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

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 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, 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© technical specifications including survey questions, sample size and sampling method. Separate satisfaction surveys shall be conducted on regular HMO and HMO point-of-service plans for commercial enrollees;

(B) The data provided to the department shall be in electronic form and meet the specifications of Table A;

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

(D) Medicare and Medicaid health care plans shall participate in a member satisfaction survey conducted 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—

(A) Quality indicator rates 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) The quality indicators data shall conform to specifications listed in Table B; and

(D) In 1998 the data shall be submitted by September 1. In subsequent years the data 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 enrollee data 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) The enrollee data shall include the data elements and conform to the specifications listed in Table C of this rule and shall be submitted on magnetic media.

(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.

(6) 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. 1997. 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.*

**Original authority 1997.*

Table A

Member Satisfaction Survey File Specifications

Based on CAHPS™ 2.0H Adult Questionnaire (Commercial)

Survey Question	Content	Type	Column position	Response
Q1	Coverage	N	1	1=Yes 2=No
Q2	Plan Name	A	2-31	Name of Health Plan
Q3	All/Most Care	N	32	1=Yes 2=No
Q4	Cont Enrollment	N	33	1 through 5
Q5	Get New Provider	N	34	1=Yes 2=No
Q6	Problem Finding	N	35	1 through 4
Q7	Personal Dr/RN	N	36	1=Yes 2=No
Q8	Rate Dr/RN	N	37-38	0 through 11
Q9	Specialist Need	N	39	1=Yes 2=No
Q10	Spec Referral Prob	N	40	1 through 4
Q11	See Specialist	N	41	1=Yes 2=No
Q12	Rate Specialist	N	42-43	0 through 11
Q13	Spec/Personal Same	N	44	1 through 3
Q14	Call Help/Office Hrs	N	45	1=Yes 2=No
Q15	Get Help Needed	N	46	1 through 5
Q16	Reg/Routine Care	N	47	1=Yes 2=No
Q17	When Needed	N	48	1 through 5
Q18	Reg Appt Wait	N	49	1 through 8
Q19	Ill/Injury Care	N	50	1=Yes 2=No
Q20	When Needed	N	51	1 through 5
Q21	Ill/Injury Wait	N	52	1 through 8
Q22	ER Visit	N	53-55	NNN (0-999)
Q23	# Office Visits	N	56	1 through 7
Q24	Care Problem	N	57	1 through 4
Q25	Delay Problem	N	58	1 through 4
Q26	Wait GT 15 minutes	N	59	1 through 5
Q27	Staff Courtesy	N	60	1 through 5
Q28	Staff Helpful	N	61	1 through 5
Q29	Provider Listen	N	62	1 through 5
Q30	Provider Explain	N	63	1 through 5
Q31	Provider Respect	N	64	1 through 5
Q32	Provider Time	N	65	1 through 5
Q33	Rate Provider	N	66-67	0 through 11
Q34	Claim Forms	N	68	1 through 3
Q35	Claim Time	N	69	1 through 6
Q36	Claim Correct	N	70	1 through 6
Q37	Payment Clear	N	71	1 through 6
Q38	Look for written	N	72	1=Yes 2=No
Q39	Problem Looking	N	73	1 through 4
Q40	Call for Information	N	74	1=Yes 2=No
Q41	Problem Getting	N	75	1 through 4
Q42	Complaint	N	76	1=Yes 2=No
Q43	Resolve Complaint	N	77	1 through 7
Q44	Settle Complaint	N	78	1 through 4
Q45	Paperwork	N	79	1=Yes 2=No
Q46	Paperwork Problem	N	80	1 through 4

Q47	Rate Plan	N	81-82	0 through 10
Q48	Rate Overall Health	N	83	1 through 5
Q49	Smoke 100 Cigarette	N	84	1 through 3
Q50	Smoke Now	N	85	1 through 4
Q51	Quit Smoking When	N	86	1 through 3
Q52	Advised To Quit	N	87	1 through 6
Q53	Age	N	88	1 through 7
Q54	Gender	N	89	1=Male 2=Female
Q55	Education	N	90	1 through 6
Q56	Hispanic/Latino	N	91	1=Yes 2=No
Q57	Race	N	92	1 through 5
Q58	Someone Help	N	93	1=Yes 2=No
Q59	How Help	N	94	1 through 5
Q60	Plan Name Label	A	95-124	Plan Name Label

