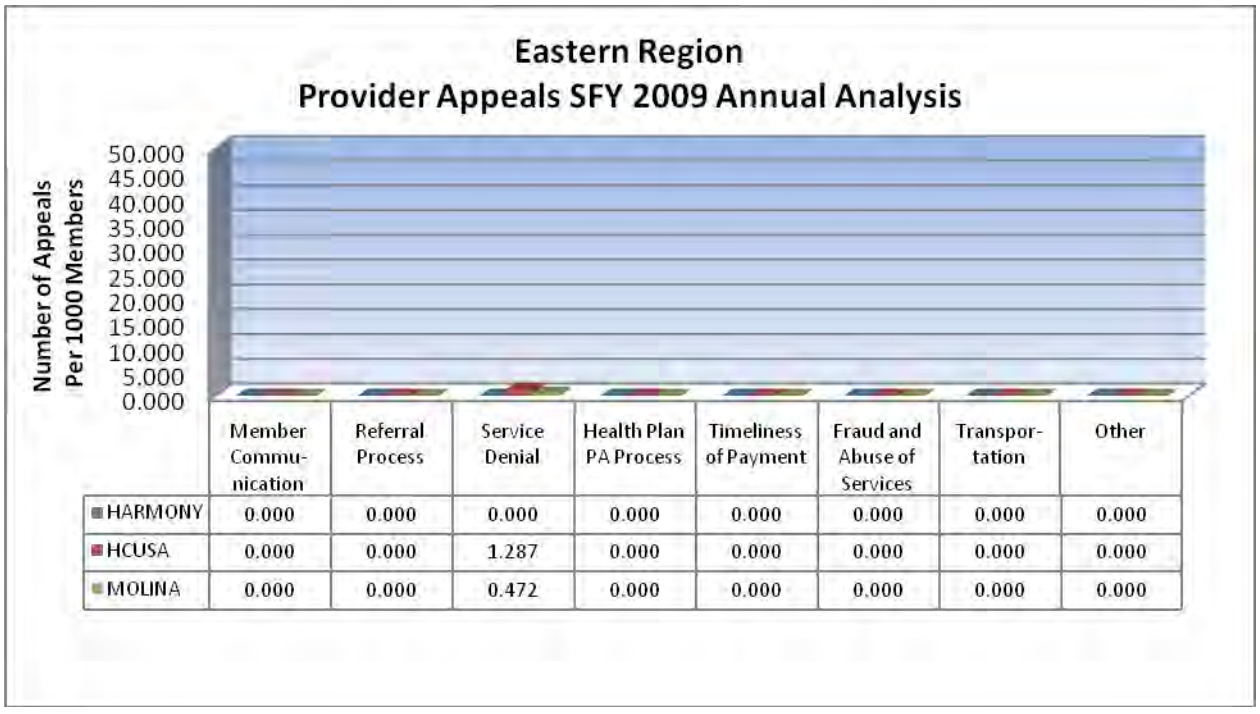
	Claim Denial	Health Plan Policy	Health Plan Information Systems	Network Adequacy/ Availability	Health Plan Staff Behavior	Interpreter Services	Member Behavior	Member Compliance with Treatment Plan	Member Missed/ Late Appoint-ments
HARMONY	10.646	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
HCUSA	1.417	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
MOLINA	8.886	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000



	Member Commu-nication	Referral Process	Service Denial	Health Plan PA Process	Timeliness of Payment	Fraud and Abuse of Services	Transpor-tation	Other
HARMONY	0.000	0.000	3.871	0.000	0.000	0.000	0.000	0.000
HCUSA	0.000	0.000	0.449	0.000	0.000	0.000	0.000	0.000
MOLINA	0.000	0.000	0.505	0.000	0.000	0.000	0.000	0.000

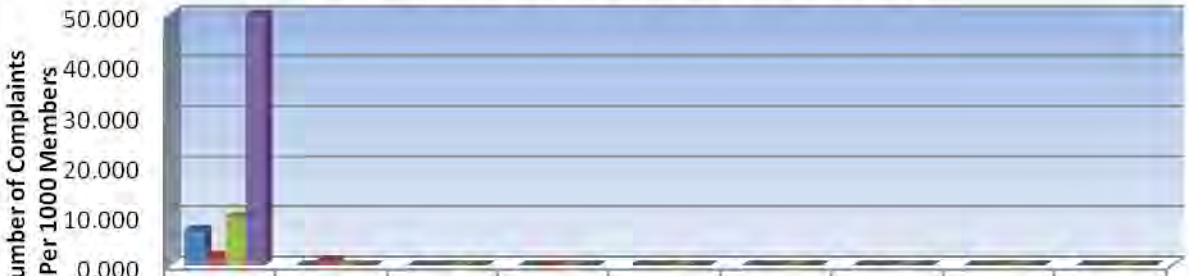


	Claim Denial	Health Plan Policy	Health Plan Information Systems	Network Adequacy/ Availability	Health Plan Staff Behavior	Interpreter Services	Member Behavior	Member Compliance with Treatment Plan	Member Missed/ Late Appoint-ments
HARMONY	0.149	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
HCUSA	0.285	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
MOLINA	1.481	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000



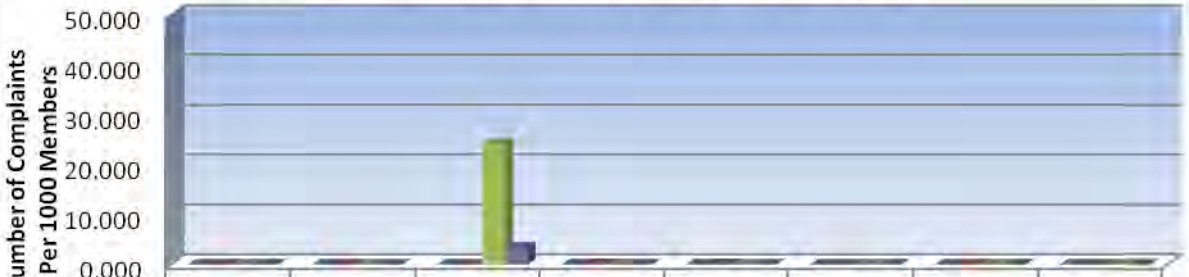
	Member Commu-nication	Referral Process	Service Denial	Health Plan PA Process	Timeliness of Payment	Fraud and Abuse of Services	Transpor-tation	Other
HARMONY	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
HCUSA	0.000	0.000	1.287	0.000	0.000	0.000	0.000	0.000
MOLINA	0.000	0.000	0.472	0.000	0.000	0.000	0.000	0.000

Western Region
Provider Complaints SFY 2009 Annual Analysis

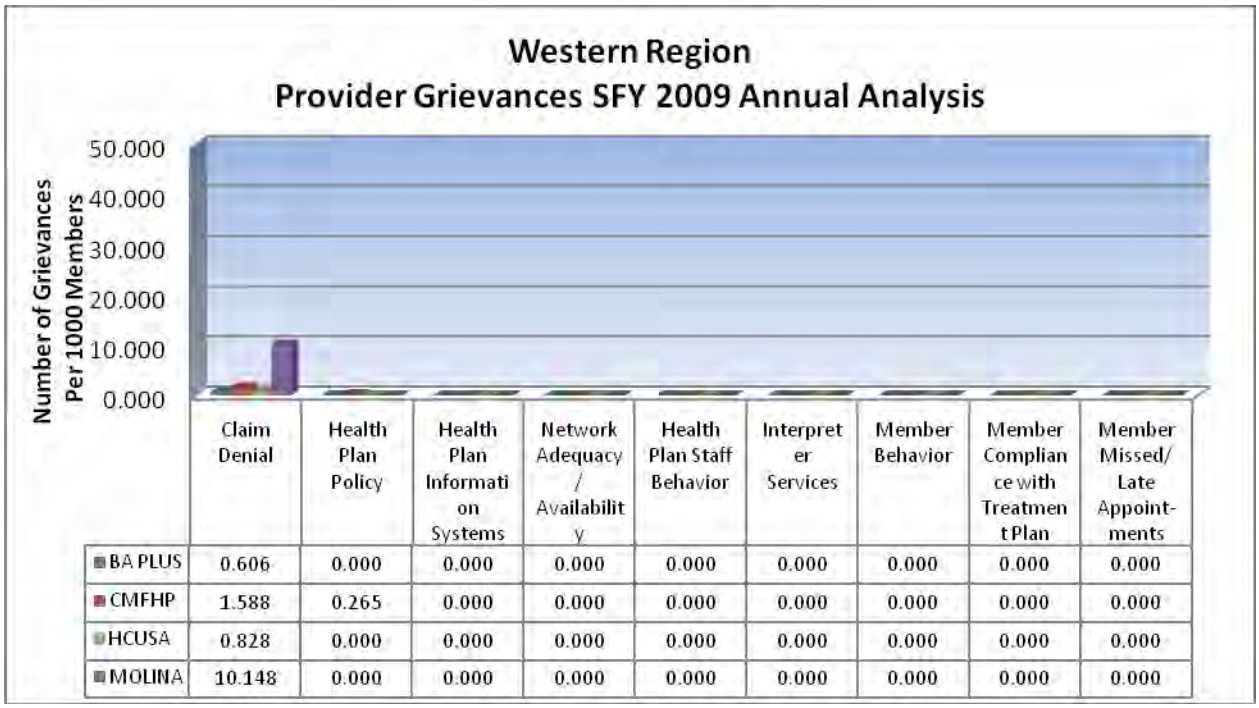


	Claim Denial	Health Plan Policy	Health Plan Information Systems	Network Adequacy / Availability	Health Plan Staff Behavior	Interpreter Services	Member Behavior	Member Compliance with Treatment Plan	Member Missed/ Late Appoint-ments
BA PLUS	7.061	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
CMFHP	1.852	1.038	0.000	0.000	0.000	0.000	0.000	0.000	0.000
HCUSA	9.686	0.055	0.000	0.000	0.000	0.000	0.000	0.000	0.000
MOLINA	85.070	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000

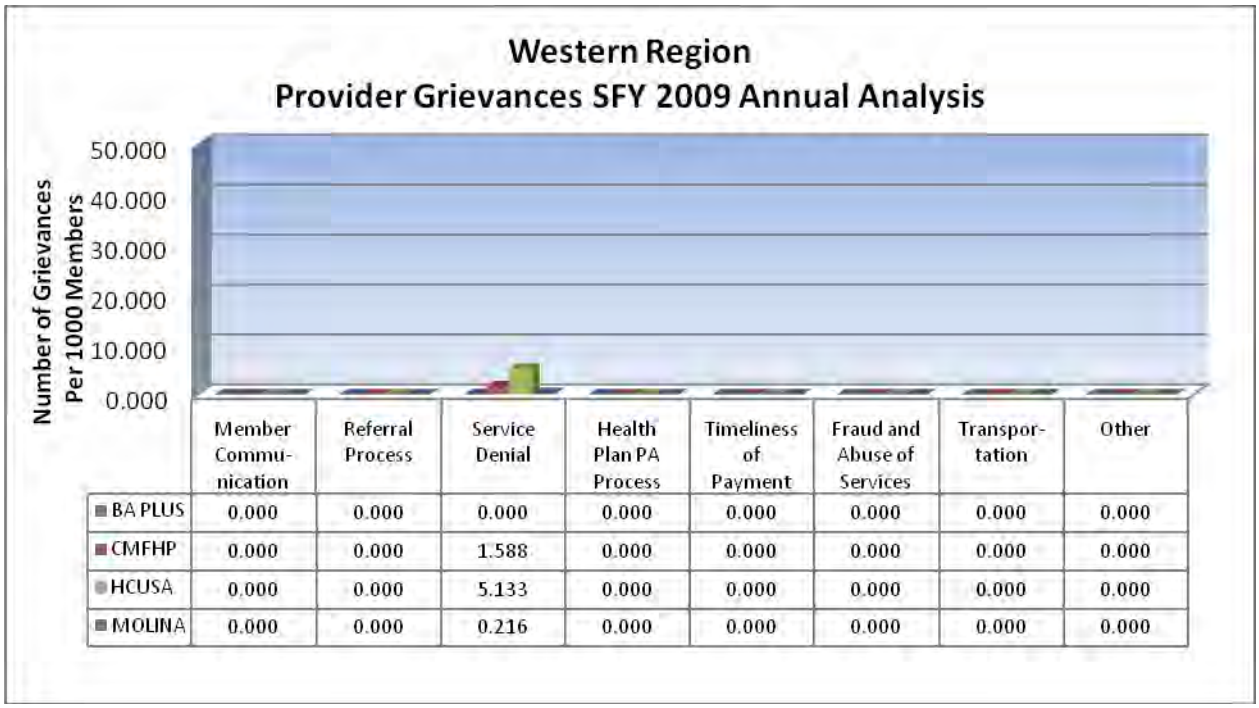
Western Region
Provider Complaints SFY 2009 Annual Analysis



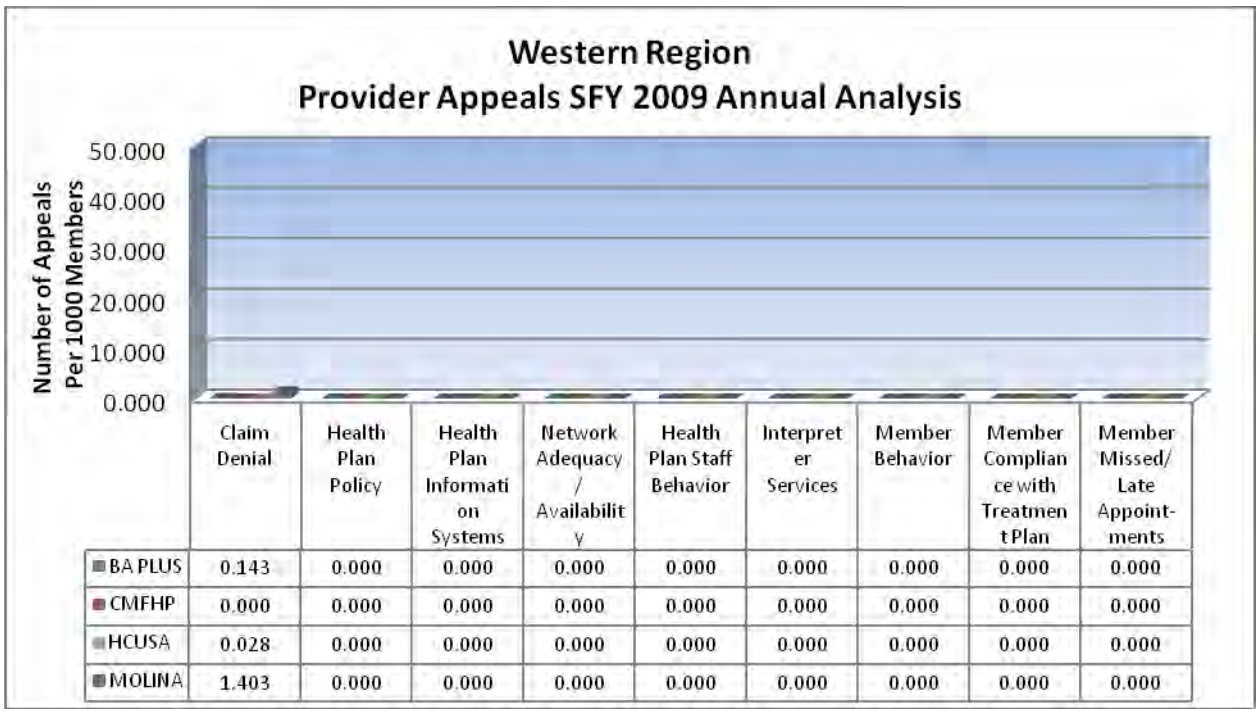
	Member Commu-nication	Referral Process	Service Denial	Health Plan PA Process	Timeliness of Payment	Fraud and Abuse of Services	Transpor-tation	Other
BA PLUS	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
CMFHP	0.000	0.000	0.000	0.020	0.020	0.000	0.000	0.000
HCUSA	0.000	0.000	24.202	0.055	0.000	0.000	0.000	0.000
MOLINA	0.000	0.000	3.347	0.000	0.000	0.000	0.000	0.000



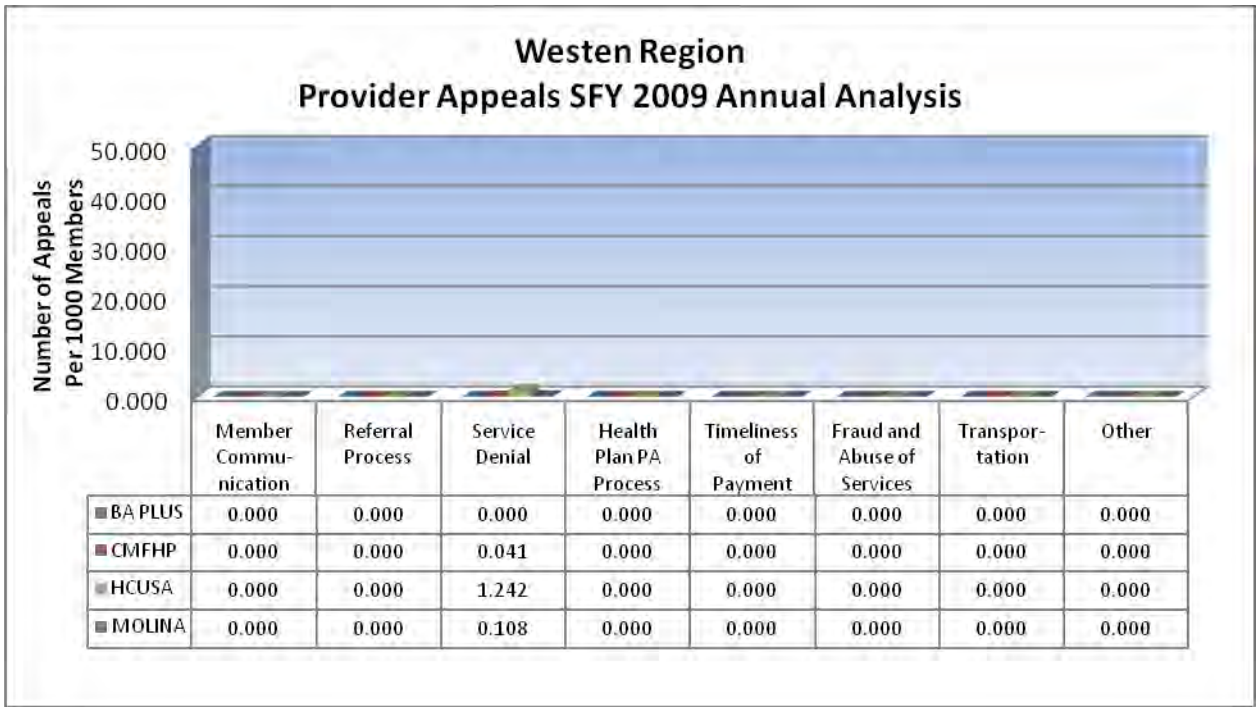
	Claim Denial	Health Plan Policy	Health Plan Information Systems	Network Adequacy / Availability	Health Plan Staff Behavior	Interpreter Services	Member Behavior	Member Compliance with Treatment Plan	Member Missed/ Late Appoint-ments
BA PLUS	0.606	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
CMFHP	1.588	0.265	0.000	0.000	0.000	0.000	0.000	0.000	0.000
HCUSA	0.828	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
MOLINA	10.148	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000



	Member Commu-nication	Referral Process	Service Denial	Health Plan PA Process	Timeliness of Payment	Fraud and Abuse of Services	Transpor-tation	Other
BA PLUS	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
CMFHP	0.000	0.000	1.588	0.000	0.000	0.000	0.000	0.000
HCUSA	0.000	0.000	5.133	0.000	0.000	0.000	0.000	0.000
MOLINA	0.000	0.000	0.216	0.000	0.000	0.000	0.000	0.000



	Claim Denial	Health Plan Policy	Health Plan Information Systems	Network Adequacy / Availability	Health Plan Staff Behavior	Interpreter Services	Member Behavior	Member Compliance with Treatment Plan	Member Missed/ Late Appoint-ments
BA PLUS	0.143	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
CMFHP	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
HCUSA	0.028	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
MOLINA	1.403	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000



	Member Commu-nication	Referral Process	Service Denial	Health Plan PA Process	Timeliness of Payment	Fraud and Abuse of Services	Transpor-tation	Other
BA PLUS	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
CMFHP	0.000	0.000	0.041	0.000	0.000	0.000	0.000	0.000
HCUSA	0.000	0.000	1.242	0.000	0.000	0.000	0.000	0.000
MOLINA	0.000	0.000	0.108	0.000	0.000	0.000	0.000	0.000

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MO HealthNet Managed Care
Fraud and Abuse Annual Summary
SFY 2009

Central Region				
	HCUSA	**Mo Care**	**Molina**	**Total**
Cases Closed*	16	12	0	28
Cases Open*	11	6	1	18
	27	**18**	**1**	**46**
Percent Member Cases	**Percent Provider Cases**	**Percent Referred by MHD**	**Percent Pharmacy Cases**	**Percent Referred to Enforcement**
65.22%	34.78%	58.70%	50.00%	15.22%

Eastern Region				
	Harmony	**HCUSA**	**Molina**	**TOTAL**
Cases Closed*	11	42	42	95
Cases Open*	8	29	18	55
	19	**71**	**60**	**150**
Percent Member Cases	**Percent Provider Cases**	**Percent Referred by MHD**	**Percent Pharmacy Cases**	**Percent Referred to Enforcement**
80.67%	19.33%	22.67%	71.33%	12.00%

Western Region					
	BA Plus	**CMFHP**	**HCUSA**	**Molina**	**TOTAL**
Cases Closed*	1	1	8	14	24
Cases Open*	1	19	2	7	29
	2	**20**	**10**	**21**	**53**
Percent Member Cases	**Percent Provider Cases**	**Percent Referred by MHD**	**Percent Pharmacy Cases**	**Percent Referred to Enforcement**	
86.79%	13.21%	47.17%	56.60%	20.75%	

* Unique member/provider count

ATTACHMENTS

Attachment 1

1915b WEEKLY MO HEALTHNET MANAGED CARE HEALTH PLAN ENROLLMENT ANNUAL SUMMARY EASTERN REGION STATE FISCAL YEAR 09 (1 JULY 2008 - 30 JUNE 2009)

WEEK ENDING:	TOTAL WEEKLY ENROLLMENT:	Harmony Health Plan of Missouri		HealthCareUSA		Molina Healthcare of Missouri	
		enrollment	*% of total*	*enrollment*	*% of total*	*enrollment*	*% of total*
03-Jul	172,903	10,701	6.19%	105,542	61.04%	56,660	32.77%
11-Jul	173,392	10,811	6.24%	105,723	60.97%	56,858	32.79%
18-Jul	171,782	10,669	6.21%	104,902	61.07%	56,211	32.72%
25-Jul	**171,010**	**10,539**	**6.16%**	**104,563**	**61.14%**	**55,908**	**32.69%**
01-Aug	172,833	11,055	6.40%	105,423	61.00%	56,355	32.61%
08-Aug	172,882	11,108	6.43%	105,395	60.96%	56,379	32.61%
15-Aug	171,325	11,039	6.44%	104,396	60.93%	55,890	32.62%
22-Aug	171,459	11,119	6.48%	104,416	60.90%	55,924	32.62%
30-Aug	**172,010**	**11,271**	**6.55%**	**104,699**	**60.87%**	**56,040**	**32.58%**
05-Sep	172,222	11,388	6.61%	104,686	60.79%	56,148	32.60%
12-Sep	173,229	11,501	6.64%	105,304	60.79%	56,424	32.57%
19-Sep	171,848	11,472	6.68%	104,435	60.77%	55,941	32.55%
26-Sep	**172,175**	**11,570**	**6.72%**	**104,590**	**60.75%**	**56,015**	**32.53%**
03-Oct	172,707	11,681	6.76%	104,772	60.66%	56,254	32.57%
10-Oct	173,382	11,801	6.81%	105,099	60.62%	56,482	32.58%
17-Oct	171,964	11,752	6.83%	104,238	60.62%	55,974	32.55%
24-Oct	172,771	11,897	6.89%	104,682	60.59%	56,192	32.52%
31-Oct	173,017	11,945	6.90%	104,924	60.64%	56,148	32.45%
07-Nov	173,286	12,047	6.95%	105,038	60.62%	56,201	32.43%
14-Nov	173,401	12,141	7.00%	105,129	60.63%	56,131	32.37%
21-Nov	172,693	12,025	6.96%	104,828	60.70%	55,840	32.33%
28-Nov	172,709	12,097	7.00%	104,809	60.69%	55,803	32.31%
05-Dec	173,006	12,203	7.05%	104,974	60.68%	55,829	32.27%
12-Dec	173,761	12,408	7.14%	105,417	60.67%	55,936	32.19%
19-Dec	172,765	12,314	7.13%	104,955	60.75%	55,496	32.12%
26-Dec	172,761	12,394	7.17%	104,924	60.73%	55,443	32.09%
02-Jan	172,920	12,480	7.22%	104,971	60.70%	55,469	32.08%
09-Jan	173,491	12,587	7.26%	105,351	60.72%	55,553	32.02%
16-Jan	172,227	12,445	7.23%	104,703	60.79%	55,079	31.98%
23-Jan	172,697	12,472	7.22%	105,046	60.83%	55,179	31.95%
30-Jan	173,841	12,683	7.30%	105,736	60.82%	55,422	31.88%
06-Feb	173,886	12,687	7.30%	105,805	60.85%	55,394	31.86%
13-Feb	174,657	12,780	7.32%	106,279	60.85%	55,598	31.83%
20-Feb	173,517	12,790	7.37%	105,576	60.84%	55,151	31.78%
27-Feb	174,424	12,968	7.43%	106,070	60.81%	55,386	31.75%
06-Mar	174,217	12,935	7.42%	106,061	60.88%	55,221	31.70%
13-Mar	176,503	13,236	7.50%	107,449	60.88%	55,818	31.62%
20-Mar	176,009	13,226	7.51%	107,232	60.92%	55,551	31.56%
27-Mar	176,623	13,328	7.55%	107,745	61.00%	55,550	31.45%
03-Apr	176,216	13,265	7.53%	107,596	61.06%	55,355	31.41%
10-Apr	177,104	13,379	7.55%	108,121	61.05%	55,604	31.40%
17-Apr	176,012	13,477	7.66%	107,643	61.16%	54,892	31.19%
24-Apr	176,801	13,590	7.69%	108,058	61.12%	55,153	31.19%
01-May	176,851	13,645	7.72%	108,061	61.10%	55,145	31.18%
08-May	177,563	13,769	7.75%	108,454	61.08%	55,340	31.17%
15-May	176,585	13,712	7.77%	107,857	61.08%	55,016	31.16%
22-May	177,212	13,794	7.78%	108,313	61.12%	55,105	31.10%
29-May	177,394	13,833	7.80%	108,478	61.15%	55,083	31.05%
05-Jun	177,916	13,906	7.82%	108,843	61.18%	55,167	31.01%
12-Jun	177,926	13,926	7.83%	108,929	61.22%	55,071	30.95%
19-Jun	177,676	14,021	7.89%	108,959	61.32%	54,696	30.78%
26-Jun	178,411	14,116	7.91%	109,423	61.33%	54,872	30.76%

NOTES:

Enrollment totals include enrollees with a future start date.

