

Rules of  
**Department of Health  
and Senior Services**

**Division 10—Office of the Director**

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

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**Title 19—DEPARTMENT OF  
HEALTH AND SENIOR SERVICES**  
**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 Main-  
tenance Organizations Definitions**

*PURPOSE: This rule establishes the proce-  
dures 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 and Senior Services;

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

(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<sup>®</sup> 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<sup>®</sup> technical  
specifications, including survey instrument,  
sample size, sampling method, collection  
protocols and CAHPS<sup>®</sup> component of the  
HEDIS<sup>®</sup> compliance audit;

(B) The commercial and Medicaid member  
satisfaction data shall be submitted to the  
department in electronic form, through a cer-  
tified survey vendor, and meet the specifica-  
tions of Table A. Table A is included herein.  
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 satisfac-  
tion 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 and a CAHPS<sup>®</sup> com-  
ponent audit verification letter shall be sub-  
mitted by June 15 or the date required by

NCQA if other than June 15. If the required  
submission date falls on a weekend or a fed-  
erally recognized holiday, the due date will be  
the first working day following the weekend  
or federal holiday; and

(D) Medicare health care plans shall par-  
ticipate in a member satisfaction survey con-  
ducted by the Centers for Medicare and  
Medicaid Services. The department will  
obtain the data from the Centers for Medicare  
and Medicaid Services.

(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<sup>®</sup> specifications;

(B) All health care plans shall submit to  
the department documentation from a NCQA  
licensed organization that the quality indica-  
tor data submitted to the department have  
been audited through a partial or complete  
compliance audit according to HEDIS<sup>®</sup> spec-  
ifications;

(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 included herein.

(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.  
If the required submission date falls on a  
weekend or a federally recognized holiday,  
the due date will be the first working day fol-  
lowing the weekend or federal holiday.

(4) In 1998 access to care data shall be sub-  
mitted by September 1. In subsequent years  
the data shall be submitted by June 15. If the  
required submission date falls on a weekend  
or a federally recognized holiday, the due  
date will be the first working day following  
the weekend or federal holiday. Access to  
care data shall include the data elements and  
conform to the specifications listed in Table  
D. Table D is included herein.

(5) A health care plan demonstrates contin-  
ual 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 sec-

tion 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.



## Table A

### Member Satisfaction Survey Data File Specifications

#### File Content

**Commercial:** Member satisfaction survey data for commercial plans 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 member level and a CAHPS® component audit verification letter from the commercial 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.

**Medicaid:** Member satisfaction survey data for MC+ plans 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 member level and a CAHPS® component audit verification letter from the child core survey (Medicaid version) plus any additional questions required by the Division of Medical Services for the reporting year. 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 and a CAHPS® component audit verification letter and their respective record layouts shall be submitted electronically, using the data submission tools (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 2002**

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.

<u>Indicator</u>	<u>Applicable to:</u>		
	<u>Commercial</u>	<u>Medicaid</u>	<u>Medicare</u>
Childhood Immunization Status	X	X	
Adolescent Well-Care Visits	X	X	
Use of Appropriate Medications for People with Asthma	X	X	
Chlamydia Screening for Women	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		X
Annual Dental Visit		X	

**File Content**

As applicable 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 2002**  
(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 2002**

**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:

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 :  
*December 31, 2002?*

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 2002**

**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. SEE NOTE BELOW.)

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

(PLEASE SPECIFY)

Note: Screening Mechanisms is a protocol by which the Managed Care Organization identifies through administrative data, members at risk for certain diseases or conditions, utilizing clinical guidelines, and then formally conveys to the network PCPs or personal physician to proactively screen these at-risk patients in their daily practice.

Case management is a protocol where case managers work with providers and physicians to coordinate the medical care that patients with complex or chronic illnesses need to receive. Case managers help patients take care of themselves and make sure they get the right specialists, equipment and medications.

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
- c.) Promotion of the use of the National Asthma Education Prevention Program (NAEPP) among providers?  YES  NO

Note: The term *reminder/recall* in Questions 3a – 3b 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

4.) **Commercial only:** 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)

**Selected Covered Benefits:**

**ASO Contracts**

	<b><u>All</u></b>	<b><u>Some</u></b>	<b><u>None of the</u></b>
	<b><u>Contracts</u></b>	<b><u>Contracts</u></b>	<b><u>Contracts</u></b>
Immunizations.....	( )	( )	( )
Mammograms .....	( )	( )	( )
Pap Smears.....	( )	( )	( )





5.) 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)