Table B
Enrollee Data File Specifications

Indicator	Definitions
1. Breast Cancer Screening	The percentage of commercial and Medicare women age 52 through 69 years, who were continuously enrolled during the reporting year and the preceding year, and who had a mammogram during the reporting year or the preceding year. Members who have had no more than one break in enrollment of up to 45 days per year should be included in this measure. Separate calculations are required for the commercial and Medicare populations. Two separate denominators, one for each of the two required calculations, are derived using all enrolled women age 52 through 69 years of age as of December 31 of the reporting year, who were members of the plan as of December 31 of the reporting year, who were continuously enrolled during the reporting year and the preceding year and who were not identified as having had a radical bilateral mastectomy. Members who have had no more than one break in enrollment of up to 45 days per year should be included in this measure. The numerators are the number of members in the denominator for each of the two populations who have had one (or more) mammogram(s) during the reporting year or the year prior to the reporting year.
2. Eye Exams for People with Diabetes	The percentage of commercial and Medicare members with diabetes (Type I and Type II) age 31 years and older, who were continuously enrolled during the reporting year, and who had a retinal examination during the reporting year. Enrollees who have had no more than one break in enrollment of up to 45 days during the reporting year should be included in this measure. Separate calculations are required for the commercial and Medicare risk populations. Two separate denominators, one for each of the two required calculations, are derived using all members age 31 years or older as of December 31 of the reporting year, who were members of the health plan as of December 31 of the reporting year, who were continuously enrolled during the reporting year (including enrollees who have had no more than one break in enrollment of up to 45 days during the reporting year) and identified as diabetic. The numerators are the number of members in the denominator for each of the two populations who have a retinal ophthalmoscopic examination performed by an eye-care professional during the reporting year.
3. Follow-up after Hospitalization for Mental Illness	The percentage of commercial and Medicare members age six years and older who were hospitalized for treatment of selected mental health disorders who were continuously enrolled without breaks for 30 days after discharge, and who were seen on an ambulatory basis or were in day/night treatment with a mental health provider. Four separate calculations are required -- one for each of the two payers for both of the following: * the percentage of members six years and older who were hospitalized for treatment of selected mental health disorders who were continuously enrolled without breaks for 30 days after discharge, and who, and who were seen on an ambulatory basis or were in day/night treatment with a mental health provider within 30 days of hospital discharge.

Table B, continued

Indicator	Definitions
	* the percentage of members six years and older who were hospitalized for treatment of selected mental health disorders who were continuously enrolled without breaks for 7 days after discharge, and who, and who were seen on an ambulatory basis or were in day/night treatment with a mental health provider within 7 days of hospital discharge. Separate calculations are required for the commercial and Medicare populations. Plans must exclude from the denominator of this measure those discharges in which the patient has been directly transferred or readmitted within 30 (7) days after discharge to an acute or non-acute facility for a non-mental health principal diagnosis. Denominator 1: Two separate denominators, one for each of the two required calculations, are derived by counting discharges for members age six years and older at the time of discharge who have been hospitalized with a discharge date occurring during the first 335 days of the reporting year and a principal ICD-9-CM diagnosis code indicating a specified mental health disorder, and who were continuously enrolled without breaks for 30 days after discharge. Denominator 2: Two separate denominators, one for each of the two required calculations, are derived by counting discharges for members age six years and older at the time of discharge who have been hospitalized with a discharge date occurring during the first 335 days of the reporting year and a principal ICD-9-CM diagnosis code indicating a specified mental health disorder, and who were continuously enrolled without breaks for 7 days after discharge. Numerator 1: The number of discharges in the denominator for each of the two populations that were followed by an ambulatory mental health encounter or day/night treatment within 30 days of hospital discharge. Numerator 2: The number of discharges in the denominator for each of the two populations that were followed by an ambulatory mental health encounter or day/night treatment within 7 days of hospital discharge.
4. Cervical Cancer Screening	The percentage of Medicaid enrolled women age 21 through 64 years, who were continuously enrolled during the reporting year, and who received one or more Pap tests during the reporting year or the two years prior to the report year. Members who have had no more than one break in enrollment of up to 45 days during the reporting year should be included in this measure. The denominator is derived using all enrolled women age 21 through 64 years as of December 31 of the reporting year, who were members of the plan as of December 31 of the reporting year, who were continuously enrolled during the reporting year and were not identified as having had a hysterectomy with no residual cervix. The numerator is the number of members in the denominator who have had one (or more) Pap tests during the reporting year or the two years prior to the reporting year.

