

press the recovered materials for shipping. Because the taxpayer is collecting recyclable materials and converts them into a different form, which is then used to produce new products, the taxpayer's operation would qualify as a material recovery processing plant. The loaders, baling machines and crushing equipment would qualify for the material recovery processing plant exemption if they were purchased and used to establish a new, or to replace or expand an existing plant.

*AUTHORITY:* sections 144.270 and 144.705, RSMo 1994. Original rule filed Nov. 18, 1999.

*PUBLIC COST:* This proposed rule will not cost state agencies or political subdivisions more than \$500 in the aggregate.

*PRIVATE COST:* This proposed rule will not cost private entities more than \$500 in the aggregate.

*NOTICE TO SUBMIT COMMENTS:* Anyone may file a statement in support of or in opposition to this proposed rule with the Department of Revenue, Office of Legislation and Regulations, P.O. Box 629, Jefferson City, MO 65105. To be considered, comments must be received within thirty days after publication of this notice in the *Missouri Register*. No public hearing is scheduled.

**Title 16—RETIREMENT SYSTEMS**  
**Division 10—The Public School Retirement System of Missouri**  
**Chapter 6—The Nonteacher School Employee Retirement System of Missouri**

**PROPOSED AMENDMENT**

**16 CSR 10-6.020 Source of Funds.** The board is amending section (12).

*PURPOSE:* This amendment corrects the citing of an incorrect section number.

(12) The terms "salary," "salary rate" and "compensation" are synonymous when used in regulations promulgated by the board, unless the context plainly requires a different meaning.

(A) For purposes of calculating contributions and benefits, those terms mean the regular remuneration earned by a member as an employee of any covered district during a school year, including (unless excluded by subsection (12)(B)):

1. Salary paid under the terms of the basic employment agreement;
2. Wages;
3. Payments for extra duties, whether or not related to the employee's regular position;
4. Overtime payments;
5. Career ladder payments made pursuant to sections 168.500 to 168.515, RSMo;
6. Supplemental salary paid in addition to workers' compensation;
7. Medical benefits as specified in section [(5)](10) of this rule;
8. Payment for annual leave, sick leave or similar paid leave actually used by the member;
9. Payment for leaves of absence if at least one hundred percent (100%) of previous contract rate;
10. Compensation on which taxation is deferred under *Internal Revenue Code* (IRC) section 401(k), 403(b), 457, 414(h)(2) or similar plans established by the employer under the IRC;
11. Salary reductions for purposes of a plan established by the employer under IRC section 125; and

12. Other similar payments that are earned by a member as an employee of any covered district during a school year.

*AUTHORITY:* section 169.610, RSMo 1994. Original rule filed Dec. 19, 1975, effective Jan. 1, 1976. For intervening history, please consult the *Code of State Regulations*. Amended: Filed Nov. 18, 1999.

*PUBLIC COST:* This proposed amendment will not cost state agencies or political subdivisions more than \$500 in the aggregate.

*PRIVATE COST:* This proposed amendment will not cost private entities more than \$500 in the aggregate.

*NOTICE TO SUBMIT COMMENTS:* Anyone may file a statement in support of or in opposition to this proposed amendment with the Public School Retirement System of Missouri, Joel M. Walters, Executive Director, P.O. Box 268, Jefferson City, MO 65102. To be considered, comments must be received within thirty days after publication of this notice in the *Missouri Register*. No public hearing is scheduled.

**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**

**PROPOSED AMENDMENT**

**19 CSR 10-5.010 Monitoring Health Maintenance Organizations Definitions.** The department proposes to amend this rule by amending subsection (1)(C); amending subsections (2)(A), (B), (C) and (D); amending section (3); amending subsections (3)(A), (C) and (D); amending subsections (4)(A) and (B); amending section (5) and replacing Tables A, B, C and D.