Source: Missouri Department of Social Services, Mo HealthNet Division, State Session MPRI screen.

Monthly totals are based on enrollment data as of the last Friday of the month.

g:\reports\enrllmnt\plans\1915B\Weekly FY 2009.xls Revised: 26-Jun-09

Attachment 2

1915b WEEKLY MO HEALTHNET MANAGED CARE
HEALTH PLAN ENROLLMENT ANNUAL SUMMARY
CENTRAL REGION
STATE FISCAL YEAR 09 (1 JULY 2008 - 30 JUNE 2009)

WEEK ENDING:	TOTAL WEEKLY ENROLLMENT:	HealthCareUSA		Molina Healthcare of Missouri		Missouri Care	
		enrollment	*% of total*	*enrollment*	*% of total*	*enrollment*	*% of total*
03-Jul	64,239	24,277	37.79%	5,507	8.57%	34,455	53.64%
11-Jul	64,467	24,325	37.73%	5,561	8.63%	34,581	53.64%
18-Jul	63,808	24,114	37.79%	5,501	8.62%	34,193	53.59%
25-Jul	**63,425**	**24,027**	**37.88%**	**5,483**	**8.64%**	**33,915**	**53.47%**
01-Aug	64,363	24,168	37.55%	5,597	8.70%	34,598	53.75%
08-Aug	64,400	24,152	37.50%	5,596	8.69%	34,652	53.81%
15-Aug	63,999	23,966	37.45%	5,550	8.67%	34,483	53.88%
22-Aug	64,137	24,014	37.44%	5,586	8.71%	34,537	53.85%
30-Aug	**64,313**	**24,062**	**37.41%**	**5,598**	**8.70%**	**34,653**	**53.88%**
05-Sep	64,366	24,047	37.36%	5,614	8.72%	34,705	53.92%
12-Sep	64,725	24,172	37.35%	5,700	8.81%	34,853	53.85%
19-Sep	64,295	23,983	37.30%	5,689	8.85%	34,623	53.85%
26-Sep	**64,582**	**24,117**	**37.34%**	**5,739**	**8.89%**	**34,726**	**53.77%**
03-Oct	64,574	24,049	37.24%	5,739	8.89%	34,786	53.87%
10-Oct	64,788	24,063	37.14%	5,802	8.96%	34,923	53.90%
17-Oct	64,137	23,881	37.23%	5,749	8.96%	34,507	53.80%
24-Oct	64,545	24,010	37.20%	5,810	9.00%	34,725	53.80%
31-Oct	64,621	24,026	37.18%	5,797	8.97%	34,798	53.85%
07-Nov	64,836	24,060	37.11%	5,858	9.04%	34,918	53.86%
14-Nov	64,991	24,121	37.11%	5,883	9.05%	34,987	53.83%
21-Nov	64,782	24,087	37.18%	5,853	9.03%	34,842	53.78%
28-Nov	64,856	24,093	37.15%	5,863	9.04%	34,900	53.81%
05-Dec	65,076	24,209	37.20%	5,883	9.04%	34,984	53.76%
12-Dec	65,463	24,309	37.13%	5,935	9.07%	35,219	53.80%
19-Dec	65,262	24,247	37.15%	5,891	9.03%	35,124	53.82%
26-Dec	65,445	24,329	37.17%	5,882	8.99%	35,234	53.84%
02-Jan	65,507	24,319	37.12%	5,894	9.00%	35,294	53.88%
09-Jan	65,861	24,490	37.18%	5,925	9.00%	35,446	53.82%
16-Jan	65,327	24,327	37.24%	5,845	8.95%	35,155	53.81%
23-Jan	65,632	24,559	37.42%	5,857	8.92%	35,216	53.66%
30-Jan	66,068	24,723	37.42%	5,897	8.93%	35,448	53.65%
06-Feb	66,221	24,812	37.47%	5,901	8.91%	35,508	53.62%
13-Feb	66,529	24,926	37.47%	5,919	8.90%	35,684	53.64%
20-Feb	66,385	24,892	37.50%	5,884	8.86%	35,609	53.64%
27-Feb	66,876	25,094	37.52%	5,941	8.88%	35,841	53.59%
06-Mar	66,748	25,048	37.53%	5,929	8.88%	35,771	53.59%
13-Mar	67,843	25,513	37.61%	5,988	8.83%	36,342	53.57%
20-Mar	67,715	25,399	37.51%	5,994	8.85%	36,322	53.64%
27-Mar	68,026	25,521	37.52%	6,025	8.86%	36,480	53.63%
03-Apr	67,646	25,484	37.67%	5,992	8.86%	36,170	53.47%
10-Apr	67,941	25,666	37.78%	6,024	8.87%	36,251	53.36%
17-Apr	67,647	25,590	37.83%	6,023	8.90%	36,034	53.27%
24-Apr	67,895	25,657	37.79%	6,045	8.90%	36,193	53.31%
01-May	67,840	25,674	37.84%	6,010	8.86%	36,156	53.30%
08-May	68,185	25,821	37.87%	6,041	8.86%	36,323	53.27%
15-May	67,792	25,628	37.80%	6,025	8.89%	36,139	53.31%
22-May	68,007	25,716	37.81%	6,032	8.87%	36,259	53.32%
29-May	68,000	25,714	37.81%	6,034	8.87%	36,252	53.31%
05-Jun	68,116	25,778	37.84%	6,051	8.88%	36,287	53.27%
12-Jun	67,895	25,733	37.90%	6,016	8.86%	36,146	53.24%
19-Jun	67,760	25,687	37.91%	6,030	8.90%	36,043	53.19%
26-Jun	68,125	25,835	37.92%	6,064	8.90%	36,226	53.18%

NOTES:

Enrollment totals include enrollees with a future start date.

Source: Missouri Department of Social Services, Mo HealthNet Division, State Session MPRI screen.

Monthly totals are based on enrollment data as of the last Friday of the month.

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Revised: 26-Jun-09

Attachment 3

1915b WEEKLY MO HEALTHNET MANAGED CARE HEALTH PLAN ENROLLMENT ANNUAL SUMMARY WESTERN REGION STATE FISCAL YEAR 09 (1 JULY 2008 - 30 JUNE 2009)

WEEK ENDING:	TOTAL WEEKLY ENROLLMENT:	Blue-Advantage Plus of Kansas City		Children's Mercy Family Health Partners		HealthCare USA		Molina Healthcare of Missouri	
		enrollment	*% of total*	*enrollment*	*% of total*	*enrollment*	*% of total*	*enrollment*	*% of total*
03-Jul	108,745	25,084	23.07%	43,011	39.55%	33,046	30.39%	7,604	6.99%
11-Jul	109,100	25,150	23.05%	43,138	39.54%	33,128	30.36%	7,684	7.04%
18-Jul	107,933	24,843	23.02%	42,751	39.61%	32,778	30.37%	7,561	7.01%
25-Jul	**107,419**	**24,714**	**23.01%**	**42,566**	**39.63%**	**32,662**	**30.41%**	**7,477**	**6.96%**
01-Aug	108,705	25,029	23.02%	42,951	39.51%	32,945	30.31%	7,780	7.16%
08-Aug	108,844	25,058	23.02%	42,947	39.46%	32,982	30.30%	7,857	7.22%
15-Aug	107,796	24,851	23.05%	42,440	39.37%	32,681	30.32%	7,824	7.26%
22-Aug	107,920	24,922	23.09%	42,493	39.37%	32,623	30.23%	7,882	7.30%
30-Aug	**108,255**	**25,067**	**23.16%**	**42,514**	**39.27%**	**32,755**	**30.26%**	**7,919**	**7.32%**
05-Sep	108,620	25,154	23.16%	42,654	39.27%	32,804	30.20%	8,008	7.37%
12-Sep	109,398	25,329	23.15%	42,963	39.27%	32,994	30.16%	8,112	7.42%
19-Sep	108,462	25,129	23.17%	42,616	39.29%	32,694	30.14%	8,023	7.40%
26-Sep	**108,839**	**25,195**	**23.15%**	**42,670**	**39.20%**	**32,795**	**30.13%**	**8,179**	**7.51%**
03-Oct	109,124	25,267	23.15%	42,804	39.23%	32,841	30.10%	8,212	7.53%
10-Oct	109,602	25,381	23.16%	42,955	39.19%	32,992	30.10%	8,274	7.55%
17-Oct	108,560	25,140	23.16%	42,643	39.28%	32,570	30.00%	8,207	7.56%
24-Oct	109,091	25,243	23.14%	42,890	39.32%	32,656	29.93%	8,302	7.61%
31-Oct	109,380	25,294	23.12%	42,965	39.28%	32,806	29.99%	8,315	7.60%
07-Nov	109,531	25,339	23.13%	43,013	39.27%	32,870	30.01%	8,309	7.59%
14-Nov	109,643	25,318	23.09%	43,056	39.27%	32,888	30.00%	8,381	7.64%
21-Nov	109,221	25,255	23.12%	42,888	39.27%	32,755	29.99%	8,323	7.62%
28-Nov	109,431	25,273	23.09%	42,953	39.25%	32,846	30.02%	8,359	7.64%
05-Dec	109,921	25,354	23.07%	43,163	39.27%	32,969	29.99%	8,435	7.67%
12-Dec	110,385	25,483	23.09%	43,379	39.30%	33,049	29.94%	8,474	7.68%
19-Dec	109,598	25,185	22.98%	43,196	39.41%	32,831	29.96%	8,386	7.65%
26-Dec	109,764	25,180	22.94%	43,303	39.45%	32,877	29.95%	8,404	7.66%
02-Jan	109,913	25,209	22.94%	43,293	39.39%	32,926	29.96%	8,485	7.72%
09-Jan	110,435	25,320	22.93%	43,450	39.34%	33,067	29.94%	8,598	7.79%
16-Jan	109,451	25,093	22.93%	43,115	39.39%	32,727	29.90%	8,516	7.78%
23-Jan	109,841	25,208	22.95%	43,441	39.55%	32,697	29.77%	8,495	7.73%
30-Jan	110,700	25,354	22.90%	43,812	39.58%	32,927	29.74%	8,607	7.78%
06-Feb	110,881	25,364	22.87%	43,884	39.58%	33,006	29.77%	8,627	7.78%
13-Feb	111,361	25,484	22.88%	44,124	39.62%	33,061	29.69%	8,692	7.81%
20-Feb	110,807	25,324	22.85%	44,013	39.72%	32,814	29.61%	8,656	7.81%
27-Feb	111,532	25,508	22.87%	44,286	39.71%	32,979	29.57%	8,759	7.85%
06-Mar	111,286	25,477	22.89%	44,198	39.72%	32,877	29.54%	8,734	7.85%
13-Mar	112,738	25,780	22.87%	44,824	39.76%	33,285	29.52%	8,849	7.85%
20-Mar	112,225	25,695	22.90%	44,596	39.74%	33,117	29.51%	8,817	7.86%
27-Mar	112,797	25,864	22.93%	44,803	39.72%	33,246	29.47%	8,884	7.88%
03-Apr	112,477	25,772	22.91%	44,709	39.75%	33,178	29.50%	8,818	7.84%
10-Apr	112,891	25,883	22.93%	44,832	39.71%	33,296	29.49%	8,880	7.87%
17-Apr	112,507	25,704	22.85%	44,725	39.75%	33,195	29.50%	8,883	7.90%
24-Apr	112,979	25,810	22.84%	44,911	39.75%	33,305	29.48%	8,953	7.92%
01-May	113,098	25,821	22.83%	44,950	39.74%	33,361	29.50%	8,966	7.93%
08-May	113,808	25,919	22.77%	45,211	39.73%	33,596	29.52%	9,082	7.98%
15-May	113,191	25,822	22.81%	44,957	39.72%	33,386	29.50%	9,026	7.97%
22-May	113,726	25,941	22.81%	45,190	39.74%	33,526	29.48%	9,069	7.97%
29-May	113,829	25,981	22.82%	45,215	39.72%	33,544	29.47%	9,089	7.98%
05-Jun	114,123	26,117	22.88%	45,370	39.76%	33,567	29.41%	9,069	7.95%
12-Jun	114,011	26,128	22.92%	45,370	39.79%	33,482	29.37%	9,031	7.92%
19-Jun	113,644	26,008	22.89%	45,305	39.87%	33,344	29.34%	8,987	7.91%
26-Jun	114,119	26,155	22.92%	45,489	39.86%	33,466	29.33%	9,009	7.89%

NOTES:

Enrollment totals include enrollees with a future start date.

Source: Missouri Department of Social Services, Mo HealthNet Division, State Session MPRI screen.

Monthly totals are based on enrollment data as of the last Friday of the month.

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Attachment 4

CHIP WEEKLY MO HEALTHNET MANAGED CARE
HEALTH PLAN ENROLLMENT ANNUAL SUMMARY
EASTERN REGION
STATE FISCAL YEAR 09 (1 JULY 2008 - 30 JUNE 2009)

WEEK ENDING:	TOTAL WEEKLY ENROLLMENT:	Harmony Health Plan of Missouri		HealthCareUSA		Molina Healthcare of Missouri	
		enrollment	*% of total*	*enrollment*	*% of total*	*enrollment*	*% of total*
03-Jul	16,115	805	5.00%	9,739	60.43%	5,571	34.57%
11-Jul	16,168	812	5.02%	9,787	60.53%	5,569	34.44%
18-Jul	16,137	823	5.10%	9,709	60.17%	5,605	34.73%
25-Jul	**16,289**	**822**	**5.05%**	**9,807**	**60.21%**	**5,660**	**34.75%**
01-Aug	16,639	867	5.21%	9,991	60.05%	5,781	34.74%
08-Aug	16,915	896	5.30%	10,149	60.00%	5,870	34.70%
15-Aug	16,549	873	5.28%	9,929	60.00%	5,747	34.73%
22-Aug	16,664	857	5.14%	10,005	60.04%	5,802	34.82%
30-Aug	**16,793**	**880**	**5.24%**	**10,065**	**59.94%**	**5,848**	**34.82%**
05-Sep	17,041	902	5.29%	10,210	59.91%	5,929	34.79%
12-Sep	17,112	902	5.27%	10,251	59.91%	5,959	34.82%
19-Sep	16,826	876	5.21%	10,052	59.74%	5,898	35.05%
26-Sep	**16,981**	**892**	**5.25%**	**10,175**	**59.92%**	**5,914**	**34.83%**
03-Oct	17,245	921	5.34%	10,384	60.21%	5,940	34.44%
10-Oct	17,367	937	5.40%	10,430	60.06%	6,000	34.55%
17-Oct	17,155	931	5.43%	10,318	60.15%	5,906	34.43%
24-Oct	17,358	975	5.62%	10,415	60.00%	5,968	34.38%
31-Oct	**17,460**	**985**	**5.64%**	**10,461**	**59.91%**	**6,014**	**34.44%**
07-Nov	17,623	1,003	5.69%	10,550	59.86%	6,070	34.44%
14-Nov	17,657	1,016	5.75%	10,595	60.00%	6,046	34.24%
21-Nov	17,467	1,014	5.81%	10,485	60.03%	5,968	34.17%
28-Nov	17,542	1,006	5.73%	10,550	60.14%	5,986	34.12%
05-Dec	17,772	1,036	5.83%	10,729	60.37%	6,007	33.80%
12-Dec	17,994	1,060	5.89%	10,844	60.26%	6,090	33.84%
19-Dec	17,761	1,040	5.86%	10,755	60.55%	5,966	33.59%
26-Dec	17,873	1,038	5.81%	10,836	60.63%	5,999	33.56%
02-Jan	18,022	1,068	5.93%	10,910	60.54%	6,044	33.54%
09-Jan	18,266	1,115	6.10%	11,033	60.40%	6,118	33.49%
16-Jan	18,058	1,108	6.14%	10,899	60.36%	6,051	33.51%
23-Jan	18,004	1,105	6.14%	10,885	60.46%	6,014	33.40%
30-Jan	18,188	1,126	6.19%	11,006	60.51%	6,056	33.30%
06-Feb	18,317	1,161	6.34%	11,085	60.52%	6,071	33.14%
13-Feb	18,406	1,165	6.33%	11,130	60.47%	6,111	33.20%
20-Feb	18,164	1,147	6.31%	11,006	60.59%	6,011	33.09%
27-Feb	18,438	1,162	6.30%	11,211	60.80%	6,065	32.89%
06-Mar	18,596	1,164	6.26%	11,341	60.99%	6,091	32.75%
13-Mar	17,523	1,092	6.23%	10,666	60.87%	5,765	32.90%
20-Mar	17,428	1,093	6.27%	10,578	60.70%	5,757	33.03%
27-Mar	17,519	1,121	6.40%	10,634	60.70%	5,764	32.90%
03-Apr	17,586	1,147	6.52%	10,652	60.57%	5,787	32.91%
10-Apr	17,754	1,160	6.53%	10,759	60.60%	5,835	32.87%
17-Apr	17,593	1,162	6.60%	10,672	60.66%	5,759	32.73%
24-Apr	17,762	1,178	6.63%	10,802	60.82%	5,782	32.55%
01-May	17,791	1,165	6.55%	10,824	60.84%	5,802	32.61%
08-May	18,105	1,174	6.48%	11,020	60.87%	5,911	32.65%
15-May	17,924	1,166	6.51%	10,914	60.89%	5,844	32.60%
22-May	18,094	1,177	6.50%	11,044	61.04%	5,873	32.46%
29-May	18,062	1,172	6.49%	11,018	61.00%	5,872	32.51%
05-Jun	18,379	1,200	6.53%	11,233	61.12%	5,946	32.35%
12-Jun	18,446	1,212	6.57%	11,289	61.20%	5,945	32.23%
19-Jun	18,273	1,203	6.58%	11,179	61.18%	5,891	32.24%
26-Jun	18,283	1,202	6.57%	11,191	61.21%	5,890	32.22%

NOTES:

Enrollment totals include enrollees with a future start date.

Source: Missouri Department of Social Services, Mo HealthNet Division, State Session MPRI screen.

Monthly totals are based on enrollment data as of the last Friday of the month.

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Attachment 5

CHIP WEEKLY MO HEALTHNET MANAGED CARE
HEALTH PLAN ENROLLMENT ANNUAL SUMMARY
EASTERN REGION
STATE FISCAL YEAR 09 (1 JULY 2008 - 30 JUNE 2009)

WEEK ENDING:	TOTAL WEEKLY ENROLLMENT:	Harmony Health Plan of Missouri		HealthCareUSA		Molina Healthcare of Missouri	
		enrollment	*% of total*	*enrollment*	*% of total*	*enrollment*	*% of total*
03-Jul	16,115	805	5.00%	9,739	60.43%	5,571	34.57%
11-Jul	16,168	812	5.02%	9,787	60.53%	5,569	34.44%
18-Jul	16,137	823	5.10%	9,709	60.17%	5,605	34.73%
25-Jul	**16,289**	**822**	**5.05%**	**9,807**	**60.21%**	**5,660**	**34.75%**
01-Aug	16,639	867	5.21%	9,991	60.05%	5,781	34.74%
08-Aug	16,915	896	5.30%	10,149	60.00%	5,870	34.70%
15-Aug	16,549	873	5.28%	9,929	60.00%	5,747	34.73%
22-Aug	16,664	857	5.14%	10,005	60.04%	5,802	34.82%
30-Aug	**16,793**	**880**	**5.24%**	**10,065**	**59.94%**	**5,848**	**34.82%**
05-Sep	17,041	902	5.29%	10,210	59.91%	5,929	34.79%
12-Sep	17,112	902	5.27%	10,251	59.91%	5,959	34.82%
19-Sep	16,826	876	5.21%	10,052	59.74%	5,898	35.05%
26-Sep	**16,981**	**892**	**5.25%**	**10,175**	**59.92%**	**5,914**	**34.83%**
03-Oct	17,245	921	5.34%	10,384	60.21%	5,940	34.44%
10-Oct	17,367	937	5.40%	10,430	60.06%	6,000	34.55%
17-Oct	17,155	931	5.43%	10,318	60.15%	5,906	34.43%
24-Oct	17,358	975	5.62%	10,415	60.00%	5,968	34.38%
31-Oct	**17,460**	**985**	**5.64%**	**10,461**	**59.91%**	**6,014**	**34.44%**
07-Nov	17,623	1,003	5.69%	10,550	59.86%	6,070	34.44%
14-Nov	17,657	1,016	5.75%	10,595	60.00%	6,046	34.24%
21-Nov	17,467	1,014	5.81%	10,485	60.03%	5,968	34.17%
28-Nov	17,542	1,006	5.73%	10,550	60.14%	5,986	34.12%
05-Dec	17,772	1,036	5.83%	10,729	60.37%	6,007	33.80%
12-Dec	17,994	1,060	5.89%	10,844	60.26%	6,090	33.84%
19-Dec	17,761	1,040	5.86%	10,755	60.55%	5,966	33.59%
26-Dec	17,873	1,038	5.81%	10,836	60.63%	5,999	33.56%
02-Jan	18,022	1,068	5.93%	10,910	60.54%	6,044	33.54%
09-Jan	18,266	1,115	6.10%	11,033	60.40%	6,118	33.49%
16-Jan	18,058	1,108	6.14%	10,899	60.36%	6,051	33.51%
23-Jan	18,004	1,105	6.14%	10,885	60.46%	6,014	33.40%
30-Jan	18,188	1,126	6.19%	11,006	60.51%	6,056	33.30%
06-Feb	18,317	1,161	6.34%	11,085	60.52%	6,071	33.14%
13-Feb	18,406	1,165	6.33%	11,130	60.47%	6,111	33.20%
20-Feb	18,164	1,147	6.31%	11,006	60.59%	6,011	33.09%
27-Feb	18,438	1,162	6.30%	11,211	60.80%	6,065	32.89%
06-Mar	18,596	1,164	6.26%	11,341	60.99%	6,091	32.75%
13-Mar	17,523	1,092	6.23%	10,666	60.87%	5,765	32.90%
20-Mar	17,428	1,093	6.27%	10,578	60.70%	5,757	33.03%
27-Mar	17,519	1,121	6.40%	10,634	60.70%	5,764	32.90%
03-Apr	17,586	1,147	6.52%	10,652	60.57%	5,787	32.91%
10-Apr	17,754	1,160	6.53%	10,759	60.60%	5,835	32.87%
17-Apr	17,593	1,162	6.60%	10,672	60.66%	5,759	32.73%
24-Apr	17,762	1,178	6.63%	10,802	60.82%	5,782	32.55%
01-May	17,791	1,165	6.55%	10,824	60.84%	5,802	32.61%
08-May	18,105	1,174	6.48%	11,020	60.87%	5,911	32.65%
15-May	17,924	1,166	6.51%	10,914	60.89%	5,844	32.60%
22-May	18,094	1,177	6.50%	11,044	61.04%	5,873	32.46%
29-May	18,062	1,172	6.49%	11,018	61.00%	5,872	32.51%
05-Jun	18,379	1,200	6.53%	11,233	61.12%	5,946	32.35%
12-Jun	18,446	1,212	6.57%	11,289	61.20%	5,945	32.23%
19-Jun	18,273	1,203	6.58%	11,179	61.18%	5,891	32.24%
26-Jun	18,283	1,202	6.57%	11,191	61.21%	5,890	32.22%

NOTES:

Enrollment totals include enrollees with a future start date.

Source: Missouri Department of Social Services, Mo HealthNet Division, State Session MPRI screen.

Monthly totals are based on enrollment data as of the last Friday of the month.