Table B, continued

Indicator	Definitions
5. Childhood Immunization Status	The percentage of Medicaid and commercially enrolled children who turned two years old during the reporting year, who were continuously enrolled for 12 months immediately preceding their second birthday (including members who have had no more than one gap in enrollment of up to 45 days during the 12 months immediately preceding their second birthday), and who have received the recommended immunizations. This specification uses membership data to identify children who have turned two years old during the reporting year and claims/encounter data to identify those two-year-old members who have received the specified vaccinations. Health plans will report nine rates for each payer (i.e., Medicaid and commercial). Separate calculations are required for the Medicaid and commercial populations. Two separate denominators, one for each of the two populations are derived using all enrolled children whose second birthday occurred during the reporting year, who were members of the plan as of their second birthday and who were continuously enrolled for 12 months immediately preceding their second birthday and who were not contraindicated for any of the specified antigens. The numerator is the number of members in the denominator for each of two populations (Medicaid and commercial) who received the immunizations as stated in the current HEDIS specifications.

Table C

Indicator	Definition
1. Prenatal Care In The First Trimester	The percentage of Medicaid and commercially enrolled women who delivered a live birth during the reporting year, who were continuously enrolled for 44 weeks prior to delivery, and who had a prenatal visit 26 to 44 weeks prior to delivery (or prior to Estimated Date of Confinement (EDC), if known). Members who have had no more than one break in enrollment of up to 45 days during the 44 weeks prior to delivery should be included.
2. Cesarean Section Rate	The percentage of Medicaid and commercially enrolled women who delivered a live birth during the reporting year having a Cesarean section.
3. Vaginal Birth After Cesarean Section Rate(VBAC Rate)	The percentage of Medicaid and commercially enrolled women who had a vaginal delivery resulting in a live birth during the reporting year and who had a previous C-section.

Table C continued

Health Care Plan Enrollee File Specifications

Field name	Position	Field Length	Description
Missouri Specific Company Code	1-7	7	Unique identifier assigned by Dept of Insurance at time of licensing
Plan Type	8	1	1=HMO 2=POS
Financial Class Type	9	1	1=Commercial 2=Medicare 3=Medicaid
Type of Coverage	10	1	1=Single 2=Family
Relationship Code	11-12	2	Relationship of Enrollee to Subscriber 01=Subscriber 02=Spouse 03=Child 04=Disabled Dependent
Subscriber ID	13-22	10	SSN or, if unavailable, a Plan Unique ID Number
Enrollee ID	23-32	10	SSN or, if unavailable, a Plan Unique ID Number
First Name	33-47	15	First Name of Enrollee
Middle Inital	48	1	Middle Initial of Enrollee
Last Name	49-63	15	Last Name of Enrollee
Address	64-93	30	Street Address of Enrollee
Second Address	94-123	30	Street Address Continued
City	124-143	20	City of residence
State	144-145	2	State
Zip Code	146-155	10	NNNNN-NNNN
Enrollee Gender	156	1	1=Male 2=Female
Enrollee Birth Date	157-164	8	MMDDYYYY
Enrollee Weeks of Continual Enrollment*	165-167	3	NNN
The following questions refer to the previous calendar year and if enrollee was hosptialized and/or had a live birth.			
Enrollee 1st Hospital	168-177	10	Name of Hospital
Enrollee 1st Hospital Admission Date	178-183	6	MMDDYY
Enrollee 2nd Hospital	184-193	10	Name of Hospital
Enrollee 2nd Hospital Admission Date	194-199	6	MMDDYY
Enrollee More Hospital Admissions this yr	200	1	1=Yes 2=No
Live Birth this yr	201	1	1=Yes 2=No
Delivery Hospital	202-211	10	Name of Hospital of birth

* One break of up to 45 days per year should be allowed when figuring weeks of continual enrollment.