*PURPOSE:* This amendment is to clarify the use of the term "health care plan" by modifying the definition in subsection (1)(C); to clarify the requirements on submission of annual member satisfaction survey data by modifying subsections (2)(A), (B), (C) and (D); to amend the submission requirements for the quality indicator data by modifying section (3) and subsections (3)(A), (C) and (D); to clarify the submission requirements for the enrollee linkage data by modifying subsections (4)(A) and (B); to update Table A to reflect consistency with standards of the National Quality Assurance Committee; to update Table B to reflect the data specifications for the quality indicators; to revise Table C to enhance the quality of the birth-linkage data; and to revise Table D to expand health care access information.

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

(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;

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

(A) The member satisfaction survey shall be conducted according to HEDIS<sup>®</sup> technical specifications, including survey [questions] instrument, sample size, [and] sampling method, and collection protocols. [Separate satisfaction surveys shall be conducted on regular HMO and HMO point-of-service plans for commercial enrollees] Each licensed health care plan shall submit, at a minimum, a separate satisfaction survey for their commercial enrollees;

(B) The data provided to the department shall be **submitted through the survey vendor** in electronic form and meet the specifications of Table A. **Table A is incorporated herein by reference;**

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

(D) **Medicaid and Medicare [and Medicaid]** health care plans shall participate in a member satisfaction survey *[conducted]* **directed** by the Division of Medical Services and the Health Care Financing Administration, respectively. The department will obtain the data from the agencies conducting the surveys.

(3) Starting in 1998, health care plans shall provide annually to the department, audited quality indicator *[rates and the numerators and denominators of the rates]* **data—**

(A) Quality indicator *[rates]* **data** shall be in accordance to all HEDIS<sup>®</sup> specifications;

(C) **Each licensed health care plan shall submit, at a minimum, separate quality indicator data files for their commercial, Medicaid and Medicare enrollees.** The quality indicator/s/ 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 *[the]* a **final data file** shall be submitted by June 15 or the date required by NCQA if other than June 15.

(4) Starting in 1998, all commercial health care plans shall submit annually to the department enrollee data for linkage with department data to produce quality indicators—

(A) *[The]* **A final enrollee data file** shall be submitted to the department by September 1, 1998, and by April 1 of each year thereafter, on persons enrolled in a health care plan as of December 31 of the previous year;

(B) **Each licensed health care plan shall submit, at a minimum, a separate enrollee data file for their commercial enrollees.** The enrollee data shall be **submitted in electronic form and shall [include the data elements and] conform to the file record contents and specifications listed in Table C of this rule [and shall be submitted on magnetic media]. Table C is incorporated herein by reference.**

(5) 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.**

*AUTHORITY: section 192.068, RSMo [Supp. 1997] Supp. 1999. Emergency rule filed Jan. 16, 1998, effective Jan. 26, 1998, terminated April 15, 1998. Original rule was filed Jan. 16, 1998, effective Aug. 30, 1998. Amended: Filed Oct. 30, 1998, effective May 30, 1999. Amended: Filed Dec. 20, 1999.*

*PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than \$500 in the aggregate.*

*PRIVATE COST: This proposed amendment will not cost private entities more than \$500 in the aggregate.*

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Department of Health, Center for Health Information Management and Epidemiology, Garland Land, Director, P.O. Box 570, Jefferson City, MO 65102, (573) 751-6272. To be considered, comments must be received within thirty days after publication of this notice in the Missouri Register. No public hearing is scheduled.*

**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.

**File format and media**

The member satisfaction survey data shall be submitted to the Department electronically as PC ASCII or ANSI files. 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: CY1999**

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:

<u>Indicator</u>	<u>Commercial</u>	<u>Medicaid</u>	<u>Medicare</u>
Childhood Immunization Status	X	X	
Adolescent Immunization Status	X	X	
Breast Cancer Screening*	X		X
Cervical Cancer Screening*		X	
Beta Blocker Treatment After Heart Attack	X		X
Comprehensive Diabetes Care	X		X
Antidepressant Medication Management	X	X	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, 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: CY1999**

(continued)

**File format and media**

The quality indicator data shall be submitted hardcopy as well as electronically, in a data file format to be specified by the Department. The file format will be provided to the plans for the option of data entry on diskette using Microsoft Excel or Access software, or on-line data entry to the Department via the Internet. 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.