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Attachment 6

CHIP WEEKLY MO HEALTHNET MANAGED CARE
HEALTH PLAN ENROLLMENT ANNUAL SUMMARY
CENTRAL REGION

WEEK ENDING:	TOTAL WEEKLY ENROLLMENT:	HealthCareUSA		Molina Healthcare of Missouri		Missouri Care	
		enrollment	*% of total*	*enrollment*	*% of total*	*enrollment*	*% of total*
03-Jul	8,573	3,679	42.91%	648	7.56%	4,246	49.53%
11-Jul	8,640	3,707	42.91%	651	7.53%	4,282	49.56%
18-Jul	8,651	3,732	43.14%	649	7.50%	4,270	49.36%
25-Jul	**8,648**	**3,734**	**43.18%**	**656**	**7.59%**	**4,258**	**49.24%**
01-Aug	8,831	3,809	43.13%	685	7.76%	4,337	49.11%
08-Aug	8,969	3,863	43.07%	688	7.67%	4,418	49.26%
15-Aug	8,846	3,810	43.07%	690	7.80%	4,346	49.13%
22-Aug	8,882	3,837	43.20%	703	7.91%	4,342	48.89%
30-Aug	**8,897**	**3,821**	**42.95%**	**724**	**8.14%**	**4,352**	**48.92%**
05-Sep	8,985	3,853	42.88%	748	8.32%	4,384	48.79%
12-Sep	8,988	3,855	42.89%	748	8.32%	4,385	48.79%
19-Sep	8,911	3,855	43.26%	718	8.06%	4,338	48.68%
26-Sep	**8,972**	**3,889**	**43.35%**	**719**	**8.01%**	**4,364**	**48.64%**
03-Oct	9,032	3,917	43.37%	731	8.09%	4,384	48.54%
10-Oct	9,037	3,910	43.27%	732	8.10%	4,395	48.63%
17-Oct	8,939	3,871	43.30%	730	8.17%	4,338	48.53%
24-Oct	9,061	3,921	43.27%	734	8.10%	4,406	48.63%
31-Oct	**9,118**	**3,925**	**43.05%**	**739**	**8.10%**	**4,454**	**48.85%**
07-Nov	9,213	3,948	42.85%	762	8.27%	4,503	48.88%
14-Nov	9,191	3,928	42.74%	763	8.30%	4,500	48.96%
21-Nov	9,074	3,878	42.74%	746	8.22%	4,450	49.04%
28-Nov	9,079	3,895	42.90%	737	8.12%	4,447	48.98%
05-Dec	9,190	3,931	42.77%	748	8.14%	4,511	49.09%
12-Dec	9,278	3,956	42.64%	757	8.16%	4,565	49.20%
19-Dec	9,111	3,901	42.82%	734	8.06%	4,476	49.13%
26-Dec	9,105	3,893	42.76%	727	7.98%	4,485	49.26%
02-Jan	9,154	3,915	42.77%	733	8.01%	4,506	49.22%
09-Jan	9,234	3,924	42.50%	743	8.05%	4,567	49.46%
16-Jan	9,083	3,853	42.42%	742	8.17%	4,488	49.41%
23-Jan	9,052	3,852	42.55%	732	8.09%	4,468	49.36%
30-Jan	9,093	3,866	42.52%	747	8.22%	4,480	49.27%
06-Feb	9,144	3,873	42.36%	761	8.32%	4,510	49.32%
13-Feb	9,237	3,912	42.35%	761	8.24%	4,564	49.41%
20-Feb	9,132	3,875	42.43%	746	8.17%	4,511	49.40%
27-Feb	9,240	3,926	42.49%	758	8.20%	4,556	49.31%
06-Mar	9,334	3,986	42.70%	760	8.14%	4,588	49.15%
13-Mar	8,713	3,700	42.47%	725	8.32%	4,288	49.21%
20-Mar	8,635	3,665	42.44%	726	8.41%	4,244	49.15%
27-Mar	8,664	3,673	42.39%	733	8.46%	4,258	49.15%
03-Apr	8,748	3,669	41.94%	734	8.39%	4,345	49.67%
10-Apr	8,869	3,727	42.02%	741	8.35%	4,401	49.62%
17-Apr	8,810	3,703	42.03%	728	8.26%	4,379	49.70%
24-Apr	8,876	3,743	42.17%	735	8.28%	4,398	49.55%
01-May	8,938	3,777	42.26%	745	8.34%	4,416	49.41%
08-May	9,042	3,797	41.99%	768	8.49%	4,477	49.51%
15-May	9,024	3,790	42.00%	769	8.52%	4,465	49.48%
22-May	9,087	3,823	42.07%	778	8.56%	4,486	49.37%
29-May	9,065	3,794	41.85%	774	8.54%	4,497	49.61%
05-Jun	9,147	3,835	41.93%	784	8.57%	4,528	49.50%
12-Jun	9,216	3,874	42.04%	784	8.51%	4,558	49.46%
19-Jun	9,172	3,856	42.04%	777	8.47%	4,539	49.49%
26-Jun	9,171	3,851	41.99%	783	8.54%	4,537	49.47%

NOTES:

Enrollment totals include enrollees with a future start date.

Source: Missouri Department of Social Services, Mo HealthNet Division, State Session MPRI screen.

Monthly totals are based on enrollment data as of the last Friday of the month.

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Attachment 7

CHIP WEEKLY MO HEALTHNET MANAGED CARE
HEALTH PLAN ENROLLMENT ANNUAL SUMMARY
WESTERN REGION
STATE FISCAL YEAR 09 (1 JULY 2008 - 30 JUNE 2009)

WEEK ENDING:	TOTAL WEEKLY ENROLLMENT:	Blue-Advantage Plus of Kansas City		Children's Mercy Family Health Partners		HealthCare USA		Molina Healthcare of Missouri	
		enrollment	*% of total*	*enrollment*	*% of total*	*enrollment*	*% of total*	*enrollment*	*% of total*
03-Jul	11,863	2,678	22.57%	5,358	45.17%	3,049	25.70%	778	6.56%
11-Jul	11,893	2,689	22.61%	5,343	44.93%	3,082	25.91%	779	6.55%
18-Jul	11,774	2,640	22.42%	5,303	45.04%	3,065	26.03%	766	6.51%
25-Jul	**11,841**	**2,661**	**22.47%**	**5,326**	**44.98%**	**3,086**	**26.06%**	**768**	**6.49%**
01-Aug	12,146	2,726	22.44%	5,462	44.97%	3,164	26.05%	794	6.54%
08-Aug	12,354	2,754	22.29%	5,549	44.92%	3,247	26.28%	804	6.51%
15-Aug	12,064	2,683	22.24%	5,439	45.08%	3,158	26.18%	784	6.50%
22-Aug	12,222	2,715	22.21%	5,493	44.94%	3,213	26.29%	801	6.55%
30-Aug	**12,257**	**2,717**	**22.17%**	**5,500**	**44.87%**	**3,225**	**26.31%**	**815**	**6.65%**
05-Sep	12,408	2,755	22.20%	5,542	44.66%	3,275	26.39%	836	6.74%
12-Sep	12,479	2,778	22.26%	5,588	44.78%	3,278	26.27%	835	6.69%
19-Sep	12,287	2,705	22.02%	5,524	44.96%	3,248	26.43%	810	6.59%
26-Sep	**12,384**	**2,707**	**21.86%**	**5,604**	**45.25%**	**3,264**	**26.36%**	**809**	**6.53%**
03-Oct	12,594	2,783	22.10%	5,681	45.11%	3,303	26.23%	827	6.57%
10-Oct	12,666	2,796	22.07%	5,734	45.27%	3,297	26.03%	839	6.62%
17-Oct	12,387	2,721	21.97%	5,631	45.46%	3,214	25.95%	821	6.63%
24-Oct	12,630	2,793	22.11%	5,724	45.32%	3,281	25.98%	832	6.59%
31-Oct	**12,727**	**2,829**	**22.23%**	**5,737**	**45.08%**	**3,308**	**25.99%**	**853**	**6.70%**
07-Nov	12,900	2,872	22.26%	5,833	45.22%	3,316	25.71%	879	6.81%
14-Nov	12,941	2,880	22.25%	5,838	45.11%	3,337	25.79%	886	6.85%
21-Nov	12,746	2,823	22.15%	5,785	45.39%	3,274	25.69%	864	6.78%
28-Nov	12,740	2,831	22.22%	5,775	45.33%	3,276	25.71%	858	6.73%
05-Dec	12,925	2,848	22.03%	5,844	45.21%	3,355	25.96%	878	6.79%
12-Dec	13,020	2,883	22.14%	5,873	45.11%	3,388	26.02%	876	6.73%
19-Dec	12,821	2,835	22.11%	5,816	45.36%	3,319	25.89%	851	6.64%
26-Dec	12,907	2,862	22.17%	5,827	45.15%	3,359	26.02%	859	6.66%
02-Jan	13,026	2,877	22.09%	5,871	45.07%	3,403	26.12%	875	6.72%
09-Jan	13,166	2,900	22.03%	5,933	45.06%	3,454	26.23%	879	6.68%
16-Jan	12,930	2,838	21.95%	5,809	44.93%	3,406	26.34%	877	6.78%
23-Jan	12,976	2,848	21.95%	5,866	45.21%	3,395	26.16%	867	6.68%
30-Jan	13,086	2,875	21.97%	5,914	45.19%	3,420	26.13%	877	6.70%
06-Feb	13,178	2,892	21.95%	5,983	45.40%	3,429	26.02%	874	6.63%
13-Feb	13,282	2,925	22.02%	6,019	45.32%	3,463	26.07%	875	6.59%
20-Feb	13,118	2,854	21.76%	5,968	45.49%	3,441	26.23%	855	6.52%
27-Feb	13,327	2,898	21.75%	6,060	45.47%	3,496	26.23%	873	6.55%
06-Mar	13,456	2,960	22.00%	6,086	45.23%	3,526	26.20%	884	6.57%
13-Mar	12,594	2,797	22.21%	5,690	45.18%	3,279	26.04%	828	6.57%
20-Mar	12,450	2,760	22.17%	5,640	45.30%	3,220	25.86%	830	6.67%
27-Mar	12,602	2,796	22.19%	5,716	45.36%	3,236	25.68%	854	6.78%
03-Apr	12,697	2,851	22.45%	5,734	45.16%	3,271	25.76%	841	6.62%
10-Apr	12,824	2,867	22.36%	5,806	45.27%	3,301	25.74%	850	6.63%
17-Apr	12,667	2,797	22.08%	5,743	45.34%	3,299	26.04%	828	6.54%
24-Apr	12,785	2,862	22.39%	5,758	45.04%	3,332	26.06%	833	6.52%
01-May	12,767	2,845	22.28%	5,773	45.22%	3,309	25.92%	840	6.58%
08-May	12,987	2,906	22.38%	5,878	45.26%	3,357	25.85%	846	6.51%
15-May	12,922	2,887	22.34%	5,853	45.29%	3,335	25.81%	847	6.55%
22-May	13,012	2,918	22.43%	5,899	45.34%	3,350	25.75%	845	6.49%
29-May	13,019	2,898	22.26%	5,911	45.40%	3,360	25.81%	850	6.53%
05-Jun	13,161	2,913	22.13%	5,985	45.48%	3,402	25.85%	861	6.54%
12-Jun	13,258	2,924	22.05%	6,053	45.66%	3,406	25.69%	875	6.60%
19-Jun	13,154	2,897	22.02%	6,001	45.62%	3,377	25.67%	879	6.68%
26-Jun	13,205	2,902	21.98%	6,023	45.61%	3,391	25.68%	889	6.73%

NOTES:

Enrollment totals include enrollees with a future start date.

Source: Missouri Department of Social Services, Mo HealthNet Division, State Session MPRI screen.

Monthly totals are based on enrollment data as of the last Friday of the month.

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Attachment 8

1915b MO HealthNet Managed Care ASSIGNMENTS
ALL REGIONS - STATEWIDE
STATE FISCAL YEAR 2009 (1 JULY 2008 - 30 JUNE 2009)

	Algorithm A	Case Assigned C	Member Assigned M	Subtotal A+C+M	Newborn N	Reassigned R	Participant Selection S	Subtotal N+R+S	TOTAL ACM+NRS
JULY	3,131	467	3,297	**6,895**	1,465	13,215	5,428	**20,108**	**27,003**
AUGUST	3,929	883	3,951	**8,763**	1,508	13,861	5,950	**21,319**	**30,082**
SEPTEMBER	3,714	531	4,010	**8,255**	1,461	13,720	6,220	**21,401**	**29,656**
OCTOBER	3,935	523	4,351	**8,809**	1,392	15,055	6,780	**23,227**	**32,036**
NOVEMBER	3,656	536	3,725	**7,917**	1,209	15,013	6,721	**22,943**	**30,860**
DECEMBER	3,481	481	3,735	**7,697**	1,372	13,875	6,247	**21,494**	**29,191**
JANUARY	3,391	542	3,482	**7,415**	1,350	13,429	6,031	**20,810**	**28,225**
FEBRUARY	3,239	533	3,344	**7,116**	1,208	12,254	7,675	**21,137**	**28,253**
MARCH	3,505	580	3,370	**7,455**	1,525	14,731	7,246	**23,502**	**30,957**
APRIL	3,379	399	3,665	**7,443**	1,498	19,971	8,042	**29,511**	**36,954**
MAY	3,313	0	3,781	**7,094**	1,389	13,743	8,278	**23,410**	**30,504**
JUNE	2,676	0	3,115	**5,791**	1,388	13,363	6,818	**21,569**	**27,360**
TOTAL ASSIGNMENTS:	41,349	5,475	43,826	**90,650**	16,765	172,230	81,436	**270,431**	**361,081**
***TYPE CODE ASSIGNMENT RATE:**	11.45%	1.52%	12.14%	**25.11%**	4.64%	47.70%	22.55%	**74.89%**	**100.00%**

*total number of each code divided by total of all codes Source: IFOX Revised: 07/09/09 g:operatns\reports\asgntype excel\1915b\2009\assigns all regions fy09ytdY.xls

Note: The increase in reassigns starting in Sept. is being researched through a SPAR.
The projection is the increase could be due to changes performed by FSD through more frequent review of cases.

As a result of a merger between Mercy MC+ and Community Care Plus (becoming Mercy CarePlus) as well as an open enrollment period, assignment counts for the month of July 2006, are higher than normal.
MAY and JUNE 2009 Report: System problems resulted in no members appearing in Case Assigned category. Those assignments are appearing in the Member Assigned category.

Attachment 9

MO HealthNet for Kids (Title XXI) ASSIGNMENTS
ALL REGIONS - STATEWIDE
STATE FISCAL YEAR 2009 (1 JULY 2008 - 30 JUNE 2009)

	Algorithm A	Case Assigned C	Member Assigned M	Subtotal A+C+M	Newborn N	Reassigned R	Participant Selection S	Subtotal N+R+S	TOTAL ACM+NRS
JULY	713	69	786	**1,568**	0	6,774	1,668	**8,442**	**10,010**
AUGUST	1,002	177	914	**2,093**	0	7,521	1,866	**9,387**	**11,480**
SEPTEMBER	907	85	1,011	**2,003**	0	6,928	1,762	**8,690**	**10,693**
OCTOBER	933	95	1,023	**2,051**	0	7,533	2,183	**9,716**	**11,767**
NOVEMBER	920	105	891	**1,916**	0	6,935	2,097	**9,032**	**10,948**
DECEMBER	873	98	893	**1,864**	0	6,742	1,983	**8,725**	**10,589**
JANUARY	898	94	878	**1,870**	0	7,085	1,956	**9,041**	**10,911**
FEBRUARY	837	98	762	**1,697**	0	6,428	2,492	**8,920**	**10,617**
MARCH	916	120	877	**1,913**	0	6,826	2,376	**9,202**	**11,115**
APRIL	965	63	914	**1,942**	0	12,589	2,464	**15,053**	**16,995**
MAY	842	0	862	**1,704**	0	6,934	2,435	**9,369**	**11,073**
JUNE	673	0	698	**1,371**	0	6,791	1,966	**8,757**	**10,128**
TOTAL ASSIGNMENTS:	10,479	1,004	10,509	**21,992**	0	89,086	25,248	**114,334**	**136,326**
***TYPE CODE ASSIGNMENT RATE:**	7.69%	0.74%	7.71%	**16.13%**	0.00%	65.35%	18.52%	**83.87%**	**100.00%**

*total number of each code divided by total of all codes

As a result of a merger between Mercy MC+ and Community Care Plus (becoming Mercy CarePlus) as well as an open enrollment period, assignment counts for the month of July 2007, are higher than normal.

May and June 2009 Report: System problems resulted in no members appearing in Case Assigned category. Those assignments are appearing in the Member Assigned category.

Source: IFOX

Revised: 07/09/2009

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Attachment 10

ASSIGNMENT TYPES - ALL WAIVERS
ALL MO HEALTHNET MANAGED CARE REGIONS - STATEWIDE
STATE FISCAL YEAR 2009 (1 JULY 2008 - 30 JUNE 2009)

	Algorithm A	Case Assigned C	Member Assigned M	Subtotal A+C+M	Newborn N	Reassigned R	Recipient Selection S	Subtotal N+R+S	TOTAL ACM+NRS
JULY	3,844	536	4,083	**8,463**	1,465	19,989	7,096	**28,550**	**37,013**
AUGUST	4,931	1,060	4,865	**10,856**	1,508	21,382	7,816	**30,706**	**41,562**
SEPTEMBER	4,621	616	5,021	**10,258**	1,461	20,648	7,892	**30,001**	**40,259**
OCTOBER	4,868	618	5,374	**10,860**	1,392	22,588	8,963	**32,943**	**43,803**
NOVEMBER	4,576	641	4,616	**9,833**	1,209	21,948	8,818	**31,975**	**41,808**
DECEMBER	4,354	579	4,628	**9,561**	1,372	20,617	8,230	**30,219**	**39,780**
JANUARY	4,289	636	4,360	**9,285**	1,350	20,514	7,987	**29,851**	**39,136**
FEBRUARY	4,076	631	4,106	**8,813**	1,208	18,682	10,167	**30,057**	**38,870**
MARCH	4,421	700	4,247	**9,368**	1,525	21,557	9,622	**32,704**	**42,072**
APRIL	4,344	462	4,579	**9,385**	1,498	32,560	10,506	**44,564**	**53,949**
MAY	4,155	0	4,643	**8,798**	1,389	20,677	10,713	**32,779**	**41,577**
JUNE	3,349	0	3,813	**7,162**	1,388	20,154	8,784	**30,326**	**37,488**
TOTAL ASSIGNMENTS:	51,828	6,479	54,335	**112,642**	16,765	261,316	106,594	**384,675**	**497,317**
***TYPE CODE ASSIGNMENT RATE:**	10.42%	1.30%	10.93%	**22.65%**	3.37%	52.55%	21.43%	**77.35%**	**100.00%**

May and June 2009 Report: System problems resulted in no members appearing in Case Assigned category. Those assignments are appearing in the Member Assigned category.

*total number of each code divided by total of all codes

Source: IFOX

Revised: 07/09/2009

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Attachment 11

1915b MO HEALTHNET MANAGED CARE TRANSFERS BETWEEN HEALTH PLANS
ALL MO HEALTHNET MANAGED CARE REGIONS STATEWIDE
STATE FISCAL YEAR 2009 (1 JULY 2008 - 30 JUNE 2009)

		Eastern Region	Central Region	Western Region	Total
July					
	# of Transfers:	833	298	432	1,563
	% of Total MC+ Transfers:	53.29%	19.07%	27.64%	100.00%
August					
	# of Transfers:	440	265	300	1,005
	% of Total MC+ Transfers:	43.78%	26.37%	29.85%	100.00%
September					
	# of Transfers:	621	342	551	1,514
	% of Total MC+ Transfers:	41.02%	22.59%	36.39%	100.00%
October					
	# of Transfers:	671	329	437	1,437
	% of Total MC+ Transfers:	46.69%	22.89%	30.41%	100.00%
November					
	# of Transfers:	744	337	507	1,588
	% of Total MC+ Transfers:	46.85%	21.22%	31.93%	100.00%
December					
	# of Transfers:	810	385	575	1,770
	% of Total MC+ Transfers:	45.76%	21.75%	32.49%	100.00%
January					
	# of Transfers:	731	387	500	1,618
	% of Total MC+ Transfers:	45.18%	23.92%	30.90%	100.00%
February					
	# of Transfers:	761	572	796	2,129
	% of Total MC+ Transfers:	35.74%	26.87%	37.39%	100.00%
March					
	# of Transfers:	873	337	503	1,713
	% of Total MC+ Transfers:	50.96%	19.67%	29.36%	100.00%
April					
	# of Transfers:	1,306	510	703	2,519
	% of Total MC+ Transfers:	51.85%	20.25%	27.91%	100.00%
May					
	# of Transfers:	709	266	504	1,479
	% of Total MC+ Transfers:	47.94%	17.99%	34.08%	100.00%
June					
	# of Transfers:	964	350	503	1,817
	% of Total MC+ Transfers:	53.05%	19.26%	27.68%	100.00%
Total Transfer TO:		9463	4378	6311	20152

This summary information is from the monthly report, Transfers Between Health Plans.
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Source: IFOX Revised: 10/08/09

Attachment 12

MO HealthNet For Kids (Title XXI) TRANSFERS BETWEEN HEALTH PLANS
ALL MC+ REGIONS STATEWIDE
STATE FISCAL YEAR 2009 (1 JULY 2008 - 30 JUNE 2009)

		Eastern Region	Central Region	Western Region	Total
July					
	# of Transfers:	173	93	104	370
	% of Total MC+ Transfers:	46.76%	25.14%	28.11%	100.00%
August					
	# of Transfers:	122	72	84	278
	% of Total MC+ Transfers:	43.88%	25.90%	30.22%	100.00%
September					
	# of Transfers:	159	82	138	379
	% of Total MC+ Transfers:	41.95%	21.64%	36.41%	100.00%
October					
	# of Transfers:	174	89	138	401
	% of Total MC+ Transfers:	43.39%	22.19%	34.41%	100.00%
November					
	# of Transfers:	175	99	132	406
	% of Total MC+ Transfers:	43.10%	24.38%	32.51%	100.00%
December					
	# of Transfers:	208	137	153	498
	% of Total MC+ Transfers:	41.77%	27.51%	30.72%	100.00%
January					
	# of Transfers:	180	117	122	419
	% of Total MC+ Transfers:	42.96%	27.92%	29.12%	100.00%
February					
	# of Transfers:	178	186	208	572
	% of Total MC+ Transfers:	31.12%	32.52%	36.36%	100.00%
March					
	# of Transfers:	212	107	169	488
	% of Total MC+ Transfers:	43.44%	21.93%	34.63%	100.00%
April					
	# of Transfers:	271	150	184	605
	% of Total MC+ Transfers:	44.79%	24.79%	30.41%	100.00%
May					
	# of Transfers:	204	62	144	410
	% of Total MC+ Transfers:	49.76%	15.12%	35.12%	100.00%
June					
	# of Transfers:	220	89	130	439
	% of Total MC+ Transfers:	50.11%	20.27%	29.61%	100.00%
Total Transfer TO:		2,276	1,283	1,706	5,265

This summary information is from the monthly report, Transfers Between Health Plans.
Source: IFOX
Revised: 10/08/09
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Attachment 13

BLUE ADVANTAGE PLUS ER PILOT PROJECT

Blue-Advantage Plus (BA+) has seen a continual increase in high emergency room (ER) utilization rates and high paid claims amount over the past three years. The 2008 utilization rates increased by 21% and paid claims amount increased by 10% in comparison to 2006. As of 2009 YTD, the utilization rates and the paid claims amount have surpassed 2006 results. The table below provides the ER utilization statistics for 2006, 2007, 2008, and 2009 YTD.

	CY2006	CY2007	CY2008	CY 09 (YTD)
Number of ER visits	20,450	21,568	24,804	20,913
Average Visits Per Member	1.8	1.8	1.9	1.8
Paid Claims Amount	$8,123,845	$8,044,334	$8,970,327	8,564,670
Average Cost Per Visit	$397.25	$372.97	$361.65	$409.53
Claims Per 1000	746.5	818.6	1219.7	969.6

Based on research conducted in early 2006 and the upward trend in ER utilization, BA+ initiated the BA+ ER Pilot Project in 2007. An ER team was developed and a list of "assumptions" was developed about why BA+ members visited the ER instead of urgent care or their PCPs' offices. By proving or disproving these assumptions, BA+ was able to identify specific and actionable opportunities to address barriers that were keeping members from receiving care in the appropriate setting. Assumptions and findings associated with barriers to appropriate ER utilization are as follows. BA+ members are going to the ER for non-acute diagnosis code reasons.

- Of the Emergency Service Medical Cost Subcategory, the highest
- utilization and claims is generated from the 1 to 6 year old and 21-44 year
- old female age band.
- Members do not know the details of the transportation benefit.
- Members were not aware of the 24/7 Nurse Advice Line.
- The Nurse Advice Line staff was not referring members to Urgent Care
- Centers.

Based on the assumptions and findings mentioned above, BA+ has implemented several interventions to aid in reducing ER utilization by 10%. Below is a list of the top five non-emergent reasons an ER visit is generated.

Top 5 non-emergent reasons for ER visits

CY2008		
Diagnosis	Number of Visits	Paid Amount
Unspecified Otitis Media	1,370	$320,211
Fever and other physiologic disturbances of temperature	1,017	$440,582
Acute Upper Respiratory Infection of Unspecified Site	880	$196.125
Acute Pharyngitis	676	$160,180
Vomiting Alone	424	$175,861
Total	4,367	$1,292,959

2009 (YTD)		
Diagnosis	Number of Visits	Paid Amount
Unspecified Otitis Media	924	$231,203
Acute Upper Respiratory Infection of	755	$190,483
Fever presenting w/ conditions classified elsewhere	655	$344,666
Fever, unspecified	569	$236,610
Acute Pharyngitis	520	$138,778
Total	3,423	$1,141,740

Interventions implemented include:
1. Case Management Intervention (2008 and ongoing): A BA+ case manager makes outbound calls to members receiving non-emergent care or for whom follow-up care can and should be provided by PCPs. The case manager reviews a weekly report that identifies members who went to the ER for non-emergent reasons and/or when a different setting could have provided treatment.

2008
In 2008, 115 outreach calls were made to the parent or guardian of 0-6 year old members. The case manager conducted a biopsychosocial assessment of the member, and offered education to the members' parents on alternative treatment settings. The case manager further encouraged the parent to make contact with the member's PCP. Twelve months prior to the initiation of this outbound call intervention, the 115 targeted members had 280 visits to the ER (costs totaling $70,356), for an average of 2.4 visits per member. 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). Out of the 115 members, 46% (53 members) did not go back to the ER within 9 months after they were educated and 54% (62 members) did return to the ER. Of the 62 member who returned to the ER after they were educated, 136 (181 annualized) visits were generated, for a post intervention average of 1.2 (1.6 annualized) visits per member. The total cost of these visits was $36,660 ($48,758 annualized), a 31% reduction. Of these, 109 (145 annualized) were for non-emergent reasons 27 (36 annualized) were for emergent reasons. The

total cost for the non-emergent visits was $27,542 ($36,631 annualized) and the total cost for the emergent visits was $9,118 ($12,127 annualized). The following table provides a breakdown of the results.