MISSOURI DEPARTMENT OF HEALTH

TABLE D. MANAGED HEALTH CARE SERVICES

Managed Care Organization Type: *Commercial*
Plan Name:

dba: _____

Line of Business:_____ *To complete Line of Business field, use values listed in Code Sheet.*

Are you an accredited managed care organization as of January 1, 1998? Yes____ No____
Name of accrediting organization:

Level of accreditation:_____ Disenrollment Rate _____

Managed Care Organization Type: *Medicare*
Plan Name:

dba: _____

Line of Business:_____ *To complete Line of Business field, use values listed in Code Sheet.*

Are you an accredited managed care organization as of January 1, 1998? Yes____ No____
Name of accrediting organization:

Level of accreditation:_____ Disenrollment Rate _____

Managed Care Organization Type: *Medicaid*
Plan Name: _____

dba: _____

Line of Business:_____ *To complete Line of Business field, use values listed in Code Sheet.*

Are you an accredited managed care organization as of January 1, 1998? Yes____ No____
Name of accrediting organization:

Level of accreditation:_____ Disenrollment Rate _____

CODE SHEET

Line of Business	Disenrollment rate
A=HMO provides a predetermined set of benefits to members for a fixed cost B=POS allows members to use out-of-network providers at increased cost.	The percent of members enrolled on Dec. 31, 1997, who were not enrolled as of December 31, 1998. Changes in product type or payee type, or any gaps in enrollment during 1998 should not be counted as disenrolled.

Contact Person at this organization for the above or similar information.

Name: _____ Phone: _____ Email: _____
Title: _____ FAX: _____

TABLE D con't.: MANAGED HEALTH CARE SERVICES

If your managed care plan has received full accreditation from an accrediting organization for the reporting year, you may skip the first five questions. If your plan has less than full accreditation, provide documents from your auditor relating to these questions. All other managed care plans must answer in detail.

In the previous calendar year, did your managed care plan provide the following services to your enrollees? This does not include similar services that were provided by your participating health providers.

1. Did your managed care plan have screening mechanisms in place to identify high-risk patients? Yes _____ No _____

2. Did your managed care plan provide case management for high-risk patients? Yes _____ No _____
If yes, for what types of high-risk patients did you provide case management? List all that apply.

_____
_____
_____
_____
_____
_____
_____

3. Did your managed care plan directly provide "specific" educational materials to "persons at-risk"?
Health promotion, disease prevention, wellness information Yes _____ No _____
Pre- and Post-surgical information Yes _____ No _____
Disease specific health information-please list the various diseases which are covered by these materials
_____ Yes _____ No _____
_____
Other -- specify Yes _____ No _____
_____ _____ _____

Enclose copies of the specific materials you sent to your at-risk enrollees.

4. Did your managed care plan directly provide "general" educational/prevention materials to "all members"?
Health promotion, disease prevention, wellness information Yes _____ No _____
Pre- and Post-surgical information Yes _____ No _____
Disease specific health information-please list the various diseases which are covered by these materials
_____ Yes _____ No _____
_____
Other -- specify Yes _____ No _____
_____ _____ _____

Enclose copies of the general materials you sent to all members.

5. Did your managed care plan conduct activities for your providers to improve their knowledge on current practice recommendations? Yes _____ No _____
If yes, attach documentation of your activities.

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

A. Members of your commercial plan.

Mammograms	Yes	_____	No	_____
Immunization	Yes	_____	No	_____
Pap smears	Yes	_____	No	_____

If yes, enclose copies of policies or the text of the reminders that were used.

TABLE D con't.: MANAGED HEALTH CARE SERVICES

6. Continued

B. Members of your Medicare plan.

Mammograms	Yes	_____	No	_____
Immunization	Yes	_____	No	_____
Well-Woman Checks	Yes	_____	No	_____

If yes, enclose copies of policies or the text of the reminders that were used.

C. Members of your Medicaid plan.

Mammograms	Yes	_____	No	_____
Immunization	Yes	_____	No	_____
Pap smears	Yes	_____	No	_____

If yes, enclose copies of policies or the text of the reminders that were used.

7. Did your managed care plan provide reminder/recall letters for your providers to use to notify your enrollees of the following preventive services that are available to them?

A. Members of your commercial plan.

Mammograms	Yes	_____	No	_____
Immunization	Yes	_____	No	_____
Pap smears	Yes	_____	No	_____

If yes, enclose copies of policies or the text of the reminders that were used.

B. Members of your Medicare plan.

Mammograms	Yes	_____	No	_____
Immunization	Yes	_____	No	_____
Well-Woman Checks	Yes	_____	No	_____

If yes, enclose copies of policies or the text of the reminders that were used.

C. Members of your Medicaid plan.

Mammograms	Yes	_____	No	_____
Immunization	Yes	_____	No	_____
Pap smears	Yes	_____	No	_____

If yes, enclose copies of policies or the text of the reminders that were used.

