

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 fo
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, collection
protocols and CAHPS[®] component of the
HEDIS[®] 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 incorporated
herein by reference. An exception to this
requirement shall be made for those Medi-
caid 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, a summary level data
file and a CAHPS[®] component audit verifica-
tion letter shall be submitted by June 15 or

the date required by NCQA if other than June
15; 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[®] 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[®] 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 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 sub-
mitted by September 1. In subsequent years
the data shall be submitted by June 15.
Access to care data shall include the data ele-
ments and conform to the specifications list-
ed in Table D. Table D is incorporated here-
in by reference.

(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.

*AUTHORITY: section 192.068, RSMo 2000. *
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,
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Amended: Filed Sept. 15, 2000, effective
April 30, 2001. Amended: Filed Oct. 2, 2001,
effective March 30, 2002.*

**Original authority: 192.068, RSMo 1997.*



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 summary level satisfaction survey data 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 summary level satisfaction survey data from the child 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 summary level satisfaction survey data 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 2001

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 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	
Beta Blocker Treatment After Heart Attack	X		X
Cholesterol Management After Acute Cardiovascular Event	X		X
Comprehensive Diabetes Care*	X		X
Antidepressant Medication Management	X		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

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 2001
(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 2001

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, 2001?

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 2001

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	()	()	()	()
Stroke/Cardiovascular Disease	()	()	()	()
Breast Cancer	()	()	()	()
Cervical Cancer	()	()	()	()
Ovarian Cancer	(NA)	()	()	()
Colorectal Cancer	()	()	()	()
Congestive Heart Failure (CHF)	()	()	()	()
Chronic Obstructive Pulmonary Disease (COPD)	()	()	()	()
Diabetes	()	()	()	()
Depression	()	()	()	()
HIV	()	()	()	()
Sickle Cell Disorders	()	()	()	()
High Risk Pregnancy	()	()	()	()
Obesity	()	()	()	()
Lead Poisoning	()	()	()	()
Chlamydia: Females	()	()	()	()
High Blood Pressure	()	()	()	()
Alcohol/Substance Abuse:				
Adolescents	()	()	()	()
Pregnant Women	()	()	()	()
Tobacco Use	()	()	()	()
Other _____	()	()	()	()
(PLEASE SPECIFY)				

Note: Screening Mechanisms for a specific condition means 1) there is an established protocol for the plan's entire membership (health fairs or special events do not qualify under this criterion), 2) this protocol is available through the PCP's or personal physician's daily practice and 3) the screening is proactively targeted to persons at risk for the condition.

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

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:		
	<u>ASO Contracts</u>		
	<u>All</u>	<u>Some</u>	<u>None of the</u>
	<u>Contracts</u>	<u>Contracts</u>	<u>Contracts</u>
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.....	()	()	()	()
Contraceptives:				
Birth control pills.....	()	()	()	()
IUDs.....	()	()	()	()
Norplant.....	()	()	()	()
Depo Provera.....	()	()	()	()
Immunizations:				
Hepatitis A.....	()	()	()	()
Hepatitis B.....	()	()	()	()
Annual eye exam for refractive errors.....	()	()	()	()
Diabetic supplies..... (strips, lancets, etc.)	()	()	()	()
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.) 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)		(B)	
	Plan	Description	Plan Sent	Description
	Provided	of Report(s)	Comparative	of Report(s)
	Reports	<u> </u>	Data	<u> </u>
Childhood Immunizations.....	()	<u> </u>	()	<u> </u>
Adolescent Immunizations.....	()	<u> </u>	()	<u> </u>
Breast Cancer Screenings.....	()	<u> </u>	()	<u> </u>
Pap Smears.....	()	<u> </u>	()	<u> </u>
Chlamydia Screenings: Females.....	()	<u> </u>	()	<u> </u>
Lead Screenings:				
12 and 24 months.....	()	<u> </u>	()	<u> </u>
Under 6 if no prior blood test.....	()	<u> </u>	()	<u> </u>
Cholesterol Management after Acute Cardiovascular Event: LDL-C Screenings	()	<u> </u>	()	<u> </u>
Beta Blocker Treatment				
After Heart Attack.....	()	<u> </u>	()	<u> </u>
Comprehensive Diabetic Care:				
Hemoglobin Testing.....	()	<u> </u>	()	<u> </u>
Retinal Disease Eye Exam.....	()	<u> </u>	()	<u> </u>
LDL-C (Lipids) Testing	()	<u> </u>	()	<u> </u>
Nephropathy Screenings.....	()	<u> </u>	()	<u> </u>
Annual Flu Shots for Older Adults.....	()	<u> </u>	()	<u> </u>
Tobacco Cessation Counseling.....	()	<u> </u>	()	<u> </u>
Other (Please specify)_____	()	<u> </u>	()	<u> </u>

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

Some Products



9.) 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.

	<u>Number of Practitioners</u>	<u>Number Who Are Board Certified</u>
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	_____	_____