Before Case Management Intervention

115 0-6 year old BA+ members	No additional ER Visits	Repeat ER Visits	# ER visits	% of Total	Cost	Average Cost/Visit
# members		115				
Emergent	8	30	38	15%	$16,136	$424
Non-emergent	75	163	238	85%	$54,220	$228
Total Visits	83	193	276	100%	$70,356	$255

After Case Management Intervention

115 0-6 year old BA+ members	No additional ER Visits	Repeat ER Visits	# ER visits	% of Total	Cost*	Average Cost/Visit*
# members	53	62				
Emergent	0	27	27 (36)	20%	$9,118 ($12,127)	$338 ($337)
Non-emergent	0	109	109 (145)	80%	$27,542 ($36,631)	$253($252)
Total Visits	0	136	136 (181)	100%	$36,660 ($48,758)	$270($271)

*Results in parenthesis indicate annualized results

This intervention has a positive impact on reducing ER visits for non-emergent reasons, from 85% of total ER visits to 80% of total ER visits, and appeared from these results to be effective in reducing the ER utilization rate from 2.4 visits per member to 1.2(1.6 annualized) visits per member. In addition, this intervention has resulted in a projected net decrease in ER total costs of $21,598/year for the 115 members impacted by the outreach intervention.

Due to the positive impact of the case management outreach intervention, BA+ has expanded the target population for the outbound call program to add members age 6 or older who have visited the ER for non-emergent conditions and/or should seek follow-up care from their PCP.

1Q09

During 1Q09, 30 BA+ members received case management outreach. Prior to the outreach intervention, the 30 targeted members had a total of 71 ER visits (cost totaling $15,726), for an average of 2.4 visits per member. Ninety percent of the visits (64 visits) were for nonemergent cases (costing $13,401), while the remaining 10% (7 visits) were for emergent cases (costing $2,324). Six months after intervention date, there was a total of 17 (34 annualized) revisits to the ER. The total cost for these visits was $9,386 ($18,772 annualized). Fifteen (30 annualized) visits were for non-emergent reasons and two (4 annualized) visits were for emergent reasons. Total cost for the non-emergent visits was $8,766 ($17,532 annualized). One member generated a $5,206 non-emergent claim which accounted for 59% of the total nonemergent cost. The total cost for the emergent visits was $619 ($1,238 annualized).

Before Case Management Intervention

30 BA+ Members (1Q09)	No additional ER Visits	Repeat ER Visits	# ER visits	% of Total	Cost	Average Cost/Visit
# members		30				
Emergent	6	1	7	10%	$2324	$332
Non-emergent	41	23	64	90%	$13,401	$209
Total Visits	47	24	71	100%	$15,725	$225

After Case Management Intervention

30 BA+ Members (1Q09)	No additional ER Visits	Repeat ER Visits	# ER visits	% of Total	Cost*	Average* Cost/Visit
# members	16	14				
Emergent	0	2	2(4)	12%	$619 ($1,238)	$310 ($309)
Non-emergent	0	15	15 (30)	88%	$8,766 ($17,532)	$584 ($584)
Total Visits	0	17	17 (34)	100%	$9,385 ($18,770)	$552 ($552)

*Results in parenthesis indicate annualized results

This intervention has a positive impact on reducing ER visits for non-emergent reasons, from 90% of total ER visits to 88% of total ER visits, and appeared from these early results to be effective in reducing the ER utilization rate from 2.4 visits per member to 0.6(1.2 annualized) visits per member.

2Q09

During 2Q09, 27 BA+ members received case management outreach. Prior to the intervention, the 27 targeted members had a total of 66 ER visits (cost totaling $22,984), for an average of 2.4 visits per member. Ninety-four percent of the visits (62 visits) were for non-emergent cases (costing $21,935), while the remaining 6% (4 visits) were for emergent cases (costing $1,050).

Three months after intervention date, there has been a total of eight (32 annualized) revisits to the ER. The total cost for these visits was $2,103 ($8,412 annualized). All eight (32 annualized) visits were for non-emergent reasons.

Before Case Management Intervention

27 BA+ Members (2Q09)	No additional ER Visits	Repeat ER Visits	# ER visits	% of Total	Cost	Average Cost/Visit
# members		27				
Emergent	2	2	4	6%	$1,050	$263
Non-emergent	44	18	62	94%	$21,935	$354
Total Visits	47	24	66	100%	$22,985	$348

After Case Management Intervention

27 BA+ Members (2Q09)	No additional ER Visits	Repeat ER Visits	# ER visits	% of Total	Cost*	Average Cost/Visit*
# members	21	6				
Emergent	0	0	0	N/A	$0	$0
Non-emergent	0	8	8 (32)	100%	$2,103 ($8,412)	$263 ($263)
Total Visits	0	8	8 (32)	100%	$2,103 ($8,412)	$263 ($263)

*Results in parenthesis indicate annualized results

Early results indicates the case management outreach intervention is effective in reducing the ER utilization rate from 2.4 visits per member to 0.3(1.2 annualized) visits per member. The projected savings for this intervention is $14,573/year for these 21 members.

2. Self-Care Guide (2009 and ongoing): BCBSKC nurse case managers continue to conduct outreach calls to members who visit the ER for non-emergent conditions. In addition, members are offered Self-Care Guides to provide guidance on when to seek PCP care or ER care. If members accept the offer of a Self-Care Guide, nurse case managers will provide education on how to use the Guides. In addition to receiving the Self-Care Guide, a survey was developed for BA+ members to complete and provide feedback on the Self-Care Guide in regards to whether or not the Self-Care Guide was useful.

1Q09
In 1Q09, out of the 30 members that received case management, only five members wanted a copy of the Self-Care Guide. Prior to the intervention, the five members receiving a Self- Care Guide had a total of 12 ER visits (cost totaling $2,632), for an average of 2.4 visits per member. All of the visits were non-emergent cases.

Out of the five members, 40% (2 members) have not returned to the ER and 60% (3 members) have returned to the ER. Of the three members that have returned to the ER, five (10 annualized) visits were generated. The total cost of the visits was $1,361 ($2,722 annualized). Four (8 annualized) visits were non-emergent cases and one (2 annualized) was an emergent case. The total cost for the non-emergent visits was $875 ($1,750 annualized) and the total cost for the emergent case was $486 ($972 annualized).

Before Care Management Intervention

5 BA+ members	No additional ER Visits	Repeat ER Visits	# ER visits	% of Total	Cost	Average Cost/Visit
# members		5				
Emergent	0	0	0	0%	$0	$0
Non-emergent	5	7	12	100%	$2,632	$219
Total Visits	5	7	12	100%	$2,632	$219

After Care Management Intervention

5 BA+ members	No additional ER Visits	Repeat ER Visits	# ER visits	% of Total	Cost*	Average Cost/Visit*
# members	2	3				
Emergent	0	1	1 (2)	20%	$486 ($972)	$486 ($486)
Non-emergent	0	4	4 (8)	80%	$875 ($1,750)	$218 ($218)
Total Visits	0	5	5 (10)	100%	$1,361 ($2,722)	$272 ($272)

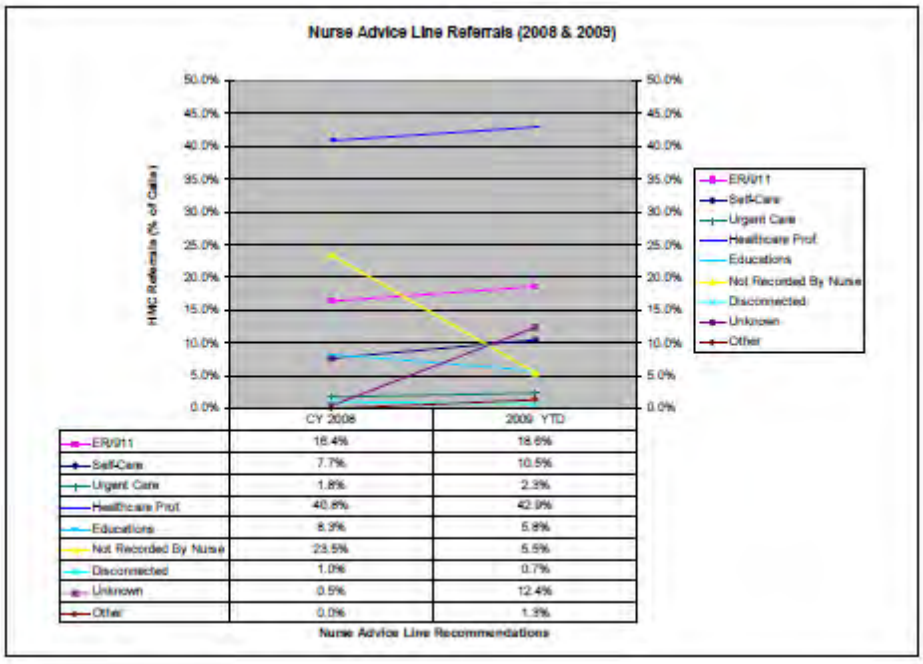
*Results in parenthesis indicate annualized results

The Self-Care Guide intervention along with the case management outreach efforts has a positive impact on reducing ER visits for non-emergent reasons, from 100% to 80%, and appeared from these results to be effective in reducing the ER utilization rate from 2.4 visits per member to 1.0 (2.0 annualized) visits per member.

During 2Q09, the nurse case management staff reported that many members declined the offer of receiving a Self-Care Guide. After changing the approach from just simply offering the Self-Care Guide to explaining the importance of the Guide and how useful the Guide can be; 3Q09 results show 26 BA+ members agreed to the offer of a Self-Care Guide. Preliminary data analysis will be reported at the end of 4Q09.

3. Nurse Advice Line (2008 and ongoing): BA+ contracts with Health Management Corporation (HMC) for 24/7 telephonic nurse advice line services. In 2008, BA+ recognized from detailed reports provided by HMC that no referrals were being made to the urgent care centers in the BA+ network. It was found that this was due to an error in BA+ network data provided to HMC and the fact that HMC did not have urgent center referrals built into their decision algorithm for handling patient referrals. HMC redesigned their decision algorithm, updated their provider network data for BA+, and in April 2008, conducted 130 hours of training to the nurse advice line staff about the urgent care center options for treatment. Subsequent reports show increases in the number of referrals of BA+ members to urgent care centers by the nurse advice line staff, increasing the likelihood of the appropriateness of the referrals to the appropriate setting.

The following graph displays the trend of the referrals made by the Nurse Advice Line Staff. In comparison to 2008, the referrals to Urgent Care Centers and PCPs have increased in 2009.



PCP referrals accounted for 42.9% of total referrals made in 2009, an increase of 2.1% in comparison to 2008. Referrals to the Urgent Care Centers accounted for 2.3% of total referrals made by the Nurse Advice Line, a 0.5% increase in comparison to 2008.

4. Well Aware (2008 and ongoing): The BA+ 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 BA+ member households each quarter.

In the Fall 2009 Well Aware, BA+ will include articles on the top 5 non-emergent ER diagnosis mentioned above. These articles will focus on symptoms and action steps to take in regards to care.

5. Urgent Care Centers (2008 and ongoing): In 2008, BA+ 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).

6. BA+ Magnet Mailer (2009 and ongoing): A flyer educating the member on appropriate settings for care, promoting the use of urgent care centers, explaining transport 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 Blue-Advantage Plus – Annual Appraisal of the QI Program – Program Year SFY2009 96 non-emergent reason, a

follow-up letter will be mailed to the member reminding them of urgent care centers, the Nurse Advice Line, and the transportation benefit.

To date, 1,682 members have received a BA+ Magnet Mailer. Of the 1,682 members, 587 members have returned to the ER.

Further detailed analysis is underway at the time of this report.

7. PCP Collaborative (2008 and Ongoing): In 2008, BA+ 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, BA+ 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, BA+ was unable to engage any high volume PCP offices for collaborative outreach efforts.

In 2009, BA+ has taken a different approach in collaborating with PCPs to provide outreach to their members who utilize the ER inappropriately. BA+ identified 5 - 10 who belong to a high volume PCP group and utilize the ER excessively for non-emergent reasons. All inhouse interventions are provided to the members identified. Once all in-house interventions have been provided to members, if the members continue to utilize the ER for non-emergent reasons, the BCBSKC Director, Provider Relations will present information to the high volume PCP group to determine if the PCP group will be able to collaborate and provide outreach.

BA+ identified nine members belonging to a specific high volume PCP group that were utilizing the ER excessively for inappropriate reasons during 1Q09. To date, one member has termed with BA+ after receiving the Magnet Mailer Intervention and the Follow-up Letter Intervention. The remaining members have all received the BA+ Magnet intervention and the follow-up letter intervention. Five members have received the case management/Self- Care Guide intervention. Results of the intervention are indicated in the table below.

Member	# Non-Emergent ER visits Prior to Intervention (1Q09)	Paid Amount (1Q09)	# Non-Emergent ER visits After Intervention (2Q09 & 3Q09)	Paid Amount After Intervention (2Q09 & 3Q09)	BA+ Magnet Mailer Intervention	Follow-Up Intervention	Case Management/ Self-Care Guide Outreach
1	6	$2,676	18	$9549	☑	☑	☑
2	7	$4,400	4	$1178	☑	☑	
3	11	$1,487	13	$3078	☑	☑	☑
4	4	$606	2	$323	☑	☑	Member Termed
5	6	$2,583	3	$1,177	☑	☑	
6	5	$3,109	3	$876	☑	☑	☑
7	6	$3,166	8	$3,178	☑	☑	
8	4	$2,357	15	$5623	☑	☑	☑
9	9	$8,694	14	$7946	☑	☑	☑

BA+ has continued to see an increase in non-emergent visits amongst the members identified in this PCP Collaborative intervention. Due to the increase in non-emergent visits, BA+ will move forward with completion of all in-house interventions and referral process to the members' PCP for possible intervention.

• Members 1, 3, 6, 8, and 9 will be referred to the BCBSKC Director, Provider Relations for PCP outreach.

• Members 2, 5, and 7 were referred to Case Management and further analysis will be conducted at the end of 4Q09 to determine if non-emergent visits to the ER continue increase. If the ER utilization continues to increase for members 2, 5, and 7, they will be referred to the Director, Provider Relations for PCP outreach.

Next Steps

1. BA+ will continue all interventions mentioned above.

2. Additional Nurse Case Managers have been hired and they will be able to reach more members and help provide more case management outreach to the entire BA+ population.

3. The 2008 Case Management Outreach intervention has proven to be successful. For the 115 members involved in the 2008 case management intervention, ER utilization decreased by 30%. BA+ will continue the case management outreach efforts as results have proven this intervention to be successful.

Quality Improvement Work Plan - 2009 - Blue-Advantage Plus

Activity and ID Type		Activity Name	Frequency	Vendor	Responsible Person	Primary Oversight Committee	Primary Target Date	Primary Completion Date	Final Review Committee	Final Target Date	Final Complete Date
Approve	3377	Patient Safety Work Plan	Annually		Banks, Cheryl	QC	1/5/2009	2/2/2009			
Update	1576	Patient Safety Initiatives Update	Annually		Banks, Cheryl	QC	1/5/2009	2/2/2009			
Report	3757	Accessibility of Utilization Management Services	Semi-Annually		Banks, Cheryl	M4	1/15/2009				
Analysis	1606	Analysis of Complaints of Quality of Care	Annually		Sitzmann, Bryan	QC	2/2/2009	3/2/2009			
Analysis	1668	Annual Adverse Quality of Care Summary	Annually		Sitzmann, Bryan	QC	2/2/2009	3/2/2009			
Analysis	3552	Screening Member Complaints to Identify Potential Office Site Deficiencies (Jul - Dec)	Semi-Annually		Sitzmann, Bryan	QC	2/2/2009	3/2/2009			
Monitor	586	Medical Director Interrater Reliability -- Medical Management Department	Annually		Sitzmann, Bryan	PRC	2/4/2009				
Report	3566	Semi-annual Appeals Timeliness Report for PRS Jul-Dec	Quarterly	PRS	Banks, Cheryl	DOC	2/8/2009	4/3/2009			
Work Plan	3484	Medical and Pharmacy Management Committee Work Plan (Pharmacy and Medical Aspects)	Annually		Neff, Owen	MPMC	2/15/2009	1/21/2009	QC/M	3/4/2009	3/2/2009
Report	3501	Quality and Accreditation Quarterly Report	Quarterly		Bowen, Shelley	SC	2/15/2009				
Report	3581	Corporate Security Annual Overview Report	Annually		McKelvy, Norma	ADMIN	2/17/2009				
Report	3580	Corporate Data Integrity and Information Access Annual Report	Annually		Taylor, Darren	ADMIN	2/17/2009				
Report	3579	Corporate Privacy Annual Overview Report	Annually		McKelvy, Norma	ADMIN	2/17/2009				

Activity and ID Type		Activity Name	Frequency	Vendor	Responsible Person	Primary Oversight Committee	Primary Target Date	Primary Completion Date	Final Review Committee	Final Target Date	Final Complete Date
Update	1144	Preventive Health Programs for Behavioral Health - Review (Educational Materials)	Annually	NDBH	Chaput, Suzanne	HBC	2/26/2009	2/26/2009			
Update	3650	A Healthier You - Annual Update	Annually		Hochart, Cindy	QC	3/2/2009	5/4/2009			
Analysis	1669	Annual Sentinel Events Summary Report	Annually		Sitzmann, Bryan	QC	3/2/2009	3/2/2009			
Approve	3376	BCBSKC Annual Appraisal of the Quality Improvement Program	Annually		Bowen, Shelley	QC	3/2/2009	3/30/2009	BOD	5/15/2009	
Analysis	84	MTM Survey Performance Measures Report (Claims, Customer Service, Membership)	Quarterly		Bibler, Mary	QC	3/2/2009	3/2/2009			
Approve	55	BCBSKC Quality Improvement Program Work Plan	Annually		Bowen, Shelley	QC	3/2/2009	3/30/2009	BOD	5/15/2009	
Approve	53	Quality Improvement System Description	Annually		Bowen, Shelley	QC	3/2/2009	3/2/2009	BOD	5/15/2009	
Approve	2888	Medical Management Program Description -- Evaluation and Approval	Annually		Wederquist, Sandy	ADMIN	3/3/2009				
Training	1573	Showcase of Quality	Annually		Bowen, Shelley	SC	4/1/2009				
Monitoring	3696	URAC Monitoring Program - CEO Attestation	Annually		Bardwell, Judy	ADMIN	4/1/2009	7/17/2009			
Approve	3526	Continuity and Coordination of Care Work Plan	Annually		Banks, Cheryl	M4	4/6/2009				
Report	3745	Credentialling Quality Improvement Projects	Annually		James, Kathy	QC	4/6/2009	4/6/2009			
Update	1470	Update Contract Amendment UM template	Annually	All	Banks, Cheryl	DOC	4/12/2009	9/30/2009			
Update	3190	Update Contract Amendment CM template	Annually	NDBH	Banks, Cheryl	DOC	4/12/2009	9/30/2009			

Activity and ID Type		Activity Name	Frequency	Vendor	Responsible Person	Primary Oversight Committee	Primary Target Date	Primary Completion Date	Final Review Committee	Final Target Date	Final Complete Date
Update	1472	Update Contract Amendment Claims template	Annually	All	Turner, Maryann	DOC	4/12/2009	9/30/2009			
Update	3223	Update Contract Amendment QI template	Annually	All	Bowen, Shelley	DOC	4/12/2009				
Update	1469	Update Contract Amendment Credentialing template	Annually	All	James, Kathy	DOC	4/12/2009	9/30/2009			
Approve	1473	Annual Review of Corporate Policy VI-12 Delegation Performance Assessment and Oversight	Annually		Bowen, Shelley	DOC	4/12/2009	11/1/2009			
Update	3722	Care Connection Advisory Committee Conflict of Interest and Confidentiality Statements	Annually		Hochart, Cindy	CCAC	4/15/2009				
Approve	549	Milliman Care Guidelines - Annual Review and Approval of Prior Auth and Concurrent Review	Annually		Williamson, Blake	MPMC	4/18/2009		QC/M	6/15/2009	
Work Plan	917	Medical Policy Committee Work Plan	Annually		Sitzmann, Bryan	MPC	4/28/2009		QC/M	6/15/2009	
Update	1080	BCBSKC Board of Directors Conflict of Interest and Confidentiality Statements	Annually		O'Connor, Sharon	BOD	5/12/2009				
Approve	891	Clinical Guidelines for COPD - Review and Revise as needed	Biennially		Wadman, Wes	CCAC	5/15/2009				
Report	3502	Quality and Accreditation Quarterly Report	Quarterly		Bowen, Shelley	SC	5/15/2009				
Approve	890	Clinical Guidelines for Asthma Management - Review and Revise as needed	Biennially		Wadman, Wes	CCAC	5/15/2009				
Approve	3453	Cllinical Guidelines for Management of Depression for the Primary Care Physician (PCP)	Biennially		Wadman, Wes	CCAC	5/15/2009				
Approve	893	Clinical Guidelines for Evaluation and Management of Diabetes - Review and Revise as needed	Biennially		Wadman, Wes	CCAC	5/15/2009				
Analysis	868	Case Management Customer Satisfaction Survey	Annually		Wederquist, Sandy	QC	6/1/2009	9/14/2009			

Activity and ID Type		Activity Name	Frequency	Vendor	Responsible Person	Primary Oversight Committee	Primary Target Date	Primary Completion Date	Final Review Committee	Final Target Date	Final Complete Date
Communi	859	Review and Revision of Provider Office Guide	Semi-Annually		Burns, Brian	QC	6/1/2009	6/29/2009			
Analysis	3252	Brand Strength Measure MTM Survey	Annually		Parrish, Susan	QC	6/1/2009	6/29/2009			
Audit	1646	Complaints and Grievances Oversight Audit - NDBH	Annually	NDBH	Fahlstrom, Sherilyn	DOC	6/11/2009				
Report	3638	NDBH Telephone Access	Semi-Annually	NDBH	McFall, Paula	ND DOC	6/19/2009	6/16/2009			
Monitor	3216	Member Communications	Annually	NDBH	Smith, Garth	ND DOC	6/19/2009	6/19/2009			
Report	1592	NDBH Annual QI Report - Annual Appraisal, System Description and Work Plan	Annually	NDBH	Chaput, Suzanne	ND DOC	6/19/2009	6/16/2009			
Report	3569	Suicide Statistics Annual Report	Annually	NDBH	Chaput, Suzanne	ND DOC	6/19/2009	6/16/2009	QC/M	8/4/2009	8/3/2009
Monitor	1138	Appeals of NDBH UM Determinations (Regular semi-annually Report)	Semi-Annually	NDBH	McFall, Paula	ND DOC	6/19/2009	6/16/2009			
Update	3177	Health and Behavior Committee Update	Semi-Annually	NDBH	Bardwell, Judy	ND DOC	6/19/2009	6/16/2009	QC/M	8/4/2009	8/3/2009
Monitor	1132	Utilization Trend Reports from NDBH (Semi-annual Report)	Semi-Annually	NDBH	Woodring, Lisa	ND DOC	6/19/2009	6/16/2009			
Monitor	1125	Complaints & Grievances (NDBH Regular Semi-annual Reporting)	Semi-Annually	NDBH	Chaput, Suzanne	ND DOC	6/19/2009	6/16/2009			
Update	3445	Cultural Competency Activities Update	Annually	NDBH	Smith, Garth	ND DOC	6/19/2009	6/16/2009			
Monitor	1129	Denials and Overturned Denials (Regular semi-annual Reporting)	Semi-Annually	NDBH	McFall, Paula	ND DOC	6/19/2009	6/16/2009			
Update	3364	Conflict of Interest and Confidentiality Statements - Practice Manager's Advisory Committee	Annually		Burns, Brian	PMAC	6/28/2009				

Activity and ID Type		Activity Name	Frequency	Vendor	Responsible Person	Primary Oversight Committee	Primary Target Date	Primary Completion Date	Final Review Committee	Final Target Date	Final Complete Date
Update	3363	Conflict of Interest and Confidentiality Statements - Obstetric Advisory Committee	Annually		Williamson, Blake	OBAC	6/28/2009				
Approve	3610	Annual Review of P&P for Clinical Guideline Development and Revision	Annually		Wadman, Wes	CCAC	7/9/2009				
Report	3764	Accessibility of Utilization Management Services	Semi-Annually		Banks, Cheryl	M4	7/15/2009				
Update	1603	Conflict of Interest and Confidentiality Statements for the RAC	Annually		Williamson, Blake	RAC	7/28/2009				
Analysis	3551	Screening Member Complaints to Identify Potential Office Site Deficiencies (Jan - Jun)	Semi-Annually		Sitzmann, Bryan	QC	8/3/2009	9/14/2009			
Report	3637	Approval of NDBH Annual Quality Improvement Appraisal, System Description and Work Plan	Annually	NDBH	Bowen, Shelley	QC	8/3/2009	6/29/2009			
Analysis	3703	Hospital Quality Initiatives Analysis	Annually		Cure, Chad	QC	8/3/2009	9/14/2009			
Report	3665	Annual Doral UM Audit	Annually	Doral	Nickles, Gwen	DOC	8/9/2009				
Report	3567	Semi-Annual Appeals Timeliness Report for PRS-	Semi-Annual	PRS	Banks, Cheryl	DOC	8/9/2009	9/30/2009			
Audit	9	Annual Evaluation of Quality Improvement System for NDBH	Annually	NDBH	Bowen, Shelley	DOC	8/13/2009	9/30/2009			
Analysis	3500	Hospital Quality Initiatives Analysis	Annually		Bowen, Shelley	HPQC	8/15/2009				
Report	3503	Quality and Accreditation Quarterly Report	Quarterly		Bowen, Shelley	SC	8/15/2009				
Approve	1142	Approval of SOP for Continuity and Coordination of Care (Collaboration between NDBH and BCBSKC)	Annually	NDBH	Bardwell, Judy	HBC	8/27/2009	8/27/2009			
Update	1079	Medical Advisory Committee Conflict of Interest and Confidentiality Statements	Annually		Williamson, Blake	MAC	8/28/2009				

