Rules of
Department of Health
Division 10—Office of the Director
Chapter 5—Procedures for the Collection and Submission of Data to Monitor Health Maintenance Organizations

Title 19—DEPARTMENT OF HEALTH

Division 10—Office of the Director

Chapter 5—Procedures for the Collection and Submission of Data to Monitor Health Maintenance Organizations

19 CSR 10-5.010 Monitoring Health Maintenance Organizations Definitions

PURPOSE: This rule establishes the procedures for health maintenance organizations to collect and submit data to the Department of Health pursuant to section 192.068, RSMo.

(1) The following definitions shall be used in the interpretation and enforcement of this rule:

(A) Department means Missouri Department of Health;

(B) Director means the director of the Missouri Department of Health;

(C) Health care plan means any separately licensed entity subject to the provisions of sections 354.400 to 354.636, RSMo which had enrollees in the plan for at least six (6) months of the year for which data are to be reported and for at least six (6) months of the following year;

(D) NCQA means the National Committee on Quality Assurance; and

(E) HEDIS© means the current Health Plan Employer Data and Information Set.

(2) Starting in 1998, health care plans shall submit annually to the department, member satisfaction survey data—

(A) The member satisfaction survey shall be conducted according to HEDIS© technical specifications, including survey instrument, sample size, sampling method, and collection protocols;

(B) The commercial and Medicaid member satisfaction data shall be submitted to the department in electronic form, through a certified survey vendor, and meet the specifications of Table A. Table A is incorporated herein by reference. An exception to this requirement shall be made for those Medicaid health care plans that are required to participate in a member satisfaction survey conducted by the Division of Medical Services. For these plans, the department will obtain the member satisfaction data from the Division of Medical Services;

(C) In 1998 the data shall be submitted by September 1. In subsequent years a final member-level data file shall be submitted by June 15 or the date required by NCQA if other than June 15; and

(D) Medicare health care plans shall participate in a member satisfaction survey conducted by the Health Care Financing Administration. The department will obtain the data from the Health Care Financing Administration.

(3) Starting in 1998, health care plans shall provide annually to the department, audited quality indicator data—

(A) Quality indicator data shall be in accordance to all HEDIS© specifications;

(B) All health care plans shall submit to the department documentation from a NCQA licensed organization that the quality indicator data submitted to the department have been audited through a partial or complete audit according to HEDIS© specifications;

(C) Each licensed health care plan shall submit separate quality indicator data files for their commercial, Medicaid and Medicare enrollees. Health care plans that contract with the Division of Medical Services to provide coverage in more than one Medicaid region, shall submit separate quality indicator data for the enrollees in each region. The quality indicator data shall be submitted to the department in electronic form and conform to the specifications listed in Table B. Table B is incorporated herein by reference; and

(D) In 1998 the data shall be submitted by September 1. In subsequent years a final data file shall be submitted by June 15 or the date file required by NCQA if other than June 15.

(4) In 1998 access to care data shall be submitted by September 1. In subsequent years the data shall be submitted by June 15. Access to care data shall include the data elements and conform to the specifications listed in Table D. Table D is incorporated herein by reference.

(5) A health care plan demonstrates continual or substantial failure to comply with the provisions of this rule when the health care plan has been notified by the department that it fails to comply with the provisions of section 192.068, RSMo and this rule and the health care plan—

(A) Fails to provide required data;

(B) Fails to submit data that meet the data standards detailed in this rule; or

(C) Fails to submit data within the time frames established in this rule.

AUTHORITY: section 192.068, RSMo Supp. 1999. Emergency rule filed Jan. 16, 1998, effective Jan. 26, 1998, terminated April 15, 1998. Original rule filed Jan. 16, 1998, effective Aug. 30, 1998. Amended: Filed Oct. 30, 1998, effective May 30, 1999. Amended: Filed Dec. 20, 1999, effective May 30, 2000. Amended: Filed Sept. 15, 2000, effective April 30, 200I.*

**Original authority: 192.068, RSMo 1997.*

Table A

Member Satisfaction Survey Data File Specifications

File Content

Member satisfaction survey data shall be based on the version of the NCQA-required Consumer Assessment of Health Plans Study (CAHPS) Questionnaire, applicable for the reporting year. The data reported to the Department shall include the adult core set of questions, plus any NCQA-mandated or –recommended items for the adult segment of the questionnaire. The data shall also include any HEDIS measures specified in Table B, for a given product line and reporting year, that are collected via the CAHPS survey tool.

File format and media

The member-level satisfaction survey data shall be submitted electronically, using the data submission tool (DST) specified by the Department. Other file specifications shall conform to those required by NCQA for submission of the CAHPS Questionnaire results by the certified vendors.