Table C

**Health Care Plan - Live Birth Data**

*File Specifications*

**Record Filtering**

This file contains records for female enrollees of the health care plan who delivered a live birth during the reporting year, including those who resided or gave birth outside Missouri. Each live birth shall be reported as a separate record (i.e. separate records shall be submitted for multiple births or for multiple enrollees delivering live births with the same subscriber number).

**File Media**

Live birth data shall be submitted to the Department electronically as PC ANSI or ASCII files.

**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 C

### Health Care Plan - Live Birth Data

*Record Layout*

## LAYOUT FOR HEADER RECORD

## Columns

Field Name	Begin	End	Field Length	Data Type	Justify	Fill w/ leading zeroes
Plan Name	1	46	46	C	L	--

## LAYOUT FOR ENROLLEE LEVEL RECORDS

## Columns

Field Name	Begin	End	Field Length	Data Type	Justify	Fill w/ leading zeroes
Health Care Plan ID	1	5	5	C	L	Y
Plan Type	6	6	1	N	--	
Financial Class Type	7	7	1	N	--	
Type of Coverage	8	8	1	N	--	
Relationship Code	9	10	2	C	--	Y
Subscriber ID	11	21	11	C	L	
Enrollee ID	22	32	11	C	L	
First Name	33	46	14	C	L	
Middle Initial	47	47	1	C	--	
Last Name	48	62	15	C	L	
Enrollee Maiden Name	63	77	15	C	L	
Address1	78	107	30	C	L	
Address2	108	121	14	C	L	
Geocode	122	125	4	C	--	Y
City	126	145	20	C	L	
State	146	147	2	C	L	
Zip Code	148	152	5	C	L	
Enrollee Birth Date	153	160	8	C	--	Y*
Continuous Enrollment	161	161	1	N	--	
Birth Hospital Name	162	181	20	C	L	
Hospital Federal Tax I.D.	182	190	9	N	R	
Hospital Admit Date	191	198	8	C	--	Y*

\* Both month and year. See "Description of File Contents" on the page following for example.

**Table C**  
**Health Care Plan - Live Birth Data**  
*Description of File Contents*

<b>Field Name</b>	<b>Field Values</b>
<b>Health Care Plan ID</b>	Five digit code issued by Dept. of Insurance (NAICID) If none issued, use any unique 7 char string
<b>Plan Type</b>	1=HMO    2=POS    3=Other
<b>Financial Class Type</b>	1=Commercial    2=Medicare    3=Medicaid
<b>Type of Coverage</b>	1=Single    2=Family
<b>Relationship Code</b>	Relationship of Birth Mother to Subscriber 01= Subscriber (self) 02= Spouse of Subscriber 03= Child of Subscriber 04= Disabled Dependent
<b>Subscriber ID</b>	Subscriber's SSN in the format XXXXXXXXXX (no dashes). Field should be left justified with leading zeroes retained. If SSN unknown, insert unique Plan ID.
<b>Enrollee ID</b>	Mother's SSN in the format XXXXXXXXXX (no dashes). Field should be left justified with leading zeroes retained. If SSN unknown, insert unique Plan ID.
<b>First Name</b>	First Name of Birth Mother, preferably as given on birth record
<b>Middle Initial</b>	Middle initial of birth mother
<b>Last Name</b>	Last name of birth mother, preferably as given on birth record
<b>Enrollee Maiden Name</b>	Birth Mother's Maiden Name
<b>Address1</b>	House number and Street Name
<b>Address2</b>	Apartment, lot number, etc.
<b>Geocode*</b>	Enrollee city of residence, represented as a four digit Missouri city code, including leading zero(s) Example: Blue Springs = 0425
<b>City</b>	Name of enrollee city of residence
<b>State</b>	Enrollee state of residence, either as two digit FIPS or two character postal abbreviation. Example: Missouri=29 or MO
<b>Zip Code</b>	Five digit postal code. Should crosscheck with city and state. Example: if zip is 63011, city should be 'Ballwin', not 'St. Louis'
<b>Enrollee Birth Date</b>	Birth mother's date of birth in format MMDDYYYY with leading zero(s) retained for month and/or day. Example 010176
<b>Continuous Enrollment**</b>	1=meets criteria    2=does not meet criteria
<b>Birth Hospital Name</b>	Full name of birth hospital
<b>Hospital Federal Tax I.D.</b>	Nine digit tax identification number of the birth hospital. Do not enter a dash.
<b>Hospital Admit Date</b>	Date birth mother was admitted to hospital, in format MMDDYYYY with leading zero(s) retained for month and/or day. Example 010199