Activity and ID Type		Activity Name	Frequency	Vendor	Responsible Person	Primary Oversight Committee	Primary Target Date	Primary Completion Date	Final Review Committee	Final Target Date	Final Complete Date
Upate	3464	Emergency Room Advisory Committee - Conflict of Interest and Confidentiality Statements	Annually		Williamson, Blake	ERAC	8/30/2009				
Analysis	3511	MTM Survey Performance Measures Report (Claims, Customer Service, Membership)	Quarterly		Bibler, Mary	QC	9/14/2009				
Update	1075	Peer Review Committee Conflict of Interest and Confidentiality Statements	Annually		Sitzmann, Bryan	PRC	9/15/2009				
Approve	892	KCQC Clinical Guidelines for Management of Hyperlipidemia - CAD Risk Modification - Review and Revise as needed	Biennially		Wadman, Wes	CCAC	9/15/2009				
Update	3365	Corporate Credentials Committee - Conflict of Interest and Confidentiality Statements	Annually		Britton, Loretta	CCC	9/21/2009				
Update	3823	Case Finding Workgroup	Monthly	NDBH	Wadman, Wes	HBC	9/24/2009				
Update	3672	Review and update audit tools for Pharmacy Patient Safety	Annually	Argus	Neff, Owen	DOC	10/11/2009				
Update	3664	Review and update audit tools for case management (new NCQA, URAC, CMS standards).	Annually	NDBH	Banks, Cheryl	DOC	10/11/2009	9/30/2009			
Approve	3455	Delegated Vendor Communication Grid Review	Annually	All	Bowen, Shelley	DOC	10/11/2009	10/1/2009			
Update	4	Review and update audit tools for utilization management	Annually	All	Nickles, Gwen	DOC	10/11/2009	9/30/2009			
Update	7	Review and update audit tools for claims	Annually	All	Turner, Maryann	DOC	10/11/2009	9/30/2009			
Update	37	Review and update audit tools for member appeals and grievances	Annually	All	Fahlstrom, Sherilyn	DOC	10/11/2009				
Update	1627	Review and update audit tools for Complaints & Grievances	Annually	All	Fahlstrom, Sherilyn	DOC	10/11/2009				
Update	8	Review and update audit tools for credentialing	Annually	All	James, Kathy	DOC	10/11/2009	9/30/2009			

Activity and ID Type		Activity Name	Frequency	Vendor	Responsible Person	Primary Oversight Committee	Primary Target Date	Primary Completion Date	Final Review Committee	Final Target Date	Final Complete Date
Update	3	Review and update Quality Improvement audit tools	Annually	All	Bowen, Shelley	DOC	10/11/2009				
Approve	343	Physician Office Guidelines for Medical Record Documentation Review Standards	Annually		Banks, Cheryl	PRC	10/15/2009				
Update	3359	Medical and Pharmacy Management Committee-COI and Confidentiality Statements	Annually		Neff, Owen	MPMC	10/17/2009				
Update	3824	Case Finding Workgroup	Monthly	NDBH	Wadman, Wes	HBC	10/22/2009				
Upate	3371	Chiropractic Care Committee - Conflict of Interest and Confidentiality Statements	Annually		Williamson, Blake	ChCC	10/30/2009				
Update	3576	Customer Service Satisfaction Survey	Annually		Parrish, Susan	QC	11/2/2009				
Report	3265	Best Practices from Blues Research Roundtable Report	Annually		Parrish, Susan	QC	11/3/2009				
Monitor	87	Compliance With Post-Hospital MI Care Guidelines	Annually		Wadman, Wes	CCAC	11/12/2009				
Audit	3625	Audit to insure members are notified of closed formulary changes.	Annually		Bardwell, Judy	ADMIN	11/15/2009				
Report	3740	Quality and Accreditation Quarterly Report	Quarterly		Bowen, Shelley	SC	11/15/2009				
Approve	889	Clinical Guidelines for Preventive Services for Pediatric Patients and Adult Patients - Review and Revise as needed	Annually		Wadman, Wes	CCAC	11/15/2009				
Update	3674	Corporate New Employee Training for Quality and Accreditation	Annually		Banks, Cheryl	ADMIN	11/15/2009				
Report	3821	Post-Partum Depression Treatment Criteria	Annually	NDBH	Woodring, Lisa	HBC	12/3/2009				
Update	1451	Business Continuity Project	Annually		McKelvy, Norma	QC	12/7/2009				

Activity and ID Type		Activity Name	Frequency	Vendor	Responsible Person	Primary Oversight Committee	Primary Target Date	Primary Completion Date	Final Review Committee	Final Target Date	Final Complete Date
Analysis	3271	Language Line/Cultural Competency Analysis	Annually		Parrish, Susan	QC	12/7/2009				
Communi	3504	Review and Revision of Provider Office Guide	Semi-Annually		Burns, Brian	QC	12/7/2009				
Monitor	1134	Utilization Reports (semi-annual Report)	Semi-Annually	NDBH	Woodring, Lisa	ND DOC	12/11/2009				
Report	3531	NDBH Telephone Access	Semi-Annually	NDBH	McFall, Paula	ND DOC	12/11/2009				
Monitor	1127	Complaints & Grievances (NDBH Regular semi-annual Reporting)	Semi-Annually	NDBH	Chaput, Suzanne	ND DOC	12/11/2009				
Update	3179	Health and Behavior Committee Update	Semi-Annually	NDBH	Bardwell, Judy	ND DOC	12/11/2009		QC/M	2/15/2010	
Monitor	1131	Denials and Overturned Denials (Regular semi-annual Reporting)	Semi-Annually	NDBH	McFall, Paula	ND DOC	12/11/2009				
Monitor	1140	Appeals of NDBH UM Determinations (Regular semi-annually Reporting)	Semi-Annually	NDBH	McFall, Paula	ND DOC	12/11/2009				
Communi	3709	Review of Corporate Policy VII-22 Approval of Benefits Exceptions for Blue-Advantage Plus of KC, Inc.	Annually	NDBH	Bowen, Shelley	DOC	12/13/2009				
Update	3732	Key IAD Outcomes & Objectives	Annually		Taylor, Darren	ADMIN	12/15/2009				
Work Plan	1358	Medical Advisory Committee Work Plan (MAC)	Semi-Annually		Williamson, Blake	MAC	12/28/2009		QC/M	2/15/2010	
Approve	888	Clinical Guidelines for the Health Management of Pregnant Women - Review and Revise as needed	Biennially		Wadman, Wes	CCAC	5/15/2010				
Approve	895	Clinical Guidelines for Evaluation and Management of Chronic Heart Failure in the Adult - Review Guideline	Biennially		Wadman, Wes	CCAC	5/15/2010				
Approve	896	Clinical Guidelines for Hypertension - Management in the Adult (Review & Revise as needed)	Biennially		Wadman, Wes	CCAC	5/15/2010				

Activity and ID Type		Activity Name	Frequency	Vendor	Responsible Person	Primary Oversight Committee	Primary Target Date	Primary Completion Date	Final Review Committee	Final Target Date	Final Complete Date
Approve	3609	Clinical Guideline for Secondary prevention of myocardial infarction (Beta blocker after acute MI) - Review and revise as needed	Biennially		Wadman, Wes	CCAC	5/15/2010				
Approve	3318	Clinical Guidelines for PCP Management of ADHD - Review and Revise as needed	Biennially	NDBH	Wadman, Wes	CCAC	5/15/2010				
Approve	3451	Clinical Guideline for Post Acute MI Management - Review and revise as needed	Biennially		Wadman, Wes	CCAC	5/15/2010				
Approve	3452	Clinical Guideline for Management of Anticoagulant Therapy for Non-Valvular Atrial Fibrillation	Biennially		Wadman, Wes	CCAC	5/15/2010				
Monitor	52	Vendor Delegation Assessment Survey	Biennially	All	Bowen, Shelley	DOC	6/11/2010				
Update	3400	Review/Revise Vendor Application Forms for Delegated Activities	Annually	All	Bowen, Shelley	DOC	6/14/2010				
Approve	3635	Clinical Guidelines for ADHD for Behavioral Health Practitioners - Review and Revise as needed	Biennially	NDBH	Wadman, Wes	CCAC	7/15/2010				
Approve	1143	Clinical Guidelines for Depression for Behavioral Health Practitioners - Review and Revise as needed	Biennially	NDBH	Wadman, Wes	CCAC	7/15/2010				
Report	3630	URAC Accreditation Application Submission - HUM, PCRED, CM	Triennially		Bardwell, Judy	ADMIN	9/30/2010				

Attachment 15

CMFHP 2010 Work Plan

GOAL	ACTIONS
Health Services/General	
NCQA	Submit NCQA Accreditation Application
NCQA	Submit evidence of NCQA Accreditation Application to the state
NCQA	Policy Review
NCQA	Review meeting processes
NCQA	Monitor HEDIS scoring
NCQA	Review of all vendor contracts for NCQA compliance
NCQA	Amend vendor contracts as necessary for NCQA compliance
NCQA	Status update to the state with projected date for on-site review
NCQA	Facilitate statewide NCQA steering committee meetings
Utilization Management	
NCQA Standards Training for UM	Training of UM staff on standards
	Review and update UM program description to meet NCQA requirements
Review of NOA letters	Review and update all Notice of Action letters to meet NCQA requirements
Clinical Criteria Review	Review and make available via website to Providers
Inter-Rater Reliability Audit Tool	Implement formalized inter-rater reliability tool for UM nurses
Timelines audit tool	Develop and implement semi-annual audit of authorizations for monitoring timelines
Precert Manual	Annual review and update of Precert Manual
Clinical Services	
NCQA CM/UM Standard Training for Care Management Staff	Present overview of CM/UM standards to Care Management Staff

Attachment 15

CMFHP 2010 Work Plan

GOAL	ACTIONS
Care Management Re-training Specific to NCQA Standards	Develop Care Management re-training module and instruct staff
Revise Documentation Guidelines Specific to NCQA requirements	Revise documentation opportunities in CARE specific to NCQA requirements
	Test new revisions in CARE
	Implement Version 3.0 and train staff
Identify and Implement Evidenced Based Criteria for Complex Care Management	Research and select criteria set
	Investigate integration opportunities with CARE
	Train staff on use of criteria and documentation requirements
	Audit documentation of criteria use
Revisions to Care Management Assessments to Meet NCQA Standards	Update CM assessments to support documentation of NCQA requirements (cultural and linguistic needs, benefits, life planning, etc)
	Address barriers, self-management, ADL's, short/long term goals, compliance, caregiver resources, etc)
	Train staff on new documentation requirements including but not limited to development of short and long term goals focused on disease specific clinical outcomes
Implement Satisfaction Survey for Care Management	Write survey tool
	Implement survey process

Attachment 15

CMFHP 2010 Work Plan

GOAL	ACTIONS
	Evaluate results
Evaluate Care Management Audit Tool and Process	Revise documentation tools and process to ensure compliance with NCQA standards
Health Literacy Program	Evaluate extension of program to other target populations
ER Telephonic Program	Identify opportunities to add additional hospitals to the ER telephonic program
Health Improvement	
Develop plan for improving spirometry screening rates	Conduct literature review for programs to increase spirometry rates
	Survey PCP offices to identify barriers to spirometry
	Develop interventions to impact the rate of spirometry testing
Investigate barriers to diagnosing obesity in PCP offices	Meet with other health Medicaid Health Plans to identify issues with billing and claims.
	Survey PCP offices to identify barriers to using diagnosis code
	Develop interventions to overcome barriers to diagnosing obesity
Develop Depression DM Program	Develop DM registry criteria for Depression Program.
	Coordinate with Behavioral Health contractor to develop interventions and screening process for care management
	Develop member education materials
	Develop Clinical Practice Guidelines and physician education
Develop Diabetes Program	Develop DM registry criteria for Diabetes Program.
	Coordinate with care management to develop interventions and screening process for care management

Attachment 15

CMFHP 2010 Work Plan

GOAL	ACTIONS
	Develop member education materials
	Develop Clinical Practice Guidelines and physician education
Develop newsletter for adult population	Identify areas of prevention and wellness for adult members
	Coordinate with Community Relations to develop newsletter
	Publish and distribute newsletter twice each year
Integrate additional media for Prevention and Wellness	Investigate new and emerging technologies that would increase communication and education for members
	Develop audience-appropriate education materials on relevant Prevention and Wellness topics
	Coordinate with Community Relations to launch the new communication platform
Quality	

CMFHP 2010 Work Plan

GOAL	ACTIONS
Improve HEDIS rates for identified measures	Coordinate HEDIS processes to assure validity and reliability of outcomes
	Update and improve record reviews to maximize time and quality reviews
	Continue mailings to include: yearly wellness reminders and schedules to members for children, adolescents, women and men; cervical cancer and Chlamydia screening; periodic Teen Newsletters.
	Continue participation in Statewide Dental PIP and health plan dental PIP
	Coordinate and collaborate with behavioral health subcontractor to assess and improve decreased utilization rates for Mental Health Follow Up After Hospitalization
Improve Maternal Health Outcomes identified by DHSS	Outreach to members and providers to increase the rate of prenatal care initiation in the first trimester of pregnancy
	Target OB Education to high volume provider offices to increase the rate of prenatal care initiation in the first trimester of pregnancy and notification to the health plan for assessment and case management services
	Continue targeted OB care management to outreach to high risk pregnant women for improved birth outcomes
	Continued OB care management to all members regarding: community services; WIC services; risks of smoking during pregnancy and risks related to second hand smoke; risks of drug and alcohol use; risks of lead exposure; signs and symptoms of premature labor; primary care providers for mother and infant; anticipated well child visits for infants and children; child birthing classes; behavioral health access and benefits; transportation options; nurse line access; advance directives;

Attachment 15

CMFHP 2010 Work Plan

GOAL	ACTIONS
	Parents as Teachers; and patient safety

CMFHP 2010 Work Plan

GOAL	ACTIONS
	Continued post delivery care and education to all members regarding: family planning; birth spacing; contraception; folic acid supplements prior to next pregnancy; and initiation of early prenatal care for future pregnancies
Improve CAHPS outcomes for Medicaid Child Survey	Assess for changes related to ineligibles in sample
	Coordinate with Provider Relations to encourage providers to improve communication to members
Update QM program for compliance with NCQA	Update QMC processes and documentation to meet NCQA standards
	Update QM Plan to meet NCQA Standards
	Update QI work plan to include NCQA required elements.
	Update QI Annual Evaluation to meet NCQA standards
Update member grievance and appeal processes to meet NCQA standards	Update member grievance and appeal processes to meet NCQA standards
	Update member grievance and appeal letters to meet NCQA standards
	Update Provider and Appeal Policy and processes to meet contract compliance.
	Update provider grievance and appeal letters to meet NCQA standards
Update medical record review processes to include HEDIS hybrid reviews, disease management and medical record	Update medical record review processes to include HEDIS hybrid reviews, disease management and medical record documentation.

CMFHP 2010 Work Plan

GOAL	ACTIONS
documentation.	
	Identify key review elements for DM
	Identify key review elements for medical record documentation
	Identify key review elements for clinical practice guidelines
	Identify key review elements for advance directives
	Assess MedCapture capabilities to add review measures into review database
Monitor for sentinel events	Continue to monitor health plan process for sentinel events
Monitor member grievance and appeal processes	Monitor member appeal processes related to new provider processes
	Monitor member grievances related to transportation for continued improvement
Monitor Provider complaint and appeal processes	Monitor provider complaint and appeal process changes related to new RFP changes.
Customer Relations	
Begin working toward compliance with NCQA CLAS standards	Obtain race/ethnicity data from the state as well as from member contacts to help determine additional population characteristics and health disparities
	Update the Cross Cultural Resource Guide and distribute to providers and advocates
	Translate and record all current audio health programs into Spanish
Compliance	
Develop new mechanisms for detecting fraud and	Fraud and Abuse Committee to discuss and develop quarterly reports

CMFHP 2010 Work Plan

GOAL	ACTIONS
abuse	
Develop process for investigating high volume fraud and abuse referrals from MO HealthNet	Fraud and Abuse Committee to discuss and develop process
Ensure compliance with NCQA delegation oversight standards	Evaluate standards against current process
	Implement changes needed to comply with standards

Harmony Health Plan of Missouri
2009-2010 Work Plan

Attachment 16

Harmony Health Plan: 2010 Work Plan

Quality Metric	Performance Goal or Objective	Responsible Person(s)	HHPI Oversight Committee/Workgroup	Reporting Frequency/ Target Date	Goal Met/ Not Met/ Partially Met	Goal Status - Ongoing/ Closed	Summary / Brief Analysis if goals not met
COMMUNITY OUTREACH AND HEALTH EDUCATION							
Physicals for School Children	TBD	Director, Marketing	Quality Improvement Committee	Quarterly			
Immunizations for School Children	TBD	Director, Marketing	Quality Improvement Committee	Quarterly			
Dental Exams and Cleanings	TBD	Director, Marketing	Quality Improvement Committee	Quarterly			
Hearing Exams	TBD	Director, Marketing	Quality Improvement Committee	Quarterly			
Vision Exams	TBD	Director, Marketing	Quality Improvement Committee	Quarterly			
Glucosse Testing	TBD	Director, Marketing	Quality Improvement Committee	Quarterly			
Fitness Workshops	TBD	Director, Marketing	Quality Improvement Committee	Quarterly			
Health Literature	TBD	Director, Marketing	Quality Improvement Committee	Quarterly			
Health Living Coloring Books	TBD	Director, Marketing	Quality Improvement Committee	Quarterly			
Notebook Paper	TBD	Director, Marketing	Quality Improvement Committee	Quarterly			
Book Bags	TBD	Director, Marketing	Quality Improvement Committee	Quarterly			
Pencil Pouches	TBD	Director, Marketing	Quality Improvement Committee	Quarterly			
Rulers: State and Capitals	TBD	Director, Marketing	Quality Improvement Committee	Quarterly			
HHPI Periodicty Letters	TBD	Director, Marketing	Quality Improvement Committee	Quarterly			
Member Newsletter	Target 2/year	Director, Marketing	Quality Improvement Committee	Quarterly			
PATIENT SAFETY							
Total # of Adverse Incidents (Critical Incidents)	Monitor	Director, Quality Improvement	Quality Improvement Committee	Monthly		Ongoing	
Total Adverse Incidents per 1000	0%	Director, Quality Improvement	Quality Improvement Committee	Monthly		Ongoing	
Total # of QOC Investigated	Monitor	Director, Quality Improvement	Quality Improvement Committee	Monthly		Ongoing	
QOC Rate/1000	0%	Director, Quality Improvement	Quality Improvement Committee	Monthly		Ongoing	
NETWORK ACCESS							
Appointment Access							
PCP Urgent Sick Care	</= 24 hrs	Sr Director Network Development/Customer Support Mgr	Network Quality Review Committee	Annually			
PCP Sick Care	</= 1 week						
PCP Routine Well Care	</= 5 weeks						
Specialist Appt	</= 30 Days					Ongoing	
Network Adequacy							
Practitioners credentialed	Monitor	Network Director	Network Quality Review Committee/Medical Advisory Committee	Monthly		Ongoing	
Practitioners re-credentialed	Monitor	Network Director	Network Quality Review Committee/Medical Advisory Committee	Monthly		Ongoing	
Practitioners met re-credentialing 3 year recredentialing cycle	> 90	Network Director	Network Quality Review Committee/Medical Advisory Committee	Monthly		Ongoing	
Practitioners terminated	Monitor	Network Director	Network Quality Review Committee/Medical Advisory Committee	Monthly		Ongoing	
voluntary	Monitor	Network Director	Network Quality Review Committee/Medical Advisory Committee	Monthly		Ongoing	
involuntary	Monitor	Network Director	Network Quality Review Committee/Medical Advisory Committee	Monthly		Ongoing	

Harmony Health Plan of Missouri
2009-2010 Work Plan

Quality Metric	Performance Goal or Objective	Responsible Person(s)	HHPI Oversight Committee/Workgroup	Reporting Frequency/ Target Date	Goal Met/ Not Met/ Partially Met	Goal Status - Ongoing/ Closed	Summary / Brief Analysis if goals not met
Network Development Focus							
Targeted OB Recruitment	5 additional OB in underserved areas	Network Director	Network Quality Review Committee/Medical Advisory Committee	Monthly		Ongoing	Recruitment of 5 additional OB's in underserved areas. Target completion date 12/31/09
CLINICAL SERVICES							
IP Precert Non-Authorization Rate--Medicaid	Monitor	Manager, Appeals Director UM	Quality Improvement Committee /Utilization Management Committee	Monthly		Ongoing	
IP Precert Non-Authorization Rate--Medicare	Monitor	Manager, Appeals Director UM	Quality Improvement Committee /Utilization Management Committee	Monthly		Ongoing	
IP Internal Non-Authorization Overturn Rate - Medicaid		Manager, Appeals Director UM	Quality Improvement Committee /Utilization Management Committee	Monthly		Ongoing	
IP Internal Non-Authorization Uphold Rate --Medicare		Manager, Appeals Director UM	Quality Improvement Committee /Utilization Management Committee	Monthly		Ongoing	
% 1st Level Expedited inpatient Appeals Meeting Resolution Timeliness (72 hrs) - Medicaid	>95%	Manager, Appeals Director UM	Quality Improvement Committee /Utilization Management Committee	Monthly		Ongoing	
Days/1000	223	Director Utilization Management / Director, Clinical Services	Quality Improvement Committee	Ongoing			
Admits/K	62	Director Utilization Management / Director, Clinical Services	Quality Improvement Committee	Ongoing			
ALOS	3.6	Director Utilization Management / Director, Clinical Services	Quality Improvement Committee	Ongoing			
Readmission Rate - 30 Day	6%	Director Utilization Management / Director, Clinical Services	Quality Improvement Committee	Ongoing			
Over / Under Utilization	Monitoring Indicator	Director, Utilization Management	N/A	Ongoing			
CM / DM Programs							
# members participating in Hugs	Monitor	Manager CM/Social Service Specialists	Utilization Management Committee/Quality Improvement Committee	Monthly		Ongoing	
# members in CM	Monitor	Manager CM	Utilization Management Committee/Quality Improvement Committee	Monthly		Ongoing	
# members in DM	Monitor	Manager CM	Utilization Management Committee/Quality Improvement Committee	Monthly		Ongoing	
Documentation Audits							
Physician Advisors		Medical Director	Medical Advisory Committee	Quarterly		Ongoing	
Care Managers		Managers Case Management	Utilization Management Committee/Quality Improvement Committee	Quarterly		Ongoing	
PreCertification Team		Manager Utilization Management	Utilization Management Committee/Quality Improvement Committee	Quarterly		Ongoing	
Care Managers		Manager Case Management	Utilization Management Committee/Quality Improvement Committee	Quarterly		Ongoing	
Disease Management		Manager, Disease Management	Utilization Management Committee/Quality Improvement Committee	Quarterly		Ongoing	
Inter-Rater Reliability							
Physician Advisors	≥ 90%	Medical Director	Medical Advisory Committee	Annual		Ongoing	
Care Managers	≥ 90%	Manager, Case Management	Not Met	Annual		Ongoing	
Member Services							

Harmony Health Plan of Missouri
2009-2010 Work Plan

Quality Metric	Performance Goal or Objective	Responsible Person(s)	HHPI Oversight Committee/Workgroup	Reporting Frequency/ Target Date	Goal Met/ Not Met/ Partially Met	Goal Status - Ongoing/ Closed	Summary / Brief Analysis if goals not met
Customer Satisfaction Survey	80% Very Satisfied or Satisfied	Director, Operations	CSQIW/Quality Improvement Committee	Monthly		Ongoing	
First Call Resolution	86%	Director, Operations	CSQIW/Quality Improvement Committee	Monthly		Ongoing	
Call Quality Percentage	90%	Director, Operations	CSQIW/Quality Improvement Committee	Monthly		Ongoing	
Service Level	80% of calls answered in 30 seconds or less	Director, Operations	CSQIW/Quality Improvement Committee	Monthly		Ongoing	
Average Speed of Answer (ASA)	30 seconds	Director, Operations	CSQIW/Quality Improvement Committee	Monthly		Ongoing	
Call Abandonment Rate	≤ 5%	Director, Operations	CSQIW/Quality Improvement Committee	Monthly		Ongoing	
Member Complaint Resolution							
# Member Complaints/Grievances	Monitor	Director, Appeals & Grievances	Medical Advisory Committee	Monthly		Ongoing	
Member Complaint/Grievance Rate/1000	Monitor	Director, Appeals & Grievances	Medical Advisory Committee	Monthly		Ongoing	
% Met Complaint TAT (Telephonic 30 days; Written 60 days)	Monitor	Director, Appeals & Grievances	Medical Advisory Committee	Monthly		Ongoing	
Average TAT	≥ 90%	Director, Appeals & Grievances	Medical Advisory Committee	Monthly		Ongoing	
PROVIDER PERFORMANCE							
Continuity and Care Coordination							
Site Visits/Medical Record Reviews							
Medical Record Reviews							
# Record Reviews Completed	Monitor	Director, Quality Improvement	Quality Improvement Committee	Monthly		Ongoing	
# Record Reviews Compliant with Standards	>90%	Director, Quality Improvement	Quality Improvement Committee	Monthly		Ongoing	
Site Visits							
# Site Visits Completed	Monitor	Network Director	Network Quality Review Committee/Quality Improvement Committee	Monthly		Ongoing	
# Sites Meeting Standard	>90%	Network Director	Network Quality Review Committee/Quality Improvement Committee	Monthly		Ongoing	
High Volume Site Visits							
# Site Visits Completed	Monitor	Director, QI	Quality Improvement Committee	Quarterly			
# Sites Meeting Standard	≥ 90%	Director, QI		Quarterly			
REGULATORY COMPLIANCE							
Regulatory Report Filing	98%	Sr Director State & Regulatory Affairs	Quality Improvement Committee	Monthly		Ongoing	
Regulatory Reporting Acceptance	100%	Sr Director State & Regulatory Affairs	Quality Improvement Committee	Monthly		Ongoing	
Medicaid Sales Complaints	Monitor	Director, Compliance	Quality Improvement Committee	Monthly		Ongoing	
Policy and Procedure Updates	Monitor	Director, Compliance	Quality Improvement Committee	Monthly		Ongoing	
HEALTH SERVICES GOALS/OBJECTIVE Goals/objectives CY 2009 HEDIS 2010							
I. Quality Goals/Objectives - CY 2009 HEDIS 2010							
A. DHSS 2009 Quality With-Holds	Target 7 of 8, Stretch 8 of 8	Director QI/UM	Quality Improvement Committee	Annually		Ongoing	
1. W15 Well Child Visit under 15 months	Target 7 of 8, Stretch 8 of 8	Director QI/UM	Quality Improvement Committee	Annually		Ongoing	
2. LSc Lead Screening	Target 7 of 8, Stretch 8 of 8	Director QI/UM	Quality Improvement Committee	Annually		Ongoing	
3. CIS Childhood Immunization Status Combo-3	Target 7 of 8, Stretch 8 of 8	Director QI/UM	Quality Improvement Committee	Annually		Ongoing	