File consistency

Plans that elect to submit separate files for sub-groups of their enrollment population must consistently do so for all data submission categories required by this rule.

Table B

Quality Indicator Data Specifications
Reporting Period: CY 2000

Data reported for each of the indicators listed below shall conform to the NCQA HEDIS Data Submission Tool and all other HEDIS technical specifications for indicator descriptions and calculations. An "X" in the table below indicates data are to be reported for this quality indicator if the health care plan offers this product line to Missouri residents.

	Applicable to:		
Indicator*	**Commercial**	**Medicaid**	**Medicare**
Childhood Immunization Status	X	X	
Adolescent Immunization Status	X	X	
Breast Cancer Screening	X		X
Cervical Cancer Screening		X	
Controlling High Blood Pressure	X		X
Cholesterol Management After Acute Cardiovascular Event	X		X
Comprehensive Diabetes Care	X		X
Antidepressant Medication Management	X		X
Advising Smokers to Quit (CAHPS)	X		
Flu Shots for Older Adults (CAHPS)			X
Annual Dental Visit		X	

*The plan may elect to use the prior year's data when the indicator is subject to rotation and is off-cycle for NCQA reporting.

File Content

For each of the quality indicators listed above, except for those collected via the CAHPS questionnaire, the plans shall report the following elements from the NCQA HEDIS Data Submission Tool:

1. Data collection methodology (Administrative or Hybrid.)
2. Eligible member population (i.e., members who meet all denominator criteria.)
3. Minimum required sample size (MRSS) or other sample size
4. Number of original sample records excluded because of valid data errors.
5. Number of records excluded because of contraindications identified through administrative data.
6. Number of records excluded because of contraindications identified through medical record review.
7. Additional records added from the auxiliary list.
8. Denominator
9. Numerator events by administrative data
10. Numerator events by medical record
11. Reported rate
12. Lower 95% confidence interval
13. Upper 95% confidence interval

All data elements above shall conform to the HEDIS technical specifications, as outlined in the NCQA-published technical manuals.

Table B

Quality Indicator Data Specifications
Reporting Period: CY 2000
(continued)

File format and media

The quality indicator data shall be submitted electronically, in a data file format to be specified by the Department. All other data specifications shall conform to those required by NCQA for submission of the audited quality indicator data.

File Consistency

Plans that elect to submit separate files for sub-groups of their enrollment population must consistently do so for all data submission categories required by this rule. Health care plans that contract with the Division of Medical Services to provide coverage in more than one Medicaid region, shall submit separate quality indicator data for the enrollees in each region.

Table D

Managed Health Care Services

File Specifications

Responses to the survey items in Table D must be submitted electronically, in a data file format specified by the Department.

Table D must be completed for each managed care product line (Commercial, Medicaid, or Medicare) offered by each licensed health care plan. Responses should be based on activity or status during the reporting period, within each product line (payer). Survey questions in Table D shall apply, except where otherwise noted, only to fully insured (ERISA exempt) enrollments.

Table D
Managed Health Care Services
Reporting Period: CY 2000

I. HEALTH PLAN INFORMATION

Instructions: Submit one set of Table D information, Parts I and II, for each product line (i.e. type of payor) offered by your organization.

1.) Product Line (CHECK ONE): ( ) Commercial ( ) Medicare ( ) Medicaid

2.) Missouri Department of Insurance Licensed Plan Name:

_____ Dba (if applicable): _____

3.) Extended NAIC Identification Number (7-digit): _ _ _ _ _ _ _

4.) Name as marketed to your members (for Consumer's Guide display purposes):

_____

5.) List the following for each of your products within this product line:

a.) Product Name	b.) HMO/POS	c.) Customer Service	d.) RN Hotline

(Marketed; ----------Phone Numbers----------)

6.) Through what organization was your managed care organization accredited as of :

a.) *January 1, 2000*?
Accrediting organization: ( ) NCQA ( ) URAC ( ) JCAHO ( ) None
Level of Accreditation: _____ _____ _____

b.) *December 31, 2000*?
Accrediting organization: ( ) NCQA ( ) URAC ( ) JCAHO ( ) None
Level of Accreditation: _____ _____ _____

7.) Managed Care Organization Contact Person for Table D Information:

a.) Name: _____ b.) Title: _____

c.) Phone: _____ d.) Fax: _____ e.) E-mail: _____

Table D
Managed Health Care Services
Reporting Period: CY 2000

II. HEALTH PLAN SERVICES

1.) Please indicate for each of the following high risk conditions/diseases, if your managed care plan (A) has screening mechanisms, (B) provides case management, (C) provides specific educational materials to persons-at-risk, and (D) distributes educational material for all plan enrollees*. (CHECK ALL THAT APPLY)