TABLE D con't.: MANAGED HEALTH CARE SERVICES

8. For the reporting period, did your managed care plan offer the following benefits to your enrollees? Indicate on the appropriate lines the number of your products offering each of the following benefits.

	Offered through all benefit packages	Offered through some benefit packages	Offered By Rider Clause Only	Not offered through any benefit package
Prescription coverage of prenatal vitamins including folic acid				
Coverage of birth control pills for contraceptive purposes.				
Coverage of IUDs				
Coverage of Norplant for contraceptive purposes.				
Coverage of Depo Provera for contraceptive purposes.				
Annual eye examinations for refractive errors				
Coverage of autologous bone marrow transplants				
Coverage of stem cell rescue for breast cancer				
Access to chiropractic services				
Access to podiatric services				
Unconditional approval for annual flu shots				
Either smoking cessation classes or cessation medications				
Routine physical examinations				
Pap smears				
Conduct Wellness surveys				

9. Did you provide practice profiles on preventive services (not hospital utilization) to your providers or require providers to send you their practice preventive services profiles and return comparative benchmark information to them (e.g. immunization rate)? If yes, list the specific preventive services practice profiles and check the appropriate column. Yes _____ No _____

Preventive Services Practice Profiles	Provided by Plan to Physician	Required by Plan and submitted by Physician

Enclose a sample of the profiles and/or the benchmark information provided concerning the listed topics. Delete any identifying information.

TABLE D con't.: MANAGED HEALTH CARE SERVICES

10. Did your managed care plan promote the use of nationally recognized clinical practice guidelines by your providers? If yes, for each practice guideline complete the following table. If you wish to add other guidelines, attach a second page.

Clinical practice guideline	Organization that developed practice guideline	Did you provide this guideline to your practitioners?	Did you monitor provider compliance with this guideline?
A.			
B.			
C.			
D.			
E.			
F.			
G.			
H.			
I.			
J.			
K.			
L.			
M.			
N.			
O.			
P.			
Q.			
S			

12. Provide the name of each hospital in your network and the number of the procedures listed below that were performed in that facility for the reporting period. Use additional sheets if more than 10 hospitals in your network performed the procedures.

Procedure (ICD-9-CM Codes)	Hospital Where Procedure was Performed	Number of Procedures Performed
Cardiac Catherization (37.21, 37.22 and 37.23)		
Hospital # 1		
Hospital # 2		
Hospital # 3		
Hospital # 4		
Hospital # 5		
Hospital # 6		
Hospital # 7		

Hospital # 8		
Hospital # 9		
Hospital #10		

TABLE D con't.: MANAGED HEALTH CARE SERVICES

12. Continued

Procedure (ICD-9-CM Codes)	Hospital Where Procedure was Performed	Number of Procedures Performed
Cardiac Angiography (88.50, 88.52, 88.53, 88.54, 81.55, 88.56 and 88.57)		
Hospital # 1		
Hospital # 2		
Hospital # 3		
Hospital # 4		
Hospital # 5		
Hospital # 6		
Hospital # 7		
Hospital # 8		
Hospital # 9		
Hospital #10		
Coronary Artery Bypass and Angiography (36.10, 36.11, 36.12, 36.13, 36.14, 36.15, 36.16, 36.17 and 36.19)		
Hospital # 1		
Hospital # 2		
Hospital # 3		
Hospital # 4		
Hospital # 5		
Hospital # 6		
Hospital # 7		
Hospital # 8		
Hospital # 9		
Hospital #10		
Total Hip Replacements (81.21, 81.51, 81.52 and 81.53)		
Hospital # 1		
Hospital # 2		
Hospital # 3		

Hospital # 4		
Hospital # 5		
Hospital # 6		
Hospital # 7		
Hospital # 8		
Hospital # 9		
Hospital #10		

TABLE D con't.: MANAGED HEALTH CARE SERVICES

12. Continued

Procedure (ICD-9-CM Codes)	Hospital Where Procedure was Performed	Number of Procedures Performed
Prostatectomy (60.29, 60.3, 60.4, 60.5 and 60.62)		
Hospital # 1		
Hospital # 2		
Hospital # 3		
Hospital # 4		
Hospital # 5		
Hospital # 6		
Hospital # 7		
Hospital # 8		
Hospital # 9		
Hospital #10		

13. Did your managed care plan provide a RN hotline for your members? (Check one)

__ Yes, for all products _____ Yes for some products _____ No Products