Quality Metric	Performance Goal or Objective	Responsible Person(s)	HHPI Oversight Committee/Workgroup	Reporting Frequency/ Target Date	Goal Met/ Not Met/ Partially Met	Goal Status - Ongoing/ Closed	Summary / Brief Analysis if goals not met
4. W36 Well-Child Vist 3rd, 4th, 5th and 6th Year of Life	Target 7 of 8, Stretch 8 of 8	Director QI/UM	Quality Improvement Committee	Annually		Ongoing	
5. PPC Timeliness of Prenatal Care	Target 7 of 8, Stretch 8 of 8	Director QI/UM	Quality Improvement Committee	Annually		Ongoing	
6. PPV Post Partum Care	Target 7 of 8, Stretch 8 of 8	Director QI/UM	Quality Improvement Committee	Annually		Ongoing	
7. CCS Cervical Cancer Screening	Target 7 of 8, Stretch 8 of 8	Director QI/UM	Quality Improvement Committee	Annually		Ongoing	
8. BCS Breast Cancer Screening	Target 7 of 8, Stretch 8 of 8	Director QI/UM	Quality Improvement Committee	Annually		Ongoing	
9. ASM Appropriate Medications for People with Asthma: Combined Rate	Target 7 of 8, Stretch 8 of 8	Director QI/UM	Quality Improvement Committee	Annually		Ongoing	
10. AWC Adolescent Well-Care Visits ages 12-21	Target 7 of 8, Stretch 8 of 8	Director QI/UM	Quality Improvement Committee	Annually		Ongoing	
B. Statistically Significant HEDIS Results							
1. Goals - IMD HEDIS Statistically Significant	Target 33% (Net), Stretch 50%	Director QI/UM	Quality Improvement Committee	Annually		Ongoing	
2. Goals - PFQ +10% year over year Quality Compass	Target 150% improvement, Stretch 200%	Director QI/UM	Quality Improvement Committee	Annually		Ongoing	
II. Utilization Management							
A. Goals - Utilization Management Trending							
1. Goals - UM IMD	Target <1.25% increase, Stretch Flat	VP/Medical Director	Quality Improvement Committee	Monthly		Ongoing	
2. Goals - UM Readmission Rates	Target Flat, Stretch <3% increase	VP/Medical Director	Quality Improvement Committee	Monthly		Ongoing	
3. Goals - UM - HUGS	Target >80% Participation, Stretch >90% Participation	Social Service Specialist	Quality Improvement Committee	Monthly		Ongoing	
4. Goals - UM - ER Utilization Outreach	Target <10%, Stretch <15%	Manager CM/DM, Director UM	Quality Improvement Committee			Ongoing	
III. Field Activities - Quality Improvement - Education							
A. Quality - Education/Outreach - Provider							
1. Provider Education/Outreach Meetings	8/Week, Stretch 10/Week	Quality Analyst	Quality Improvement Committee	Monthly		Ongoing	
2. Quality - Education/Outreach Meetings	HHPI Associates Target - Quarterly, 2 /Qtr Stretch 3/Qtr	Quality Analyst	Quality Improvement Committee	Monthly		Ongoing	
3. Reporting - Team Field Activity Database Completion	Target - Weekly, Stretch Daily, Report monthly	Sr Quality Analyst	Quality Improvement Committee	Monthly		Ongoing	
4.. Provider HHPI Newsletters Target	Target - Submit ideas for 4 articles/year	Quality Analyst	Quality Improvement Committee	Monthly		Ongoing	
B. Quality - Education/Outreach - Member							
1. Attend Community Events	2/Qtr Stretch 3/Qtr.	Quality Analyst	Quality Improvement Committee			Ongoing	
C. Quality - Networking/Improving Relationships						Ongoing	
1. Quality - Networking Relationships - State	Minimum Meeting once every 3 months.	Director QI/UM	Quality Improvement Committee			Ongoing	
2. Quality - Networking Relationships - EQRO		Director QI/UM	Quality Improvement Committee				
3. Quality - Networking Relationships - Provider Visits	Target 8/ week Stretch 10/week	Director QI/UM	Quality Improvement Committee			Ongoing	
4. Quality - Networking Relationships - Member Visits		Quality Analyst	Quality Improvement Committee			Ongoing	
5. Quality - Networking Relationships - IPA Visits	Target Meet with each IPA annually	VP/Medical Director	Quality Improvement Committee			Ongoing	
6. Quality - Networking Relationships - Health Fairs		Quality Analyst	Quality Improvement Committee			Ongoing	
7. Quality - Networking Relationships - Department of Public Health		Director QI/UM	Quality Improvement Committee			Ongoing	

Quality Metric	Performance Goal or Objective	Responsible Person(s)	HHPI Oversight Committee/Workgroup	Reporting Frequency/ Target Date	Goal Met/ Not Met/ Partially Met	Goal Status - Ongoing/ Closed	Summary / Brief Analysis if goals not met
8. Quality - Networking Relationships - Advocacy Groups		Director QI/UM	Quality Improvement Committee			Ongoing	
9. Quality - Networking Relationships - Maternal Child Coalition		Director QI/UM	Quality Improvement Committee			Ongoing	
10. Quality - Networking Relationships - American Lung Association (Asthma)		Quality Analyst	Quality Improvement Committee			Ongoing	
11. Quality - Networking Relationships - Public Schools/Head Start Programs		Quality Analyst	Quality Improvement Committee			Ongoing	
12. Quality - Networking Relationships - American Cancer Society/Y-Me		Quality Analyst	Quality Improvement Committee			Ongoing	
13. Quality - Networking Relationships - American Diabetic Association		Quality Analyst	Quality Improvement Committee			Ongoing	
14. Quality - Networking Relationships - Family Case Management/Women Infants Children (FCM/WIC)		Director QI/UM	Quality Improvement Committee			Ongoing	
15. Quality - Networking Relationships - Mental Health (H-SASS/SASS)		Director QI/UM	Quality Improvement Committee			Ongoing	
IV. Quality - Incentive Programs							
A. Provider Pay for Quality (IMD)							
1. Well Child Visits 0-15 months	75th Percentile 65.42%	Director QI/UM	Quality Improvement Committee	Annually		Ongoing	
2. Lead Screening	85%	Director QI/UM	Quality Improvement Committee	Annually		Ongoing	
3. Childhood Immunizations (Combo 3)	75th Percentile 74.24%	Director QI/UM	Quality Improvement Committee	Annually		Ongoing	
4. Well Child Visits 3-6 years of age	75th Percentile 73.90%	Director QI/UM	Quality Improvement Committee	Annually		Ongoing	
5. Timeliness of Prenatal Care	75th Percentile 88.56%	Director QI/UM	Quality Improvement Committee	Annually		Ongoing	
6. Postpartum Care	75th Percentile 65.69%	Director QI/UM	Quality Improvement Committee	Annually		Ongoing	
7. Cervical Cancer Screening	75th Percentile 72.22%	Director QI/UM	Quality Improvement Committee	Annually		Ongoing	
8. Breast Cancer Screening	75th Percentile 55.97%	Director QI/UM	Quality Improvement Committee	Annually		Ongoing	
9. Asthma Medication Utilization (combined)	75th Percentile 90.74	Director QI/UM	Quality Improvement Committee	Annually		Ongoing	
C. Provider Pay for Quality (IMD OB)							
1. Timeliness of Prenatal Care	Minimum 50th Percentile	Director QI/UM	Quality Improvement Committee	Annually		Ongoing	
2. Frequency of Ongoing Prenatal Care	Minimum 50th Percentile	Director QI/UM	Quality Improvement Committee	Annually		Ongoing	
3. Postpartum Visit	Minimum 50th Percentile	Director QI/UM	Quality Improvement Committee	Annually		Ongoing	
V. Quality Reporting							
A. Quality Reporting - PFQ/HEDIS							
1. PFQ/HEDIS - Non Compliant Lists - IPA Target	IPA Target - 1/Quarter, Stretch 6/Year	HEDIS Specialist	Quality Improvement Committee	Monthly		Ongoing	
2. PFQ/HEDIS - Non Compliant Lists - Providers	Target - 1/Quarter, Stretch 6/Year	HEDIS Specialist	Quality Improvement Committee	Monthly		Ongoing	
3. PFQ/HEDIS - Non Compliant Lists - Members Telephonic	1/Quarter, Stretch 6/Year	HEDIS Specialist	Quality Improvement Committee	Monthly		Ongoing	
4. PFQ/HEDIS - Non Compliant Lists - Members Mailing	1/Quarter, Stretch 6/Year	HEDIS Specialist	Quality Improvement Committee	Monthly		Ongoing	
5. PFQ/HEDIS - Non Compliant Lists - Member Periodicity Letters	1/Quarter, Stretch N/A	HEDIS Specialist	Quality Improvement Committee	Monthly		Ongoing	
B. Quality Reporting - HEDIS Measures							
1. ADULT BMI ASSESSMENT (ASA)	75th Percentile	Director QI/UM	Quality Improvement Committee	Annually		Ongoing	
2. ADOLESCENT IMMUNIZATION STATUS (AIS)	75th Percentile	Director QI/UM	Quality Improvement Committee	Annually		Ongoing	
3. ADOLESCENT WELL CARE VISITS	75th Percentile	Director QI/UM	Quality Improvement Committee	Annually		Ongoing	

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4. ADULTS' ACCESS TO PREVENTIVE / AMBULATORY SERVICES	75th Percentile	Director QI/UM	Quality Improvement Committee	Annually		Ongoing	
5. ANNUAL MONITORING FOR PATIENTS ON PERSISTENT MEDICATIONS (COMBINED)	75th Percentile	Director QI/UM	Quality Improvement Committee	Annually		Ongoing	
6. ANTI-DEPRESSANT MED. MNGT.	75th Percentile	Director QI/UM	Quality Improvement Committee	Annually		Ongoing	
7. OUTPATIENT FOLLOW-UP (FU Visits)	75th Percentile	Director QI/UM	Quality Improvement Committee	Annually		Ongoing	
8. 84 DAY MEDICATION (Acute Med Trial)	75th Percentile	Director QI/UM	Quality Improvement Committee	Annually		Ongoing	
9. 180 DAY MEDICATION (Effective Drug Therapy)	75th Percentile	Director QI/UM	Quality Improvement Committee	Annually		Ongoing	
10. USE OF APPROPRIATE MEDICATIONS FOR PEOPLE WITH ASTHMA	75th Percentile	Director QI/UM	Quality Improvement Committee	Annually		Ongoing	
11. BREAST CANCER SCREENING (BCS)	75th Percentile	Director QI/UM	Quality Improvement Committee	Annually		Ongoing	
12. CERVICAL CANCER SCREENING	75th Percentile	Director QI/UM	Quality Improvement Committee	Annually		Ongoing	
13. CHILDHOOD IMMUNIZATION	75th Percentile	Director QI/UM	Quality Improvement Committee	Annually		Ongoing	
14. CHILDREN'S AND ADOLESCENTS' ACCESS TO PRIMARY CARE PROVIDERS	75th Percentile	Director QI/UM	Quality Improvement Committee	Annually		Ongoing	
15. CHLAMYDIA SCREENING	75th Percentile	Director QI/UM	Quality Improvement Committee	Annually		Ongoing	
16. COMPREHENSIVE DIABETES	75th Percentile	Director QI/UM	Quality Improvement Committee	Annually		Ongoing	
17. CONTROLLING HIGH BLOOD PRESSURE	75th Percentile	Director QI/UM	Quality Improvement Committee	Annually		Ongoing	
18. DISEASE MODIFYING ANTI-RHEUMATIC DRUG THERAPY IN RHEUMATOID ARTHRITIS	75th Percentile	Director QI/UM	Quality Improvement Committee	Annually		Ongoing	
19. FOLLOW-UP AFTER HOSP. FOR MENTAL ILLNESS	75th Percentile	Director HBH	Quality Improvement Committee	Annually		Ongoing	
20. FOLLOW UP FOR CHILDREN PRESCRIBED ADHD MEDS (ADD)	75th Percentile	Director HBH	Quality Improvement Committee	Annually		Ongoing	
21. AVOIDANCE OF ANTIBIOTIC TX IN ADULTS WITH ACUTE BRONCHITIS (AAB)	75th Percentile	Director HBH	Quality Improvement Committee	Annually		Ongoing	
22. INITIATION & ENGAGEMENT OF ALCOHOL AND OTHER DRUG DEPENDENCE TREATMENT (IET)	75th Percentile	Director HBH	Quality Improvement Committee	Annually		Ongoing	
23. LEAD TESTING	75th Percentile	Director QI/UM	Quality Improvement Committee	Annually		Ongoing	
24. BETA BLOCKER AFTER AMI	75th Percentile	Director QI/UM	Quality Improvement Committee	Annually		Ongoing	
25. PHARMACOTHERAPY MANAGEMENT OF COPD EXACERBATION (PCE)	75th Percentile	Director QI/UM	Quality Improvement Committee	Annually		Ongoing	
26. PRENATAL/PP CARE	75th Percentile	Director QI/UM	Quality Improvement Committee	Annually		Ongoing	
27. APPROPRIATE TESTING FOR CHILDREN WITH PHARYNGITIS (CWP)	75th Percentile	Director QI/UM	Quality Improvement Committee	Annually		Ongoing	
28. APPROPRIATE TREATMENT FOR CHILDREN WITH UPPER RESP. INFECTION (URI)	75th Percentile	Director QI/UM	Quality Improvement Committee	Annually		Ongoing	
29. USE OF IMAGING FOR LOW BACK PAIN (LBP)	75th Percentile	Director QI/UM	Quality Improvement Committee	Annually		Ongoing	
30. USE OF SPIROMETRY TESTING IN THE ASSESSMENT AND DIAGNOSIS OF CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)	75th Percentile	Director QI/UM	Quality Improvement Committee	Annually		Ongoing	
31. WEIGHT ASSESSMENT AND COUNSELING FOR NUTRITION AND PHYSICAL ACTIVITY FOR CHILDREN/ADOLESCENTS TOTAL WCC	75th Percentile	Director QI/UM	Quality Improvement Committee	Annually		Ongoing	
32. WELLCHILD VISITS IN FIRST 15 MONTHS	75th Percentile	Director QI/UM	Quality Improvement Committee	Annually		Ongoing	
33. WELLCHILD VISITS 3-6 YEARS OLD	75th Percentile	Director QI/UM	Quality Improvement Committee	Annually		Ongoing	
34. CHOLESTEROL MANAGEMENT AFTER CVE	75th Percentile	Director QI/UM	Quality Improvement Committee	Annually		Ongoing	
35. COLORECTAL CANCER SCREENING	75th Percentile	Director QI/UM	Quality Improvement Committee	Annually		Ongoing	
36. GLAUCOMA SCREENING IN OLDER ADULTS	75th Percentile	Director QI/UM	Quality Improvement Committee	Annually		Ongoing	

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37. OSTEOPOROSIS MANAGEMENT IN WOMEN	75th Percentile	Director QI/UM	Quality Improvement Committee	Annually		Ongoing	
VI. Quality Improvement - Surveys							
A. Quality Improvement - Member Satisfaction Surveys (CAHPS)	Target 1/Year	Director QI/UM	Quality Improvement Committee	Annually		Ongoing	
B. Quality Improvement - Provider Satisfaction Surveys	Target 1/Year	Director QI/UM	Quality Improvement Committee	Annually		Ongoing	
C. Quality Improvement - Access & Availability Monitoring	Target 1/Year	Director PR NIL, Manager PR SIL	Quality Improvement Committee	Annually		Ongoing	
D. Quality Improvement - GEO Access	Target 1/Year, Stretch 2/Year	Director PR NIL, Manager PR SIL	Quality Improvement Committee	Annually		Ongoing	
E. Quality Improvement - Harmony Behavioral Health	Target 1/Year, Stretch 2/Year	Director HBH	Quality Improvement Committee	Annually		Ongoing	
VII. Quality Improvement - Performance Improvement Projects (PIPs - 9)							
A. Quality Improvement - PIP -Adolescent Well Care	See Adolescent Well Care PIP	QI Analyst	Quality Improvement Committee	Quarterly		Ongoing	
B. Quality Improvement - PIP -Perinatal	See Perinatal Work Plan	QI Analyst/Social Service Specialists	Quality Improvement Committee	Quarterly		Ongoing	
C. Quality Improvement - PIP - CAHPS	See CAHPS Work Plan	QI Analyst	Quality Improvement Committee	Quarterly		Ongoing	
C. Quality Improvement - PIP - Lead Screening	See Lead Screening Work Plan	QI Analyst	Quality Improvement Committee	Quarterly		Ongoing	
D. Quality Improvement - PIP - Medical Record Review	See Medical Record Review Work Plan	QI Analyst	Quality Improvement Committee	Quarterly		Ongoing	
VII. Quality - Administrative/Compliance							
A. Audits							
1. Audits - EQRO - IMD	Target 1/Year	Director Compl & RA	Quality Improvement Committee	Annually		Ongoing	
2. Audits - HEDIS (IMD/MMD)	, Stretch 2/Year	Director Compl & RA	Quality Improvement Committee	Annually		Ongoing	
IX. Administrative							
A. Annual Evaluations/Reports	Target 1/Year	Director QI/UM	Quality Improvement Committee	Annually		Ongoing	
B. Annual Program Descriptions	Target 1/Year	Director QI/UM	Quality Improvement Committee	Annually		Ongoing	
C. Annual Work Plans	Target 1/Year	Director QI/UM	Quality Improvement Committee	Annually		Ongoing	
D. Monthly QI/UM Dashboard (Activities)	Target 10/Year - Stretch 12/year	Director QI/UM	Quality Improvement Committee	Monthly		Ongoing	
E. Quarterly Evaluation	4/Year	Director QI/UM	Quality Improvement Committee	Quarterly		Ongoing	
X. Utilization Management							
A. Activities							
1. Utilization Management - FCM Cluster Work Groups		Social Service Specialists	Quality Improvement Committee	Monthly		Ongoing	
2. Utilization Management - Pregnant Women		Social Service Specialists	Quality Improvement Committee	Monthly		Ongoing	
3. Utilization Management - Children		Director QI/UM	Quality Improvement Committee	Monthly		Ongoing	
4. Utilization Management - Adults		Director QI/UM	Quality Improvement Committee	Monthly		Ongoing	
5. Utilization Management - Case Management		Case Manager CM/DM	Quality Improvement Committee	Monthly		Ongoing	
6. Utilization Management - Disease Management		Case Manager CM/DM	Quality Improvement Committee	Monthly		Ongoing	
7. Utilization Management - Behavioral Health		Director HBH	Quality Improvement Committee	Monthly		Ongoing	
8. Utilization Management - HUGS Newsletter		Social Service Specialists	Quality Improvement Committee	Monthly		Ongoing	
9. Utilization Management - CAT Cases		VP Ops & UM	Quality Improvement Committee	Monthly		Ongoing	
10. Utilization Management - SSI/AABD		Social Service Specialists	Quality Improvement Committee	Monthly		Ongoing	

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11. Utilization Management - Health Risk Assessments		QI Specialist	Quality Improvement Committee	Monthly		Ongoing	
12. Utilization Management - HUGS		Social Service Specialists	Quality Improvement Committee	Monthly		Ongoing	
XI. Corporate/Local and Adhoc Committees							
A. Committee - Board of Directors (BOD)	Quarterly, but not less than 4 times per year.	VP/Medical Director		Quarterly, but not less than 4 times per year.		Ongoing	
B. Committee - Board of Directors (BOD) - QIC Agenda/Minutes to BOD	At least once every 3 months.	VP/Medical Director	Board of Directors	At least once every 3 months.		Ongoing	
D. Committee - Quality Improvement (QIC)	At least once every 3 months.	VP/Medical Director	Board of Directors	At least once every 3 months.		Ongoing	
F. Committee - Credentialing/Re-credentialing	At least once every 3 months.	VP/Medical Director	Quality Improvement Committee	At least once every 3 months.		Ongoing	
G. Committee - Medical Advisory (MAC)/Peer Review Committee	At least once every 3 months.	VP/Medical Director	Quality Improvement Committee	At least once every 3 months.		Ongoing	
H. Committee - Delegation Over site (DOC)	Target 12/year, not less than 8 times per year.	Sr QI Director - Corp	Quality Improvement Committee	Target 12/year, not less than 8 times per year.		Ongoing	
I. Committee - Appeals & Grievances	Target 52/year, but not less than 45 times per year.	Director Appeals, Director Grievance	Medical Advisory Committee	Target 52/year, but not less than 45 times per year.		Ongoing	
J. Committee - Pharmacy & Therapeutics	At least once every 3 months.	Med Dir Pharm	Quality Improvement Committee	At least once every 3 months.		Ongoing	
K. Committee - Customer Service Quality Improvement Work Group (CSQIW)	Target 12/year, not less than 8 times per year.	Director Member Services	Medical Advisory Committee	Target 12/year, not less than 8 times per year.		Ongoing	
L. Committee - Consumer Advisory Work Group	Target 4/year	VP Marketing - NIL - Marketing - SIL/MO	Quality Improvement Committee	Target 4/year		Ongoing	
XII. Reporting - Quality Improvement (QIC) Agenda/Minutes/Action Register							
Reporting - MAC	Target 4/year	VP/Medical Director	Medical Advisory Committee	Quarterly		Ongoing	
Reporting - HBH	Target 12/year	Director HBH	Quality Improvement Committee	Monthly		Ongoing	
Reporting - Quality Management	Target 12/year	Director QI/UM	Quality Improvement Committee	Monthly		Ongoing	
Reporting - Utilization Management	Target 12/year	VP/Medical Director	Quality Improvement Committee	Monthly		Ongoing	
Reporting - Appeals	Target 12/year	Director Appeals	Quality Improvement Committee	Monthly		Ongoing	
Reporting - Grievance	Target 12/year	Director Grievance	Quality Improvement Committee	Monthly		Ongoing	
Reporting - Compliance	Target 12/year	Director Compl & RA	Quality Improvement Committee	Monthly		Ongoing	
Reporting - Provider Relations	Target 12/year	VP PR/Network - NILED SIL/MO	Quality Improvement Committee	Monthly		Ongoing	
Reporting - Operations	Target 12/year	Director Member Services	Quality Improvement Committee	Monthly		Ongoing	
Reporting - Encounters/Claims	Target 12/year	VP Ops & UM	Quality Improvement Committee	Monthly		Ongoing	
Reporting - Marketing	Target 12/year	VP Marketing - NIL Marketing - SIL/MO	Quality Improvement Committee	Monthly		Ongoing	
Reporting - Credentialing	Target 12/year	Dir, Credentialing	Credentialing Committee/Quality Improvement Committee	Monthly		Ongoing	
Reporting - Recredentialing	Target 12/year	Dir, Credentialing	Credentialing Committee/Quality Improvement Committee	Monthly		Ongoing	
Reporting - In Queue	Target 12/year	Dir, Credentialing		Monthly		Ongoing	
Reporting - Leveling Review	Target 12/year	Dir, Credentialing		Monthly		Ongoing	
Reporting - QOC/QOS Impact	Target 12/year	Director QI/UM	Quality Improvement Committee	Monthly		Ongoing	
Reporting - Utilization Management (of Re-credentialed Provider)	Target 12/year	VP/Medical Director		Monthly		Ongoing	
Reporting - HBH	Target 12/year	Dir HBH	Quality Improvement Committee	Monthly		Ongoing	