High Risk Conditions/Diseases	(A) Screening Mechanisms	(B) Case Management	(C) Education for Persons-at-risk	(D) Education for All Plan Enrollees
Asthma	( )	( )	( )	( )
Stroke/Cardiovascular Disease	( )	( )	( )	( )
Breast Cancer	( )	( )	( )	( )
Cervical Cancer	( )	( )	( )	( )
Ovarian Cancer	( )	( )	( )	( )
Congestive Heart Failure (CHF)	( )	( )	( )	( )
Chronic Obstructive Pulmonary Disease (COPD)	( )	( )	( )	( )
Diabetes	( )	( )	( )	( )
Depression	( )	( )	( )	( )
HIV	( )	( )	( )	( )
Sickle Cell Disorders	( )	( )	( )	( )
High Risk Pregnancy	( )	( )	( )	( )
Obesity	( )	( )	( )	( )
Lead Poisoning	( )	( )	( )	( )
Chlamydia:				
Females	( )	( )	( )	( )
Males	( )	( )	( )	( )
High Blood Pressure	( )	( )	( )	( )
Tobacco Use	( )	( )	( )	( )
Other _____ (PLEASE SPECIFY)	( )	( )	( )	( )

*Education strategies for all plan enrollees may include but are not limited to newsletters, periodicals, direct mailings and similar types of media campaigns.

2.) Please indicate if your managed care plan provides any of the following:

a.) Routine distribution of educational materials on general health promotion, disease prevention and wellness ( ) YES ( ) NO

b.) Distribution of pre- and post-surgical information to enrollees ( ) YES ( ) NO

Note: The term *reminder/recall* in Questions 3a – 4b refers to notices intended to insure timely scheduling of the specific preventive screening/test or service indicated. General education materials or notices tied to anniversary dates, such as birthdays or enrollment dates, do not meet this definition.

3a.) **Commercial or Medicaid only** (If completing for a Medicare plan, skip to Question 3b)

Do you send reminder/recall letters and/or make telephone calls from your managed care plan office to your members to ensure usage of the following preventive services?

Mammograms	( ) YES	( ) NO
Immunizations	( ) YES	( ) NO
Pap smears	( ) YES	( ) NO
Diabetic Screens/Tests	( ) YES	( ) NO

3b.) **Medicare only**

Do you send reminder/recall letters and/or make telephone calls from your managed care plan office to your members to ensure usage of the following preventive services?

Mammograms	( ) YES	( ) NO
Immunizations	( ) YES	( ) NO
Well-woman checks	( ) YES	( ) NO
Diabetic Screens/Tests	( ) YES	( ) NO

4a.) **Commercial or Medicaid only** (If completing for a Medicare plan, skip to Question 4b)

Do you provide reminder/recall letters for your providers to use to notify your enrollees of the following preventive services?

Mammograms	( ) YES	( ) NO
Immunizations	( ) YES	( ) NO
Pap smears	( ) YES	( ) NO
Diabetic Screens/Tests	( ) YES	( ) NO

4b.) **Medicare only**

Do you provide reminder/recall letters for your providers to use to notify your enrollees of the following preventive services?

Mammograms	( ) YES	( ) NO
Immunizations	( ) YES	( ) NO
Well-woman checks	( ) YES	( ) NO
Diabetic Screens/Tests	( ) YES	( ) NO

5.) **Commercial only**

During the reporting period, did your plan provide coverage to your non-ASO members for the following health benefits? Please indicate if the benefit item was offered as standard coverage for all non-ASO products within the product line (commercial, Medicaid or Medicare), as standard coverage only for some non-ASO products in the product line, offered only by rider clause (employer option), or not covered at all. (CHECK ONLY ONE FOR EACH BENEFIT LISTED)

	Non-ASO Products Only			
	All Products	**Some Products**	**Offered only by rider clause**	**Not Offered**
Rx coverage of prenatal vitamins, including folic acid	( )	( )	( )	( )
Contraceptives:				
Birth control pills	( )	( )	( )	( )
IUDs	( )	( )	( )	( )
Norplant	( )	( )	( )	( )
Depo Provera	( )	( )	( )	( )
Immunizations:				
Hepatitis A	( )	( )	( )	( )
Hepatitis B	( )	( )	( )	( )
Annual eye exam for refractive errors	( )	( )	( )	( )
Insulin pumps	( )	( )	( )	( )
Autologous bone marrow transplants	( )	( )	( )	( )
Stem cell rescue for breast cancer	( )	( )	( )	( )
Access to chiropractic services	( )	( )	( )	( )
Psychotherapy services				
Individual	( )	( )	( )	( )
Group	( )	( )	( )	( )
Family	( )	( )	( )	( )
Marital	( )	( )	( )	( )
Substance abuse services:				
Inpatient/residential	( )	( )	( )	( )
Outpt./partial hospitalization	( )	( )	( )	( )
Unrestricted annual flu shots	( )	( )	( )	( )
Smoking cessation classes or cessation medications	( )	( )	( )	( )
Conduct wellness surveys*	( )	( )	( )	( )