\* Data file of geocodes is available for download from the Department, via the Internet at <http://www.health.state.mo.us/ResourceMaterial>

\*\* Continuous enrollment shall be figured in accordance with the current HEDIS specifications for PreNatal Care in the First Trimester.



**Table D****Managed Health Care Services****File Specifications**

Responses to the following questions must be submitted electronically, in a data file format specified by the Department. The file format will be provided to the plans for the option of data entry on diskette using Microsoft Access software, or on-line data entry to the Department via the Internet.

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 (payor). 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 1999

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.) NAIC Identification Number (5-digit): \_\_\_\_\_

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

\_\_\_\_\_

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

Marketed	-----Phone Numbers-----		
a.) <u>Product Name</u>	b.) <u>HMO/POS</u>	c.) <u>Customer Service</u>	d.) <u>RN Hotline</u>
_____	_____	_____	_____
_____	_____	_____	_____

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

a.) *January 1, 1999?*

Accrediting organization: ( ) NCQA    ( ) URAC    ( ) JCAHO    ( ) None  
Level of Accreditation: \_\_\_\_\_

b.) *December 31, 1999?*

Accrediting organization: ( ) NCQA    ( ) URAC    ( ) JCAHO    ( ) None  
Level of Accreditation: \_\_\_\_\_

7.) What is the Disenrollment Rate\* of this product line?

Numerator \_\_\_\_\_  
Denominator: \_\_\_\_\_ = Rate \_\_\_\_\_

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

a.) Name: \_\_\_\_\_ b.) Title: \_\_\_\_\_

c.) Phone: \_\_\_\_\_ d.) Fax: \_\_\_\_\_ e.) E-mail: \_\_\_\_\_

\* Disenrollment Rate: The percent of members enrolled on Dec. 31, 1998, who were not enrolled as of December 31, 1999. Changes in product type or payee type, or any gaps in enrollment during 1999 should not be counted as disenrolled.

**Table D**  
**Managed Health Care Services**  
**Reporting Period: CY 1999**

**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, and (C) provides specific educational materials to persons-at-risk: (CHECK ALL THAT APPLY)

<u>High Risk Conditions/Diseases</u>	<u>(A)</u> <u>Screening</u> <u>Mechanisms</u>	<u>(B)</u> <u>Case</u> <u>Management</u>	<u>(C)</u> <u>Education for</u> <u>Persons-at-risk</u>
Asthma	( )	( )	( )
Stroke/Cardiovascular Disease	( )	( )	( )
Breast Cancer	( )	( )	( )
Cervical Cancer	( )	( )	( )
Ovarian Cancer	( )	( )	( )
Congestive Heart Failure (CHF)	( )	( )	( )
Chronic Obstructive Pulmonary Disease	( )	( )	( )
Diabetes	( )	( )	( )
Depression	( )	( )	( )
HIV	( )	( )	( )
Sickle Cell Anemia	( )	( )	( )
High Risk Pregnancy	( )	( )	( )
Obesity	( )	( )	( )
Tobacco Use	( )	( )	( )
Multiple Illnesses	( )	( )	( )
Chronic Diseases	( )	( )	( )
Other _____ (PLEASE SPECIFY)	( )	( )	( )

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.) Information sent to all plan enrollees which addresses some or all of the high-risk conditions/diseases listed in Question 1. ( ) YES ( ) NO
- c.) Distribution of pre- and post-surgical information to enrollees ( ) YES ( ) NO