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Reporting - Quality Management	Target 12/year	Director QI/UM	Quality Improvement Committee	Monthly		Ongoing	
Reporting - Utilization Management	Target 12/year	VP/Medical Director	Quality Improvement Committee	Monthly		Ongoing	
Reporting - Appeals	Target 12/year	Director Appeals	Quality Improvement Committee	Monthly		Ongoing	
Reporting - Grievance	Target 12/year	Director Grievance	Quality Improvement Committee	Monthly		Ongoing	
Reporting - Compliance	Target 12/year	Director Compl & RA	Quality Improvement Committee	Monthly		Ongoing	
Reporting - Provider Relations	Target 12/year	VP PR/Network, NIL SIL/MO	Quality Improvement Committee	Monthly		Ongoing	
Reporting - Operations	Target 12/year	Director Member Services	Quality Improvement Committee	Monthly		Ongoing	
Reporting - Encounters/Claims	Target 12/year	VP Ops & UM	Encounter Work Group/Quality Improvement Committee	Monthly		Ongoing	
Reporting - Marketing	Target 12/year	VP Marketing - NILMarketing - SIL/MO	Quality Improvement Committee	Monthly		Ongoing	
Reporting/Discussion - P & T	Target 12/year	Med Dir Pharm	Pharmacy & Therapeutics Committee	Monthly		Ongoing	
Reporting - HBH	Target 12/year	Sr Director HBH	Quality Improvement Committee	Monthly		Ongoing	
Reporting - Practice/Preventive Health Guidelines	Target 12/year	Clinical Research Analyst	Medical Advisory Committee	Monthly		Ongoing	
Reporting - Peer Review (QOC/QOS cases)	Target 12/year	Director QI/UM	Quality Improvement Committee/Medical Advisory Committee	Monthly		Ongoing	
Reporting - Risk management	Target 12/year	Director Compl & RA		Monthly		Ongoing	
Reporting - Case/Disease Management	Target 12/year	Manager CM/DM	Quality Improvement Committee	Monthly		Ongoing	
Reporting - Utilization Management (Days, Over/Under, ER)	Target 12/year	Sr. Manager Compliance	Quality Improvement Committee	Monthly		Ongoing	
Reporting - Delegated Entities	Target 12/year	Director QI/UM	Delegated Oversight Committee	Monthly		Ongoing	
Reporting - Regulatory	Target 12/year	Director Compl & RA	Quality Improvement Committee	Monthly		Ongoing	
Reporting - State/EQRO Agencies	Target 12/year	Director Compl & RA	Quality Improvement Committee	Monthly		Ongoing	
Reporting - Annual Report - IL	Target 1/year	Director QI/UM	Quality Improvement Committee	Annually		Ongoing	
Reporting - Annual Report - MO	Target 1/year	Director QI/UM	Quality Improvement Committee	Annually		Ongoing	
Report - Quarterly Report - IL	Target 4/year	Director QI/UM	Quality Improvement Committee	Annually		Ongoing	
XII. Surveys							
A. Questionnaires		VP Marketing - NIL, Marketing - SIL/MO	Quality Improvement Committee	Annually		Ongoing	
B. Grievances		VP Marketing - NIL,	Quality Improvement	Monthly		Ongoing	
C. Provider Relations - Provider Manual	Target 1/year Stretch 2/year	VP PR/Network - NIL, ED SIL/MO	Quality Improvement Committee	Monthly		Ongoing	
D. Provider Relations - GEO Access	Target 1/year Stretch 2/year	VP PR/Network - NIL, ED SIL/MO	Quality Improvement Committee	Monthly		Ongoing	
E. Provider Relations - Access and Availability	Target 1/year	VP PR/Network - NIL, ED SIL/MO	Quality Improvement Committee	Annually		Ongoing	
F. Provider Relations - Provider Satisfaction Survey	Target 1/year	VP PR/Network - NIL, ED SIL/MO	Quality Improvement Committee	Annually		Ongoing	

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Attachment 17

Activity	Link to Strategy	Description/Aim	Approval/Review	Person/Dept Accountable	Minimum Frequency	Feb 24	Apr 28	Jun 23	Aug 25	Oct 25	Dec 22
Grievances and Appeals, Provider	Regulatory; Provider Relations/Network Mgt.	Complete quarterly report including turn-around times, overturn rates, high volume categories and interventions by type.	QMC Presentation. Link to: Corp G&A project, G&A regulatory reporting; Member Safety	Director Appeals & Grievances	Quarterly	X		X		X	X
Grievances and Appeals, Member	Regulatory; NCQA; increasing membership	report. Include statistics for turn-around time, overturn rates, high volume categories and interventions by type of grievance/appeal.	QMC Presentation. Link to: Corp G&A project, G&A regulatory reporting; Member Safety	Director Appeals & Grievances	Quarterly	X		X		X	X
Communication Plan/ Program Description	Regulatory, NCQA	Annual review of communication plan/ program description.	QMC Approval	Director Community Development	Annually						X
Multilingual Services Evaluation	Regulatory; NCQA	Prepare detailed report on multilingual services.	QMC Presentation Link to: Cultural Competency Committee	Director Community Development	Annually (Report with Cult Competency Report)						
CSO Quality Indicators-calls	Regulatory; increasing membership, NCQA	Complete report for all member services key indicators including calls answered, calls abandoned, ASA, service levels and any special projects.	QMC Presentation	Director Customer Services	Quarterly	X		X		X	X
CSO Quality Indicators-claims processing	Regulatory; provider network; NCQA	Complete report claims processing indicators (i.e. volume, timeliness, accuracty, special projects etc.)	QMC Presentation Links to: Med Mgt.	Director Customer Services	Quarterly	X		X		X	X
Satisfaction Survey, Provider by CSO (Program specific surveys for UM, CM and DM are reported with the applicable program/dept. updates)	Regulatory; NCQA	Review and analyze results of annual provider satisfaction survey.	QMC Presentation	Director Customer Services	Annually						X
Case Management Key Performance Indicators	Regulatory, NCQA,	Detailed report of outcomes of program (indicators, satisfaction, incentive).	QMC Presentation	Director Health Services	Quarterly	X	X	X	X	X	X
Health Services Performance - CM	Regulatory; NCQA; Increase membership, Costs, clinical outcomes	Prepare a detailed report of case management activities and outcomes (productivity, clinical, functional, cost and satisfaction).	QMC presentation	Director Health Services	Quarterly		X	X		X	X

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Activity	Link to Strategy	Description/Aim	Approval/Review	Person/Dept Accountable	Minimum Frequency	Feb 24	Apr 28	Jun 23	Aug 25	Oct 25	Dec 22
Health Services Performance - UM Preauthorization	Regulatory; NCQA; Increase membership, Costs, clinical outcomes	Review and analyze preauthorization activities (Call volumes, ASA, calls dropped, etc).	QMC presentation	Director Health Services	Quarterly		X	X		X	X
Health Services Performance - UM Productivity	Regulatory; NCQA; Increase membership, Costs, clinical outcomes	Review and analyze UM key indicators (denials by type, ALOS, bed days, etc) and at least annually : satisfaction changes to referral process for specialty and out-of-network services	QMC Presentation. Link to: Provider Relations, Consumer Safety, Appeals & Grievances	Director Health Services	Quarterly		X	X		X	X
Internal Practice Guideline (Technical Recommendations) Updates	Regulatory; NCQA	Review of new medical technology,equipment, procedures and pharmaceuticals and review of new uses for current technology, equipment, procedures and pharmeceuticals (tech assessments).	QMC Approval. Link to: Corporate Medical Technology Committee; Interqual M criteria Updates	Director Health Services	Annually & PRN					X	
Interqual UM Criteria Updates	Regulatory; NCQA	Annual review of Interqual criteria - revisions.	QMC Approval Links to Internal Practice Guidelines Updates	Director Health Services	Annually					X	
PIP - UM Decision Making (QMC approval Dec. 2008)	Regulatory; NCQA;Cost	Detailed report of assessements, interventions & outcomes AIM:Reduce variation in denial rates and improve inter-rater reliability as evidenced by decreased variation in monthly denial rate by categories report and improved outcomes of IRR assessments	QMC Presentation Link to: Med Mgt	Director Health Services; VP Medical Affairs	Annually						X
Communication & Education Materials, Provider	Regulatory	Annual review of provider communication materials (PRG, newsletters, educational mailings, etc.) with tracking of reviews/changes/ additions/ deletions)	QMC presentation	Director Provider Relations	Annually						X
Credentialing Committee Reports	Regulatory, NCQA	Assess number of providers credentialed and recredentialed and timeliness.	QMC Presentation	Director Provider Relations	Annually					X	
Credentialing Plan/Program Description	Regulatory, NCQA	Annual update/revision to credentialing plan/program description	QMC Presentation	Director Provider Relations	Annually					X	
Credentialing, Delegated Oversight Audit Results	Regulatory, NCQA	Complete annual report of all delegated credentialing oversight audits.	QMC Presentation	Director Provider Relations	Annually					X	
Open/Closed Panels	Regulatory; NCQA Access to Care	Reporting results of closed to open PCP panels and analysis of why panels are closed, any action plan and outcomes.	QMC Presentation	Director Provider Relations	Annually			X			

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Activity	Link to Strategy	Description/Aim	Approval/Review	Person/Dept Accountable	Minimum Frequency	Feb 24	Apr 28	Jun 23	Aug 25	Oct 25	Dec 22
Provider Audits - On-site Review	Regulatory; NCQA	Summary report of outcomes of provider on-site environmental and regulatory compliance audits and investigations and summary of actions taken.	QMC Presentation Link to: Peer Review; Credentialing Committee	Director Provider Relations	Annually				X		
Access and Availability Study Results	Regulatory, NCQA	Complete results of provider access and availability study and any applicable action plans bi-annually and with any significant network changes	QMC Presentation	Director Provider Relations	Annually					X	
Geo Access Results/Analysis	Regulatory; NCQA	Complete annual geo-access analysis for network adequacy.	QMC Presentation	Director Provider Relations	Annually						X
Disease Mgt-Sickle Cell Disease (QMC approval 2009)	Clinical outcomes, cost, Regulatory	Prepare detailed report of outcomes of program (indicators, satisfaction).	QMC Presentation. Links to: PAC, Med Mgt, PIP-hospital readmits Team	Director Quality Improvement	Bi-Annually	X			X		
EPSDT	Clinical outcomes, Regulatory	Prepare detailed report of annual EPSDT outcomes	QMC Presentation. Link to: HEDIS/EPSDT Team	Director Quality Improvement	Annually						X
PIP - Adolescent Well Care (QMC approved Dec. 2006)	Regulatory; Clinical outcomes	Detailed report of interventions and outcomes AIM:Improve adherence to AAP CPG for adolescent well care, as evidenced by in increase in the HEDIS rate for adolescent well-care visits.	QMC Presentation	Director Quality Improvement	Annually				X		
PIP - ED Overutilization (QMC Approved Oct. 2007)	Regulatory auto-assign; HEDIS; Clinical outcomes, safety and costs	Detailed report of interventions and outcomes AIM:Decrease non-emergent/avoidable ED utilization as evidenced by improved ED HEDIS rates and "frequent flyer" rates.	QMC Presentation Links to: HEDIS/EPSDT Team	Director Quality Improvement	Annually		X				
Consumer Safety/Adverse Events	Regulatory, NCQA, clinical outcomes	Prepare detailed report of the outcomes of investigation of any threats to consumer safety including:member complaints, potential/ actual adverse events, review of claims and pharmacy data, member, staff and provider written & verbal reports and peer review committee activity	QMC Presentation. Link to: Peer Review and Credentialing Committees	Director Quality Improvement	Bi-Annually		X				X
Cultural Competency Program	NCQA; Membership	Annual detailed report of cultural competency program activities and measures.	QMC Presentation. Links to: Multi-lingual Services Evaluation	Director Quality Improvement	Annually					X	

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Activity	Link to Strategy	Description/Aim	Approval/Review	Person/Dept Accountable	Minimum Frequency	Feb 24	Apr 28	Jun 23	Aug 25	Oct 25	Dec 22
Disease Mgt-Asthma (QMC approved 2007)	Regulatory; NCQA; Clinical outcomes, Costs	Detailed report of outcomes of program (Census, productivity, clinical, functional, cost and satisfaction indicators, and member/provider incentives).	QMC Presentation. Links to: PAC, Asthma Task Force, focus study-asthma incentive, Med Mgt, PIP-hospital readmits, PIP-ED, HEDIS/EPSDT Team	Director Quality Improvement	Bi-Annually	X			X		
Disease Mgt-Diabetes (Revised & QMC approved 2009)	Regulatory, NCQA, Clinical outcomes, cost	Detailed report of outcomes of program (Census, productivity, clinical, functional, cost and satisfaction indicators, and member/provider incentives).	QMC Presentation. Links to: PAC, Med Mgt, PIP-hospital readmits, HEDIS/EPSDT Team	Director Quality Improvement	Bi-Annually	X			X		
Disease Mgt-High Risk OB (QMC Approved 2007)	Regulatory, NCQA, Clinical outcomes, Cost	Detailed report of outcomes of program (indicators, satisfaction, incentive).	QMC Presentation. Links to: PAC, OB Task Force, focus study-BIB incentive, Med Mgt, HEDIS/EPSDT Team	Director Quality Improvement	Bi-Annually	X			X		
Disease Mgt-NICU (QMC approved 2009)	Clinical outcomes, cost, Regulatory	Prepare detailed report of outcomes of program (indicators, satisfaction).	QMC Presentation. Links to: PAC, Med Mgt, PIP-hospital readmits Team, HEDIS/EPSDT Team	Director Quality Improvement	Bi-Annually	X			X		
EQRO Audit Results	Regulatory	Provide results of the External Quality Review when made available by MO HealthNet.	QMC Presentation	Director Quality Improvement	Annually when available from MO HealthNet						
Focus study - Postpartum Depression (QMC approved Dec. 2008)	Clinical outcomes, NCQA-coordination of care across settings	Prepare detailed report of outcomes of program (indicators, satisfaction) AIM: increase identification and interventions for those at risk of having PPD to 10%-12% of all pregnancies.	QMC Presentation: Llinks to: MHNet oversight; Mgt. Mgt, Coordination of care,	Director Quality Improvement	Annually			X			
Focus study-Asthma (QMC approved March 2007; Last State approval: Sept. 2009)	Regulatoyr Requirement; Clinical outcomes	Prepare detailed report of outcomes (impacat on adherence, satisfaction) AIM: Asthma incentive designed to increase adherence to NAEPP CPGs for treatment of asthma: PCP visits, fill their med prescriptions, identify a rescue person.	QMC Presentation Link to: Asthma DM Task Force, Med Mgt, PAC; HEDIS/EPSDT Team	Director Quality Improvement	Bi-Annually (Report with DM Programs)	X			X		
Focus study-BIB (QMC Approved March 2007; Last State approval: Sept 2009)	Clinical outcomes	Prepare detailed report of outcomes (impact on adherence, satisfaction) AIM:Incentive designed to encourage adherence to ACOG CPGs for adequate prenatal care.	QMC Presentation Link to: HROB DM Task Force, Med Mgt, PAC, HEDIS/EPSDT Team	Director Quality Improvement	Bi-Annually (Report with DM Programs)	X			X		

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Activity	Link to Strategy	Description/Aim	Approval/Review	Person/Dept Accountable	Minimum Frequency	Feb 24	Apr 28	Jun 23	Aug 25	Oct 25	Dec 22
Fraud and Abuse Program	Regulatory	Prepare detailed report of fraud and abuse tracking, trending, analysis and outcomes of investigations	QMC Presentation. Link to: Member Safety, Reg. Compliance Committee; Peer Review; Credentialing	Director Quality Improvement	Annually	X					
HEDIS	Regulatory; NCQA; Increasing membeship; Clinical outcomes	Prepare detailed report with detailed statistical analysis and comparison to regional and national threhsolds for each HEDIS indicator, planned activities & outcomes of interventions	QMC Presentation. Link to: HEDIS/EPSDT Team	Director Quality Improvement	Annually				X		
Members with Special Healthcare Needs	Regulatory; NCQA Coordination of care across settings; Clinical outcomes	Report of census, health risk assessments, referrals, special projects, outcomes	QMC Presentation	Director Quality Improvement	Quarterly	X		X	X		X
PIP - Hospital Readmits (QMC approved Jan. 2008)	Clinical outcomes, safety and costs	Prepare detailed report of interventions and outcomes AIM:Reduce unscheduled, avoidable hospital readmissions as evidenced by a decrease in the 7 day, 30 day and 90 day readmission rates and decrease the multi-admit rate.	QMC Presentation	Director Quality Improvement	Annually					X	
PIP - Obesity (QMC approved 2004, start 2005, revised 2008)	Clinical outcomes	Detailed report of interventions and outcomes AIM:Increase identification and care of mbrs who are obese or at risk of obesity (BMI ≥95%) consistent with the AAP & AMA CPG as evidence by an increase in mbrs diagnosed (278.00 and 278.0) and claims for nutritional therapy (97802-97804).	QMC Presentation: Link to: Med Mgt.	Director Quality Improvement	Annually		X				
PIP - Synagis (QMC approved Sept. 2008)	Clinical outcomes, safety and costs	Detailed report of interventions & outcomes AIM: Improve early identification of members who meet criteria for Synagis to increase the number meeting criteria who receive Synagis to reduce RSV related hospitalizations.	QMC Presentation. Link to: Med Mgt	Director Quality Improvement	Annually				X		
Policies and Procedures, QI-Annual Review	Regulatory; NCQA	Annual report of policies and procedures related to QI/UM program	QMC Approval Link to: Print Committee	Director Quality Improvement	Annually						X

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Activity	Link to Strategy	Description/Aim	Approval/Review	Person/Dept Accountable	Minimum Frequency	Feb 24	Apr 28	Jun 23	Aug 25	Oct 25	Dec 22
Provider Audits - Medical Record Review	Regulatory; NCQA	Summary report of outcomes of provider medical record reviews & investigations for adherence to record storage, confidentiality, advanced directives, clinical practice guidelines, mandatory reporting of TB, STD's other communicable diseases, regulatory requirements and summary of actions and quality award winners.	QMC Presentation Link to: Member Safety, Peer Review; Credentialing Committee	Director Quality Improvement	Annuallyl						X
QI/UM Annual Program Evaluation	Regulatory; NCQA	Annual written evaluation of QI/UM program outcomes.	QMC Approval Link to: BOM	Director Quality Improvement	Annually					X	
QI/UM Committee Charter	Regulatory; NCQA	Annual update/revision to QI/UM charter	QMC Approval Link to: BOM	Director Quality Improvement	Annually					X	
QI/UM Strategy	Regulatory; NCQA	Annual update/revision to QI/UM strategy	QMC Approval Link to: BOM	Director Quality Improvement	Annually					X	
QI/UM Workplan	Regulatory	Annual update/revision to QI/UM workplan	QMC Approval Link to: BOM	Director Quality Improvement	Annually					X	
Satisfaction Survey, Member-CAHPS (Program specific surveys for UM, CM and DM are reported with the applicable program/Dept. updates)	Regulatory; NCQA; increasing membership	Complete annual CAHPS survey and analysis	QMC Presentation	Director Quality Improvement	Annually					X	
Satisfaction, Member Opt Outs from Plan	Regulatory, increase membership	Detailed report of data, analysis any interventions and outcomes for members who choose to opt out of plan, per MO HealthNet reporting.	QMC Presentation	Director Quality Improvement	Annually						X
Satisfaction, PCP Request to Change Report	Regulatory, Increase membership	Detailed report of members' requests to change PCP by reason.	QMC Presentation. Link to: Provider Relations, Consumer Safety, Appeals & Grievances	Director Quality Improvement	Annually			X			
Balanced Scorecard/Key Performance Indicators	Membership, clinical outcomes, cost, Regulatory, NCQA	Prepare balanced scorecard and detailed reports for operational, clinical, functional, cost, satisfaction and safety measures for tracking and trending progress toward goals & organization priorities.	QMC Presentation	Director Quality Improvement	Quarterly	X	X	X	X	X	X
Annual Subcontractor Evaluation	Regulatory, NCQA	Detailed report of oversight activities of subcontractors meeting MO HealthNet requirements.	QMC Approval Link to Annual Evaluation, BOM	Manager Regulatory Compliance	Annually					X	
Credentialing-Internal Audit Results	Regulatory, NCQA	Outcome of audit of random selection of credentialing & recred files with comparison to URAC & NCQA standards for credentialing.	QMC Presentation	Manager Regulatory Compliance	Annually					X	

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Activity	Link to Strategy	Description/Aim	Approval/Review	Person/Dept Accountable	Minimum Frequency	Feb 24	Apr 28	Jun 23	Aug 25	Oct 25	Dec 22
McKesson 24 hr. Nurse Call Line Oversight (QI plan, indicators, action plan, geoaccess and outcomes of audits)	Regulatory; NCQA	Prepare detailed report on QI plan and indicators & outcomes, any action plans or QI programs in process	QMC Presentation	Manager Regulatory Compliance	Bi-Annually		X			X	
MHNet Oversight (QI plan, indicators, action plan, geoaccess and outcomes of audits)	Regulatory; NCQA	Prepare detailed report on outcomes of program (indicators, outcomes, State action plans, geo access).	QMC Presentation	Manager Regulatory Compliance	Quarterly	X	X	X	X	X	X
Regulatory Compliance Plan	Regulatory; NCQA	Annual update/revision to regulatory compliance plan / program description.	QMC Approval	Manager Regulatory Compliance	Annually					X	
Communication & Educational Materials, Member	Regulatory	Annual review of member communication and education materials (newsletters, handbook, educational mailings, etc.) with tracking of reviews/ changes/ additions/ deletions)	QMC Presentation	Manager Regulatory Compliance	Annually						X
Doral Dental (QI program,indicators, action plan(s), geoaccess, oversight audit reports - State Mandatory PIP)	Regulatory	Prepare detailed report on outcomes of program (indicators, outcomes, State action plans, geo access).	QMC Presentation PIP approval	Manager Regulatory Compliance	Quarterly	X	X	X	X	X	X
Clinical Practice Guidelines	Regulatory, NCQA	Annual review of clinical and preventive care guidelines.	QMC Approval	QMC Chair, Medical Director	Annually; PRN for new CPGs						X

Attachment 18

Missouri Care Health Plan 2010 Quality Improvement Work Plan

Program Initiative	Scope/Objective	Goals/Benchmarks	Methodology	Responsible Person(s) Department	Target Date for Completion	Interventions	Update (M/D/Y)
Quality Improvement Plans & Evaluations							
Quality Assessment and Improvement (QA&I) Program Plan	Annually review & revise QM Plan based on prior year's evaluation.	To have a comprehensive and up-to-date quality management plan.	Written plan	Elizabeth Opland, Quality Management	11/30/10	N/A	
QI Annual Evaluation	Prepare annual evaluation for state in accordance with RFP Attachment 6	To complete the evaluation by the deadline & to showcase Missouri Care's activities from the prior year.	Written presentation of findings	Elizabeth Opland, Quality Management	11/30/10	SFY 2010 - Evaluation to cover contract year 7/01/09-6/30/10	
QI Work Plan	Annually review & revise QI Work Plan based on prior year's evaluation.	To have a comprehensive and up-to-date quality management work plan for 2010	Written plan	Elizabeth Opland, Quality Management	11/30/10	• Quality Improvement Work Group - all departments • State Quality Task Force	
QI Work Plan - Ongoing evaluation	Evaluate effectiveness QI Work Plan	To have completed initiatives on work plan & to have evaluated their effectiveness.	Written presentation of findings	Elizabeth Opland, Quality Management	12/31/10	Plan will be reviewed & updated quarterly.	
External Quality Review Organization (EQRO) Audit (SFY 2009, CY 2010)	Meet standards for external quality review.	Achieve "Met" on all 4 review areas (PIPS; Performance Measures; Compliance; Validation of Encounter data)	Submission of relevant documents and final on-site review	Elizabeth Opland, Quality Management	7/20/10	• State EQRO Task Force	
NCQA Audit – HEDIS MRR and Rate Production Project Plan	Meet standards set by NCQA for HEDIS measures. Create timeline/project plan for CY2009 to complete requirements for HEDIS Audit	HEDIS Roadmap complete, all MRR records reviewed, completion of convenience and final validation samples, IDSS data submission, etc.	Project plan	Elizabeth Opland, Quality Management	10/1/10		
HEDIS/ Prevention and Wellness Interventions Project Plan	Based on review of the year's HEDIS results & the effectiveness of the prior year's interventions, revise the HEDIS intervention plan.	To have a comprehensive plan in place to positively impact HEDIS measures	Project plan	Elizabeth Opland, Quality Management	12/31/10	• Statewide AWC PIP • Statewide Dental Task Force and PIP	
NCQA Accreditation Project Plan	Meet standards for NCQA health plan accredition	Score of "commendable" or better	Project plan.	Karen Holt, NCQA Manager	12/31/10	• State NCQA Task Force	
Cultural Competency Plan	Improve Cultural Competence among our members, providers, and internal staff	To have a comprehensive plan in place to effectively implement cultural competency activities	Written plan	Elizabeth Opland, Quality Management	12/31/10		