*A wellness survey is a questionnaire on health behaviors. It does not refer to a physical exam.

6.) During the reporting period, did your plan manage the following health services for your ASO group contracts? For each of the health services listed below, please indicate if it was elected as a covered benefit in all the ASO contracts with your plan, in some of the ASO contracts, or in none of the ASO contracts. (CHECK ONE COLUMN ONLY) Also indicate the proportion of your total ASO member enrollment who have coverage for the health service.

Selected Covered Benefits:

	ASO Contracts		
	All Contracts	**Some Contracts**	**None of the Contracts**
Immunizations	( )	( )	( )
Mammograms	( )	( )	( )
Pap Smears	( )	( )	( )

7.) For each preventive service listed below, please indicate (A) if your plan provided physicians routine status reports on the delivery of these services to their panel members and (B) if your plan sent comparative information to the physicians, during the reporting year. Following each response, enter a brief description of the report(s) or information that you sent.

	(CHECK IF YES)		(CHECK IF YES)	
	(A) Plan Provided Reports	**Description of Report(s)**	**(B) Plan Sent Comparative Data**	**Description of Report(s)**
Childhood Immunizations	( )	_____	( )	_____
Adolescent Immunizations	( )	_____	( )	_____
Breast Cancer Screenings	( )	_____	( )	_____
Pap Smears	( )	_____	( )	_____
Chlamydia Screenings:				
Females	( )	_____	( )	_____
Males	( )	_____	( )	_____
Lead Screenings:				
12 and 24 months	( )	_____	( )	_____
Under 6 if no prior blood test	( )	_____	( )	_____
Cholesterol Management after Acute Cardiovascular Event: LDL-C Screenings	( )	_____	( )	_____
Beta Blocker Treatment After Heart Attack	( )	_____	( )	_____
Comprehensive Diabetic Care:				
Hemoglobin Testing	( )	_____	( )	_____
Retinal Disease Eye Exam	( )	_____	( )	_____
LDL-C (Lipids) Testing	( )	_____	( )	_____
Nephropathy Screenings	( )	_____	( )	_____
Annual Flu Shots for Older Adults	( )	_____	( )	_____
Tobacco Cessation Counseling	( )	_____	( )	_____
Other (Please specify)_____	( )	_____	( )	_____

8.) Does your plan routinely conduct continuing education with your providers to improve their knowledge on current clinical practice recommendations?

( ) YES ( ) NO

9.) Please indicate the administrative policies for your HMO (non-POS) plan products, as they applied to your non-ASO members during the reporting year. (CHECK A RESPONSE FOR EACH POLICY LISTED)

	YES All HMO Product	YES Some HMO Products	NO No HMO Products
a.) Allow access to within-network OB/GYNs other than the once per year visit without referral	( )	( )	( )
b.) PCP must obtain prior authorization from HMO or its agency for referral to within-network, non-OB/GYN medical/surgical specialists	( )	( )	( )
c.) Allow members to self-refer to within-network medical/surgical specialists, other than OB/GYN	( )	( )	( )
d.) Allow members to self-refer to within-network mental health specialists	( )	( )	( )
e.) Allow medical specialists other than OB/GYN to be designated as PCP for patients with a chronic disease	( )	( )	( )
f.) Members can access some health practitioners, other than medical/surgical or mental health specialists, without referral or prior authorization	( )	( )	( )

g.) If YES for all or some products on Question 9f.), list the additional types of providers that can be accessed without referral or prior authorization:

All Products	Some Products

10.) For each of the practitioner categories below, indicate the number you had in your plan network during the reporting year and the number of that total which your MCO verified, within the past two years, as being board certified.

	Number of Practitioners	**Number Who Are Board Certified**
a.) Primary Care Physicians (excluding OB/GYNs)	_____	_____
b.) Medical/Surgical Specialists (excluding OB/GYNs)	_____	_____
c.) OB/GYNs	_____	_____
d.) Chiropractors	_____	_____
e.) Mental Health Providers	_____	_____
f.) General Dentists	_____	_____