**3a.) Commercial/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?**

- |                               |                |               |
|-------------------------------|----------------|---------------|
| <b>Mammograms</b>             | <b>( ) YES</b> | <b>( ) NO</b> |
| <b>Immunizations</b>          | <b>( ) YES</b> | <b>( ) NO</b> |
| <b>Pap smears</b>             | <b>( ) YES</b> | <b>( ) NO</b> |
| <b>Diabetic Screens/Tests</b> | <b>( ) YES</b> | <b>( ) NO</b> |

**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?**

- |                               |                |               |
|-------------------------------|----------------|---------------|
| <b>Mammograms</b>             | <b>( ) YES</b> | <b>( ) NO</b> |
| <b>Immunizations</b>          | <b>( ) YES</b> | <b>( ) NO</b> |
| <b>Well-woman checks</b>      | <b>( ) YES</b> | <b>( ) NO</b> |
| <b>Diabetic Screens/Tests</b> | <b>( ) YES</b> | <b>( ) NO</b> |

**4a.) Commercial/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?**

- |                               |                |               |
|-------------------------------|----------------|---------------|
| <b>Mammograms</b>             | <b>( ) YES</b> | <b>( ) NO</b> |
| <b>Immunizations</b>          | <b>( ) YES</b> | <b>( ) NO</b> |
| <b>Pap smears</b>             | <b>( ) YES</b> | <b>( ) NO</b> |
| <b>Diabetic Screens/Tests</b> | <b>( ) YES</b> | <b>( ) NO</b> |

**4b.) Medicare only**

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

- |                               |                |               |
|-------------------------------|----------------|---------------|
| <b>Mammograms</b>             | <b>( ) YES</b> | <b>( ) NO</b> |
| <b>Immunizations</b>          | <b>( ) YES</b> | <b>( ) NO</b> |
| <b>Well-woman checks</b>      | <b>( ) YES</b> | <b>( ) NO</b> |
| <b>Diabetic Screens/Tests</b> | <b>( ) YES</b> | <b>( ) NO</b> |

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

- ( ) YES      ( ) NO**

6.) Does your managed care plan provide a RN hotline for your members?  
 YES, for all products     YES, for some products     NO

7.) 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, or not covered at all. (CHECK ONLY ONE FOR EACH BENEFIT LISTED)

	<u>Non-ASO Product Only</u>			
	<u>All Products</u>	<u>Some Products</u>	<u>Offered only by rider clause</u>	<u>Not Offered</u>
Rx coverage of prenatal vitamins, including folic acid.....	( )	( )	( )	( )
<b>Contraceptives:</b>				
Birth control pills.....	( )	( )	( )	( )
IUDs.....	( )	( )	( )	( )
Norplant.....	( )	( )	( )	( )
Depo Provera.....	( )	( )	( )	( )
Annual eye exam for refractive errors.....	( )	( )	( )	( )
Autologous bone marrow transplants.....	( )	( )	( )	( )
Stem cell rescue for breast cancer.....	( )	( )	( )	( )
Access to chiropractic services	( )	( )	( )	( )
Access to podiatric services	( )	( )	( )	( )
Unrestricted approval for annual flu shots.....	( )	( )	( )	( )
Smoking cessation classes <u>or</u> cessation medications..	( )	( )	( )	( )
Routine physical exams....	( )	( )	( )	( )
Pap smears.....	( )	( )	( )	( )
Conduct wellness surveys	( )	( )	( )	( )

8.) 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:			Percent of ASO Enrollment Covered
	<u>All Contracts</u>	<u>ASO Contracts Some Contracts</u>	<u>None of the Contracts</u>	
Immunizations.....	( )	( )	( )	_____
Mammograms .....	( )	( )	( )	_____
Pap Smear .....	( )	( )	( )	_____

9.) For each preventive service listed below, please indicate if, during the reporting year, your plan (A) requires physicians to provide you their practice profile or (B) provides the individual practice profiles to the physicians. In column (C) indicate if you sent comparative profile information to the physicians.