Program Initiative	Scope/Objective	Goals/Benchmarks	Methodology	Responsible Person(s) Department	Target Date for Completion	Interventions	Update (MM/Y)
Cultural Competency Project Plan	Improve Cultural Competence among our members, providers, and internal staff	To have a comprehensive plan in place to effectively implement cultural competency activities	Project plan	Elizabeth Opland, Quality Management	12/31/10	• Cultural Competency Work Group - all departments	
HEDIS Interventions (Targeted to Improve HEDIS Measures)							
Annual Dental Visit							
Show Me Smiles Dental Campaign	Increase Annual Dental Visit (ADV) combined rate, as well as for specific age groupings.	HEDIS ADV goals as listed below and increased member awareness in expansion (East-West) regions.	NA	Ed Williams, Outreach and Marketing	2/1/10	• Head Start Collaboration - Distribute toothbrushes and toothpaste • Statewide Dental Task Force Interventions	
Dental Member Reminders	Increase Annual Dental Visit (ADV) combined rate, as well as for specific age groupings.	**ADV:** H2009 rate was 27.41%; increase to **30.88%**. (This will close 5% of the gap between H2009 rate and 100%; state average was 32.29%; NCQA 75th%ile was 52.79%; State Dental Task Force requires 3% increase)	HEDIS technical specifications for rate calculation (Member lists generated from monthly HEDIS intervention report)	Elizabeth Opland, Quality Management	Three times a year 2/28/10, 6/30/10, 10/31/10	• Members visit due postcards. • Dental prescription pads for PCPs. • Monitor dental vendor for effectiveness/efficiency. • Statewide Dental Task Force Interventions	
Dentist Incentive Program	Increase Annual Dental Visit (ADV) combined rate, as well as for specific age groupings.	**ADV:** H2009 rate was 27.41%; increase to **30.88%**. (This will close 5% of the gap between H2009 rate and 100%; state average was 32.29%; NCQA 75th%ile was 52.79%; State Dental Task Force requires 3% increase)	HEDIS technical specifications for rate calculation (Member lists generated from monthly HEDIS intervention report)	Elizabeth Opland, Quality Management	TBD	Dental Incentive Plan - pay dentists for each new Medicaid member added to their panel	
Antidepressant Medication Management (AMM)							
Antidepressant Medication Management - Member Mailing	Increase the member antidepressant medication adherence for the acute and continuous phases of treatment.	Improve AMM rates; goals TBD	HEDIS technical specifications for each measure.	Elizabeth Opland, Quality Management, Melody Dowling, Medical Management	Twice a year, 12/31/2010	Send letters to HEDIS non-compliant members encouraging antidepressant medication adherence.	
Antidepressant Medication Management - Clinical Practice Guidelines	Increase the member antidepressant medication adherence for the acute and continuous phases of treatment.	Improve AMM rates; goals TBD	HEDIS technical specifications for each measure.	Elizabeth Opland, Quality Management, Melody Dowling, Medical Management	Twice a year, 12/31/2011	Distribute depression clinical practice guidelines to PCPs, including information on medication management	
Asthma Medication Adherence							
Asthma - Letter and Roster to Providers	Increase ASM rates.	**ASM:** H2009 rate was 82.46%; increase to **83.34%**. (This will close 5% of the gap between H2009 rate and 100%; NCQA 75%ile is 91.12%; state average is 87.42%)	HEDIS technical specifications for rate calculation (Rosters generated from internal report)	Elizabeth Opland, Quality Management	Quarterly, 12/31/10	Mail rosters to PCPs of members identified as having persistent asthma but who have not had a controller fill. (Include Asthma Action Plan & NAEPP Guidelines)	

Program Initiative	Scope/Objective	Goals/Benchmarks	Methodology	Responsible Person(s) Department	Target Date for Completion	Interventions	Update (MO/Y)
Asthma - Member Mailing	Increase ASM rates.	**ASM:** H2009 rate was 82.46%; increase to **83.34%**. (This will close 5% of the gap between H2009 rate and 100%; NCQA 75%ile is 91.12%; state average is 87.42%)	HEDIS technical specifications for rate calculation (Member lists generated from monthly HEDIS intervention report)	Elizabeth Opland, Quality Management	Monthly, 12/31/10	Send letter to members encouraging asthma checkup. Include asthma action plan. Will be sent to members on HEDIS intervention list.	
Attention Deficit/ Hyperactivity Disorder (ADD) - Follow-Up Care for Children Prescribed ADHD Medication							
ADD - Clinical Practice Guidelines	Improve care for ADHD care - visit frequency and medication compliance	ADD goals TBD	HEDIS technical specifications for rate calculation	Elizabeth Opland, Quality Management, Melody Dowling, Medical Management	12/31/10	Distribute ADD clinical practice guidelines to PCPs	
Cervical and Breast Cancer Screening							
Cervical and Breast Cancer Screening Birthday Cards	Improve CCS an BCS screening rates.	**CCS:** H2009 rate was 70.25%; increase to **71.74%** (This will close 5% of the gap between H2009 rate and 100%; NCQA 75th%ile is 72.99%; state average is 56.47%. **BCS** is a scored NCQA Accreditation measure; goals TBD	HEDIS technical specifications for rate calculation (Member list comes from monthly On Demand report)	Elizabeth Opland, Quality Management	Monthly, 12/31/10	Mail women a CCS/BCS card reminder during their birthday month	
Childhood Immunizations - CIS - Combo 3 and Combo 10							
CIS Member Mailing	Improve member adherence to Immunization Schedule for all age groups	**CIS - Combo 3:** H2009 rate was 66.23%; increase to **67.92%**. (This will close 5% of the gap between H2009 rate and 100%. NCQA 75th%ile is 76.45%; state average is 53.58). **CIS - Combo 10** is a new 2010 HEDIS measure.	HEDIS technical specifications for rate calculation (Member list comes from monthly On Demand report)	Elizabeth Opland, Quality Management	Three times a year, ending 12/31/10	Mail state immunization schedule and record to all members missing immunizations.	
Chlamydia Screening							
CHL Provider Roster Mailings	Increase CHL screening rates in members aged 16 to 24.	**CHL:** H2009 rate was 51.16%; increase to **53.60%**. (This will close 5% of the gap between H2009 rate and 100%. NCQA 75%ile is 61.81%; state average is 55.79%).	HEDIS technical specifications for rate calculation (Member lists generated from monthly HEDIS intervention report)	Elizabeth Opland, Quality Management	Quarterly, 12/31/10	Mail PCPs a list of their patients needing CHL screening, along with stickers to flag the member's file.	
Diabetes - Comprehensive Diabetes Care (CDC)							

Program Initiative	Scope/Objective	Goals/Benchmarks	Methodology	Responsible Person(s) Department	Target Date for Completion	Interventions	Update (M/D/Y)
CDC Initiatives	Increase CDC screening rates (all measures)	Improve CDC rates; goals TBD	HEDIS technical specifications for rate calculation (Member lists generated from monthly HEDIS intervention report)	Elizabeth Opland, Quality Management, Melody Dowling, Medical Management	Quarterly, 12/31/10	TBD	
Follow-Up After Hospitalization for Mental Health							
FUH - Within 7 Days of IP Discharge	Increase FUH - 7 day rate	**FUH 7 Day:** H2009 rate was 39.34%; increase to **42.37%** (This will close 5% of the gap between H2009 and 100%; NCQA 75th%ile is 56.63%; state average is 38.24%)	HEDIS technical specifications for rate calculation	Melody Dowling, Behavioral Health; Elizabeth Opland, Quality Management	Ongoing	Behavioral case management; IP onsite outreach in which member meets with BH therapist prior to discharge; telephonic outpatient appointments.	
FUH - Within 30 Days of IP Discharge	Increase FUH - 30 day rate	**FUH 30 Day:** H2009 rate was 62.13%; increase to **64.02%**. (This will close 5% of the gap between H2009 rate and 100%; NCQA 75th%ile is 76.52%; state average is 62.06%)	HEDIS technical specifications for rate calculation	Melody Dowling, Behavioral Health; Elizabeth Opland, Quality Management	Ongoing		
Prenatal and Postpartum Care (PCC)							
Timeliness of Prenatal Care - Pregnancy Packet Mailing	Educate members on issues related to pregnancy (e.g. prenatal care; delivery; nutrition)	TOPC: H2009 rate was 92.08%; increase to **92.48%** (This will close 5% of the gap between H2009 rate and 100%; NCQA 75th%ile is 89.29%; state average is 80.84).	# sent per month is tracked.	Melody Dowling, Medical Management	Ongoing	All identified pregnant members are mailed a pregnancy packet including a Pregnancy Book.	
Post Partum Visit - Member Mailing	Educate members on importance of postpartum care & on caring for new baby.	PPV: H2009 rate was 67.21%; increase rate to **68.85%** (This will close 5% of the gap between H2009 rate and 100%; NCQA 75th%ile is 68.23%; state average is 63.08%).	# sent per month is tracked.	Melody Dowling, Medical Management	Ongoing	New mothers are sent the "You and Your Baby Booklet". Well-child checkup and imms schedules are included.	
Well-Care Visits - WC15 (First 15 months), WC34 (3-6 years), AWC (12-21 years)							

Program Initiative	Scope/Objective	Goals/Benchmarks	Methodology	Responsible Person(s) Department	Target Date for Completion	Interventions	Update (MD/Y)
EPSDT Member Visit Due and Visit Overdue Reminders	Increase the number of children receiving annual EPSDT/Well care exams & staying up-to-date on immunizations.	**WC15**: H2009 rate was 66.93%; increase rate to **68.58%**; NCQA 75th%ile is 67.39%; state average is 50.26%. **WC34**: H2009 rate was 57.87%; increase to **59.98%**; NCQA 75th%ile is 75.86%; state average is 56.91%. **AWC**: H2009 rate was 43.06%; increase to **45.91%**; NCQA 75th%ile is 53.08%; state average is 35.82%. **State EPSDT** participation rate: CY2008 rate was 68.46%; state requirement is 80%	HEDIS technical specifications for each measure.	Elizabeth Opland, Quality Management	Monthly, 12/31/2010	**Visit Due**: Mail postcards to all members (birth to 20) during their birth month to remind them to get their well-child checkups and stay up to date on immunizations. Other developmental info included in postcards. **Visit Overdue**: Mail to members who are 4 months past due for their well-child visit (ages 3 and older).	
EPSDT Provider Report - Missed Appointments	Increase the # of children receiving annual EPSDT exams & staying up-to-date on immunizations.	See above.	HEDIS technical specifications for each measure.	Elizabeth Opland, Quality Management	Ongoing	Implement new provider web portal containing rosters of members (birth to 21) overdue for well-child appointments (and all P&W screenings and HEDIS measures)	
Did Not Keep Appointment Initiative	Educate parents on importance of keeping well child and immunization appointments.	See above.	Track % of members receiving a well child visit following DNKA letter or phone call.	Elizabeth Opland, Quality Management	Ongoing	Providers notify MO Care when a member (all ages) does not show for a well child visit. Parent is sent a letter on importance of visits & of keeping appointments. When a 2nd notice is received, QM Nurse contacts parent to discuss barriers to care.	
Well-Child 34 / WIC Collaboration - Letters to members not enrolled in WIC; Well-Child checkup Flyers distributed during WIC appointment	Increase WC34 rates through partnership with county WIC offices. 2009 WIC PIP evaluation demonstrated that participation was associated with increased compliance with well child screenings.	**WC34**: H2009 rate was 57.87%; increase to **59.98%**; (This will close 5% of the gap between H2009 rate and 100%). NCQA 75th%ile is 75.86%; state average is 56.91%.	HEDIS technical specifications for rate calculation.	Elizabeth Opland, Quality Management	Biannually 1/10 and 7/10	Identify members *not enrolled* in WIC who have not had a recent well-child check. Send letter to parent to encourage WIC enrollment. WIC nutritionist distributes Missouri Care flyer on importance of well-child checkups and encourages scheduling of well child visit with PCP.	

Program Initiative	Scope/Objective	Goals/Benchmarks	Methodology	Responsible Person(s) Department	Target Date for Completion	Interventions	Update (M/D/Y)
Come In for Care Partnerships (Community Health Centers/Clinics); WC34 & AWC Missed Appointment Outreach	Improve WC34 and AWC checkup rates	WC34: H2009 rate was 57.87%; increase to **59.98%**; NCQA 75th%ile is 75.86%; state average is 56.91%. AWC: H2009 rate was 43.06%; increase to **45.91%**; NCQA 75th%ile is 53.08%; state average is 35.82%.	HEDIS technical specifications for each measure.	Elizabeth Opland, Quality Management	Biannually 6/10 and 10/10	Use monthly HEDIS intervention report to generate mailing to clinics and county health departments regarding members due for WC34 and AWC services. Letter mailed by MO Care includes provider letterhead.	
Summer W34 Well Child Mailing	Improve WC34 checkup rates	WC34: H2009 rate was 57.87%; increase to **59.98%**; (This will close 5% of the gap between H2009 rate and 100%. NCQA 75th%ile is 75.86%; state average is 56.91%.).	HEDIS technical specifications for rate calculation.	Elizabeth Opland, Quality Management	06/15/2010	Target all 3-6 years olds without a WC checkup in the calendar year with a "Summer is a good time to get a check up" flyer.	
WC34 and Adolescent Well Care (AWC) Provider Roster Mailings	Improve AWC checkup rates	**WC34: H2009 rate was 57.87%; increase to 59.98%; NCQA 75th%ile is 75.86%; state average is 56.91%.** AWC: H2009 rate was 43.06%; increase to **45.91%**; (This will close 5% of the gap between H2009 rate and 100%; NCQA 75th%ile is 53.08%; state average is 35.82%.)	HEDIS technical specifications for rate calculation, using monthly HEDIS intervention reports.	Elizabeth Opland, Quality Management	Quarterly, 12/31/2010	Mail letter with AWC screening guidelines to provider with flyer/chart sticker for members file. Provide teen health brochure for distribution to members. Encourage scheduling AWC at member's next visit.	
Adolescent Well Care (AWC) Teen Health Mailing to Members	Improve screening rates for AWC, CHL, CCS, flu shots and Immunizations	AWC: H2009 rate was 43.06%; increase to **45.91%**; NCQA 75th%ile is 53.08%; state average is 35.82%.	HEDIS technical specifications for rate calculation, using monthly HEDIS intervention reports.	Elizabeth Opland, Quality Management	Monthly, 12/31/2010	Teen brochure mailing	
Breast Cancer Screening Member Mailing (New 2010)	Improve breast cancer screening rates	BCS rate, goal TBD	HEDIS technical specifications for rate calculation, using monthly HEDIS intervention reports.	Elizabeth Opland, Quality Management	Monthly, 12/31/2010	Combined cervical cancer and breast cancer screening reminder post cards mailed to members in birthday month	
Prevention & Wellness Interventions (Not otherwise listed)							
Preventive Care Toolkits	Increase provider compliance with EPSDT, Immunizations, lead screening guidelines, Chlamydia, and Health Literacy	Improved performance on HEDIS measures of WC34, AWC, CIS, & AIS. Increased lead testing rate of 1 & 2 year old children. Increase Chlamydia rate for women 16-24.	HEDIS technical specs for HEDIS measures. Provider statisfaction with toolkit also evaluated.	Elizabeth Opland, Quality Management	Ongoing	Preventive Care Toolkit CDs delivered/mailed to provider offices. Toolkits include overview, guidelines, required, and recommended forms on EPSDT, LEAD, Imms, Chlamydia, and Health Literacy.	
AIDS Intervention	Educate members about AIDS	Increased member and provider awareness/education of AIDs	TBD	Elizabeth Opland, Quality Management	12/31/2010	Member education, Case management	

Program Initiative	Scope/Objective	Goals/Benchmarks	Methodology	Responsible Person(s) Department	Target Date for Completion	Interventions	Update (MD/Y)
Tobacco Cessation	Educate pregnant women about the importance of smoking cessation	Increased member education	TBD	Elizabeth Opland, Quality Management	12/31/2010	Member education, Case management	
Practitioner Profiling (New 2010)	Monitor practitioners' utilization practices along with members' health outcomes to identify opportunities for improvement.	TBD	TBD	Mike Dunne, Provider Relations, Elizabeth Opland, Quality Management	12/31/2010	Profiles distributed to high-volume providers	
On-hold messages	Prevention & wellness topics	Increased awareness by member of P&W topics.	Topics of messages are tracked to insure a variety of messages as well as key topics are included regularly.	Elizabeth Opland, Quality Management	Quarterly	Update on-hold messages with relevant and seasonally appropriate prevention & wellness topics.	
Education through Provider, Member, and School Nurse Newsletters	Prevention & wellness topics	Increased member and provider awareness of prevention and wellness topics.	P&W articles are tracked to make sure all HEDIS topics are covered annually and seasonal topics are covered as appropriate (e.g. flu shot)	Marketing/Outreach (All Dept. contribute articles); QM & MM responsible health ed materials	Quarterly	Prevention & wellness articles in every issue.	
Health Education materials distributed at community events	Prevention & wellness topics	Increased community awareness of prevention and wellness topics.	# of events attended and # of attendees are tracked.	Marketing/Outreach - identifies events; QM orders & selects health education materials.	Ongoing	Prevention & wellness materials distributed at community events such as health & back-to-school fairs.	
Performance Improvement Projects (PIPS)							
EPSDT PIP (new for 2010)	Increase EPSDT rates in children of all ages	WC15: H2009 rate was 66.93%; increase rate to **68.58%**; NCQA 75th%ile is 67.39%; state average is 50.26%. WC34: H2009 rate was 57.87%; increase to **59.98%**; NCQA 75th%ile is 75.86%; state average is 56.91%. AWC: H2009 rate was 43.06%; increase to **45.91%**; NCQA 75th%ile is 53.08%; state average is 35.82%. EPSDT participation: CY2008 rate was 68.46%; state requirement is 80%. CIS - Combo 3:H2009 rate was 66.23%; increase to 67.92%; NCQA 75th%ile is 76.45%; state average is 53.58%.	HEDIS technical specifications for each measure.	Elizabeth Opland, Quality Management	Quarterly, through 12/31/10	Implement new provider rosters of members due for a well-care visit during members' birthday month	

Program Initiative	Scope/Objective	Goals/Benchmarks	Methodology	Responsible Person(s) Department	Target Date for Completion	Interventions	Update (MDY)
Lead Screening in Children PIP (new for 2010)	Increase lead testing rates at 12 and 24-months of age.	**Lead**: H2009 rate was 72.99%; Increase to **74.34%.** (This will close 5% of the gap between H2009 rate and 100%; NCQA	HEDIS technical specifications for the measure.	Elizabeth Opland, Quality Management	Ongoing through 12/31/2010	Provider and member mailings, Lead screen brochure, Provider Toolkit	
Asthma Management PIP	Increase the number of members with persistant asthma who are being prescribed controller meds.	**ASM**: H2009 rate was 82.46%; Increase to **83.34%.** (This will close 5% of the gap between H2009 rate and 100%; NCQA 75%ile is 91.12%; state average is 87.42%)	HEDIS technical specifications for the measure.	Elizabeth Opland, Quality Management	Quarterly through 12/31/2010	Provider Rosters; member mailing; follow up by CR nurse after member discharged from hospital stay with asthma. CMO education of PCP when member hospitalized for asthma.	
Adolescent Well-Care PIP	Part of a State Wide PIP to increase MO rates on HEDIS AWC measure.	**AWC**: H2009 rate was 43.06%; Increase to **45.91%**; (This will close 5% of the gap between H2009 rate and 100%; NCQA 75th%ile is 53.08%; state average is 35.82%.)	HEDIS technical specifications for the measure.	Elizabeth Opland, Quality Management	Ongoing through 12/31/10	Provider Rosters - September 2010; member mailing in July 2010 and November 2010 (intervention list)	
Chlamydia Screening PIP	Increase the number of members aged 16 to 24 who are screened for chlamydia	**CHL**: H2009 rate was 51.16%; Increase to **53.60%.** (This will close 5% of the gap between H2009 rate and 100%. NCQA 75%ile is 61.81%; state average is 55.79%).	HEDIS technical specifications for the measure.	Elizabeth Opland, Quality Management	Quarterly (March, June, Sept, Dec 10)	Provider Rosters, Teen Health Mailing (parents of 12-20 year-olds), CCS/CHL birthday cards	
WC34 /WIC Collaboration PIP	Raise HEDIS Well-Child 34 rates by collaborating with local WIC agencies.	**WC34**: H2009 rate was 57.87%; Increase to **59.98%**; (This will close 5% of the gap between H2009 rate and 100%. NCQA 75th%ile is 75.86%; state average is 56.91%.).	HEDIS technical specifications for W34 rate calculation. Other PIP-specific measures.	Elizabeth Opland, Quality Management	Ongoing in 2010	Identify MO Care WIC participants. Notify WIC of members aged 6 months-4.5 years due for Well -Child Check. WIC then encourages member to seek appointment. MO Care in turn encourages members who do not participate in WIC to sign-up.	
Follow Up After Hospitalization for Mental Illness (FUH) PIP	Increase # of members receiving 7 & 30 day follow up appointments following discharge from inpatient stay for mental health.	**FUH 7 Day**: H2009 rate was 39.34%; Increase to **42.37%.** **FUH 30 Day**: H2009 rate was 62.13%; Increase to **64.02%.**	HEDIS technical specifications for 7- and 30-day FUH rate calculation (intervention based on inpatient census)	Elizabeth Opland, QM (PIP write-up and analysis) and Melody Dowling, Behavioral Health (case and care management)	Ongoing through 12/31/2010	Care manager works with inpatient facility to schedule follow up appt. Case manager works with member to ensure member keeps appointment and can get to appointment. BH manager monitors compliance of inpatient facilities in scheduling f/u appointments. Develop exclusion database.	

Program Initiative	Scope/Objective	Goals/Benchmarks	Methodology	Responsible Person(s) Department	Target Date for Completion	Interventions	Update (MD/Y)
Dental PIP	Increase Annual Dental Visit (ADV) combined rate, as well as for specific age groupings.	ADV: H2009 rate was 27.41%; increase to 30.88%. (This will close 5% of the gap between H2009 rate and 100%; state average was 32.29%; NCQA 75th%ile was 52.79%; State Dental Task Force requires 3% increase)	HEDIS technical specifications for rate calculation (Member lists generated from monthly HEDIS intervention report)	Elizabeth Opland, Quality Management	12/31/10	Member reminder post cards and PCP "prescription pads" for dental care	
Disease Management Programs							
Asthma	Disease Management	• Use of appropriate medications for people with asthma • Pharmacy adherence to controller medications • Rate of ER utilizations and IP hospitalizations for asthma • Rate of flu shots	NA	Annette Graham, Disease Management	Quarterly, 12/31/10	Member education and self-management support	
Chronic Obstructive Pulmonary Disorder (COPD)	Disease Management	• Use of spirometry testing in assessment and diagnosis of COPD • Number of ED visits • Number of hospitalizations • Rate of flu shots • Percentage of members on bronchodilators	NA	Annette Graham, Disease Management	Quarterly, 12/31/10	Member education and self-management support	
Congestive Heart Failure (CHF)	Disease Management	• Pharmacy adherence to ACEIs/ARBs • Pharmacy adherence to beta blockers • Number of ED visits • Inpatient days (hospitalizations)	NA	Annette Graham, Disease Management	Quarterly, 12/31/11	Member education and self-management support	
Diabetes	Disease Management	Annual screening of the following: • HbA1c testing • LDL-C • Retinal eye exam • Nephropathy screening • Rate of annual flu shot • Percentage of members on ACEIs/ ARBs	NA	Annette Graham, Disease Management	Quarterly, 12/31/10	Member education and self-management support	
Depression	Disease Management	TBD	NA	Annette Graham, Disease Management	Quarterly, 12/31/10	Member education and self-management support	
Credentialing							

Program Initiative	Scope/Objective	Goals/Benchmarks	Methodology	Responsible Person(s) Department	Target Date for Completion	Interventions	Update (M/D/Y)
Ongoing monitoring of providers	To monitor providers for licensure sanctions & complaints between recredentialing cycles.	Identify all providers with sanctions and quality issues and bring them back before the MQM committee if necessary.	Ongoing monitoring activities logged monthly	Elizabeth Opland, Quality Management	Monthly	Review: OIG exclusions report; Healing Arts Newsletter (semi-annually); call tracking report; sentinel/adverse events.	
Credentialing/ Recredentialing	Receive application and supporting documents. Complete primary source verification following NCQA guidelines.	Meet 180 day NCQA guidelines for primary source verification. Recredential all providers every 3 years.	# of providers initial credentialed; # of providers recredentialed. Track # of providers with expired credentials.	Aetna's CVO, @ Credentials, Elizabeth Opland, Quality Management	Ongoing		
Delegated Credentialing Audits	Complete audits of all delegated credentialing organizations.	Audit 100% of delegated providers annually.	% of delegated providers audited.	Elizabeth Opland, Quality Management	Within 1 year of prior audit (date varies by organization) - all to be completed by 12/31/10		
NCQA Accreditation							
Submit Application for Accreditation	Submit to MHD per contract for NCQA Accreditation: application, report, and status	Successful submission	N/A	Karen Holt, NCQA Manager	Status updates on 4/1/2010 and 6/30/10; completed application by 10/1/10		
Service Performance Indicators							
Provider Access Survey	Determine if appointment access standards are being met.	100% of providers surveyed will meet access standards.	Telephone survey administered by internal staff	Michael Dunne, Provider Relations	9/1/10		
Member Satisfaction Survey (Consumer Assessment of Health Plans - CAHPs)	Monitor Member Satisfaction with Missouri Care & Network	Perform at or above last year's measures and the national benchmarks.	Member survey administered by the Myers Group.	Elizabeth Opland, Quality Management	6/15/10		
Provider Satisfaction Survey	Monitor Provider Satisfaction with Missouri Care	Maintain peformance.	Provider survey administered by the Myers Group	Michael Dunne, Provider Relations	7/1/10		
Monitor member/provider grievances & appeals	Maintain quality services for members; address member concerns.	All grievances are addressed & closed.	Assignment to appropriate manager for resolution through SIC committee.	Debbly Langley. Member Services	Ongoing		
Monitoring of sentinal events/quality issues	Maintain quality care by evaluating sentinel events and quality issues.	Evaluate all sentinel events and quality concerns to determine if corrective action is needed.	All events are logged and tracked/trended. Potential quality of care issues are presented to MQM.	Elizabeth Opland, Quality Management; Medical Management	Ongoing		

Attachment 19

MOLINA
WORKPLAN FOR NEXT YEAR

Molina Healthcare of Missouri's (MHMO) workplan is driven by the goal of achieving National Committee for Quality Assurance (NCQA) accreditation in 2011. Quality Improvement activities will be related to compliance with NCQA standards. Through strategic planning, MHMO is committed to increasing targeted Healthcare Effectiveness Data and Information Set (HEDIS) scores through a combination of improved encounter data capture, reporting and member/provider incentives. MHMO plans to focus interventions on the following HEDIS measures: Adolescent, Well Care Visits, Cervical Cancer Screening, Childhood Immunizations, Timeliness of Prenatal Care and Asthma Medication use. In addition, MHMO will focus on the following Consumer Assessment of Healthcare Providers and Systems (CAHPS) scores: Health Plan Overall, Health Care Overall and Health Plan Complaint and Problem Resolution. MHMO will update policies and procedures and document detailed data analyses to meet NCQA compliance as well as compliance with the changes to the MO HealthNet Managed Care Program. Finally, MHMO will focus on improving its delegation oversight program.