	<u>Non-ASO Products 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.....	( )	( )	( )	( )
Non-Morbid Obesity:				
Prescriptions.....	( )	( )	( )	( )
Dietary Consultations...	( )	( )	( )	( )
Surgical Procedures.....	( )	( )	( )	( )
Contraceptives:				
Birth control pills.....	( )	( )	( )	( )
IUDs.....	( )	( )	( )	( )
Norplant.....	( )	( )	( )	( )
Depo Provera.....	( )	( )	( )	( )
Immunizations:				
Hepatitis A.....	( )	( )	( )	( )
Hepatitis B.....	( )	( )	( )	( )
Varivax (chicken pox)...	( )	( )	( )	( )
Annual eye exam for refractive errors.....	( )	( )	( )	( )
Diabetic supplies..... (strips, lancets, etc.)	( )	( )	( )	( )
Insulin pumps.....	( )	( )	( )	( )
Stem cell rescue for:				
Neuroblastoma.....	( )	( )	( )	( )
Breast cancer.....	( )	( )	( )	( )
Access to chiropractic services	( )	( )	( )	( )
Psychotherapy services				
Individual.....	( )	( )	( )	( )
Group.....	( )	( )	( )	( )
Family.....	( )	( )	( )	( )
Marital.....	( )	( )	( )	( )
Substance abuse services:				
Inpatient/residential.....	( )	( )	( )	( )
Outpt./partial hospitalization	( )	( )	( )	( )
Unrestricted annual flu shots	( )	( )	( )	( )
Acupuncture.....	( )	( )	( )	( )

Smoking cessation  
 Classes..... ( ) ( ) ( ) ( )  
 Medications/patches.... ( ) ( ) ( ) ( )  
 Conduct wellness surveys\* ( ) ( ) ( ) ( )

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

6.) 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 <u>Reports</u>	Description <u>of Report(s)</u>	(B) Plan Sent Comparative <u>Data</u>	Description <u>of Report(s)</u>
Childhood Immunizations.....	( )	_____	( )	_____
Adolescent Immunizations.....	( )	_____	( )	_____
Breast Cancer Screenings.....	( )	_____	( )	_____
Pap Smears.....	( )	_____	( )	_____
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)_____	( )	_____	( )	_____

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

( ) YES      ( ) NO



8.) 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)

	<u>YES All HMO Products</u>	<u>YES Some HMO Products</u>	<u>NO No HMO Products</u>
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 8f, list the additional types of providers that can be accessed without referral or prior authorization:

**All Products**

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- 9.) The following questions pertain to your managed care product Internet site:
- a) Does the Internet site for your managed care products provide a lookup reference to a list of your network physicians or other providers? YES \_\_\_\_ NO \_\_\_\_ (if NO, skip to Question 10)
- b) Does your provider listing contain the following information?
- i) Name: YES \_\_\_\_ NO \_\_\_\_;  
↳ Able to search on this criteria? YES \_\_\_\_ NO \_\_\_\_
- ii) Specialty: YES \_\_\_\_ NO \_\_\_\_;  
↳ Able to search on this criteria? YES \_\_\_\_ NO \_\_\_\_
- iii) By product: YES \_\_\_\_ NO \_\_\_\_;  
↳ Able to search on this criteria? YES \_\_\_\_ NO \_\_\_\_
- iv) County: YES \_\_\_\_ NO \_\_\_\_;  
↳ Able to search on this criteria? YES \_\_\_\_ NO \_\_\_\_
- v) City: YES \_\_\_\_ NO \_\_\_\_;  
↳ Able to search on this criteria? YES \_\_\_\_ NO \_\_\_\_
- vi) Zip Code: YES \_\_\_\_ NO \_\_\_\_;  
↳ Able to search on this criteria? YES \_\_\_\_ NO \_\_\_\_
- vii) Hospital Affiliations: YES \_\_\_\_ NO \_\_\_\_  
↳ Able to search on this criteria? YES \_\_\_\_ NO \_\_\_\_
- c) How often is provider information updated?
- i) Weekly: YES \_\_\_\_ NO \_\_\_\_
- ii) Monthly: YES \_\_\_\_ NO \_\_\_\_
- iii) Semi-Annually: YES \_\_\_\_ NO \_\_\_\_
- iv) Annually: YES \_\_\_\_ NO \_\_\_\_
- v) Other (Please specify) \_\_\_\_\_
- vi) Is the date of the update displayed?  
YES \_\_\_\_ NO \_\_\_\_
- d) Is the provider information available to:
- i) Plan Members? YES \_\_\_\_ NO \_\_\_\_
- ii) Prospective Members (Without the need to register on the site)? YES \_\_\_\_ NO \_\_\_\_



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 where applicable.

	<b><u>Number of Practitioners</u></b>	<b><u>Number Who Are Board Certified</u></b>
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	_____	_____
g.) Advanced Practice Nurse	_____	_____

*AUTHORITY: section 192.068, RSMo 2000.\*  
Emergency rule filed Jan. 16, 1998, effective  
Jan. 26, 1998, terminated April 15, 1998.  
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Aug. 30, 1998. Amended: Filed Oct. 30,  
1998, effective May 30, 1999. Amended:  
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Amended: Filed Sept. 15, 2000, effective  
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effective March 30, 2002. Amended: Filed  
Oct. 2, 2002, effective April 30, 2003.*

*\*Original authority: 192.068, RSMo 1997.*