	(CHECK "A" OR "B")    (CIRCLE Y or N)		
	<u>(A) Physicians Provide Profiles</u>	<u>(B) Plan Provides Profiles</u>	<u>(C) Plan Sends Comparative Profile Data</u>
Childhood Immunizations.....	( )	( )	Y/N
Adolescent Immunizations.....	( )	( )	Y/N
Breast Cancer Screenings.....	( )	( )	Y/N
Pap Smears.....	( )	( )	Y/N
Beta Blocker Treatment After Heart Attack.....	( )	( )	Y/N
<b>Comprehensive Diabetic Care:</b>			
Hemoglobin Testing.....	( )	( )	Y/N
Retinal Disease Eye Exam.....	( )	( )	Y/N
LDL-C (Lipids) Testing .....	( )	( )	Y/N
Nephropathy Screenings.....	( )	( )	Y/N
Annual Flu Shots for Older Adults.....	( )	( )	Y/N
Tobacco Cessation Counseling.....	( )	( )	Y/N
Other (Please specify)_____	( )	( )	Y/N

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

	<u>YES All Products</u>	<u>YES Some Products</u>	<u>NO No Plan Products</u>
a.) Allow access to OB/GYNs other than the once per year visit without referral	( )	( )	( )
b.) Patient must see PCP for referral to any specialist	( )	( )	( )
c.) PCP must contact HMO or its agency for referral to any specialist	( )	( )	( )
d.) Members can access non-OB/GYN in-network specialist without referral or prior authorization	( )	( )	( )
e.) Allow specialists other than OB/GYN to be designated as PCP for patients with chronic disease	( )	( )	( )

11.) For each procedure category listed below, please provide the hospital identifier information and the number of procedures performed on your plan members during the reporting period for the facilities in your plan network. Use additional data entry lines, as necessary.

<u>Procedure/ICD9-CM Code</u>	<u>Hospital Name</u>	<u>Federal ID #</u>	<u>Px #</u>
<b>Cardiac Catheterization</b>			
(37.21-37.23)	1. _____	_____	_____
	2. _____	_____	_____
	3. _____	_____	_____
	4. _____	_____	_____
	5. _____	_____	_____
	6. _____	_____	_____
	7. _____	_____	_____
	8. _____	_____	_____
	9. _____	_____	_____
	10. _____	_____	_____

<u>Procedure/ICD9-CM Code</u>	<u>Hospital Name</u>	<u>Federal ID #</u>	<u>Px #</u>
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**Cardiac Angiography**  
**(88.55-88.57)**

1.	_____	_____	__
2.	_____	_____	__
3.	_____	_____	__
4.	_____	_____	__
5.	_____	_____	__
6.	_____	_____	__
7.	_____	_____	__
8.	_____	_____	__
9.	_____	_____	__
10.	_____	_____	__

**Coronary Artery Bypass Graft**  
**(36.1, 36.2)**

1.	_____	_____	__
2.	_____	_____	__
3.	_____	_____	__
4.	_____	_____	__
5.	_____	_____	__
6.	_____	_____	__
7.	_____	_____	__
8.	_____	_____	__
9.	_____	_____	__
10.	_____	_____	__

**Total Hip Replacement**  
**(81.51, 81.53)**

1.	_____	_____	__
2.	_____	_____	__
3.	_____	_____	__
4.	_____	_____	__
5.	_____	_____	__



<u>Procedure/ICD9-CM Code</u>	<u>Hospital Name</u>	<u>Federal ID #</u>	<u>Px #</u>
<b>Total Hip Replacement (continued)</b>	6. _____	_____	_____
	7. _____	_____	_____
	8. _____	_____	_____
	9. _____	_____	_____
	10. _____	_____	_____

<b>Prostatectomy (60.21, 60.29, 60.3-60.5 60.61, 60.62, 60.69)</b>	1. _____	_____	_____
	2. _____	_____	_____
	3. _____	_____	_____
	4. _____	_____	_____
	5. _____	_____	_____
	6. _____	_____	_____
	7. _____	_____	_____
	8. _____	_____	_____
	9. _____	_____	_____
	10. _____	_____	_____