MO HealthNet Division Public Forum
Joplin, Missouri
November 11, 2008

The MO HealthNet Division conducted a public forum in Joplin, Missouri at the Joplin Board of Realtors Conference Room on November 11, 2008. The purpose of the forum was to discuss potential expansion of MO HealthNet (Missouri Medicaid) managed care to the southwest and south central portion of Missouri. Approximately 50 people were in attendance.

Dr. Ian McCaslin, Director, MO HealthNet Division, indicated he has three major goals for the MO HealthNet program:

1. To serve the people;
2. To do a better job of serving the people; and
3. To improve access, quality of services, and accountability.

Dr. McCaslin presented on the potential conversion to a managed care delivery system for the MO HealthNet population in the area. He stressed that no decisions have been made regarding this expansion. Many steps are required to make any change, including discussion with the MO HealthNet Oversight Committee, the Governor's Office, and appropriation authority from the Missouri General Assembly. If implemented, the earliest possible start date would be June 2010.

Conversion to managed care doesn't impact an individual's eligibility; it is a different way to serve individuals already receiving services through MO HealthNet. Individuals to be included in the proposed expansion are MO HealthNet children, pregnant women, and some parents and caretakers. These participants currently receive their MO HealthNet services via a fee-for-service delivery system. Individuals eligible for MO HealthNet under a category of assistance of elderly or permanently and totally disabled would not be converted to the managed care model and would continue to receive services fee-for-service.

MO HealthNet managed care is not new to Missouri. The state began providing services to participants in the eastern, central, and western regions of the state in 1995. As of August 2008, there were 383,517 participants receiving services through the managed care program.

Under managed care there are no changes in eligibility or MO HealthNet services. The state contracts with managed care plans and pays the plans directly for each covered member. The health plan is responsible for coordinating the health services for their members and paying the providers within their network. The state is not involved in the contracts between the managed care plans and the providers. Each health plan must have enough providers to see their members, and patients and families can choose their own doctor from those who signed up with each health plan. There must be a minimum of two health plans in each region to allow freedom of choice.

The managed care health plans are required to provide the same services as under the fee-for-service program. Some managed care plans offer additional benefits such as circumcisions (not medically necessary); special classes such as childbirth, breastfeeding, and smoking cessation; cell phone programs for high risk members; adult physical therapy if medically indicated; and guest passes and waiver of joining fees at YMCA facilities.

Each health plan must meet the service standards established by the state and are held to performance standards and to improve access and quality in care delivery. Service standards include the distance to get to a doctor; number of days it takes to get a primary care appointment (30 days or less for well check-up); and 24 hour telephone availability. Performance standards include areas of well-child visits; better management of difficult pregnancies; and healthcare effectiveness measures. Over the past three years member satisfaction in the MO HealthNet program has ranged between 75% and 81%, which is similar to those enrolled in Medicare plans or standard insurance plans.

There are noted concerns with a managed care delivery system. Examples include providers not wanting the health plans to be in their business and providers not meeting the higher credentialing standards set by the managed care plans for health plan enrollment. Credentialing standards are plan-specific and out of the control of the MO HealthNet Division, but providers must meet minimum state licensure standards. Dr. McCaslin noted any conversion to a managed care delivery of service is not without turbulence.

Individuals who desired to offer public testimony were asked to register in advance of the meeting. The list of individuals who registered in advance is attached. It is important to note that not everyone who registered testified, and comments were also given by individuals who did not preregister. The attendance sheet from the meeting is also attached.

Issues raised included:

- Rural participants having to travel great distances for care adds to transportation costs.
- Health plans won't credential mental health therapists with less than five years of experience, thereby reducing access to mental health services.
- Not including provisionally licensed therapists in health plan panels will cause a reduction of services a reduction of services.
- Transportation is not provided to mental health services.
- Seasoned therapists are leaving the professional because of administrative burdens.
- Accountability and benchmarks are critical, but reasonableness needs to be considered and do not lose sight of the client's needs.

Questions raised and answers provided during the forum include:

Are refugees included in managed care?

Yes, if they meet the federal definition of refugee and are a child or pregnant woman.

Is there a mechanism in place for the participant if they are denied service?

Yes. The managed care health plan contracts require a grievance and appeal system. Members should first go through the health plan system. There is also an ombudsman program within each of the regions. Complaints received by the MO HealthNet Division are reviewed to determine if the denied services would have been considered for coverage under fee for service. Report is given back to the health plans very quickly, often the same day.

Are the health plans held accountable to the Medicaid formulary? How often do the formularies change? How is that information exchanged with providers?

In the fee-for-service program medication is reviewed once a year for inclusion on the preferred drug list and the information posted on the website. Information on the formularies of all managed care health plans and Medicare Part D plans in Missouri is available on epocrities.com.

Was a desire to enter into these services expressed by providers in this area?

Calls were not received from anyone in Joplin. However, the agency received contact from Cox and St. John's Hospitals in Springfield to consider managed care in southwest Missouri. The most frequent request received by the division is to increase fee-for-service rates.

What is the connection between public health departments and the managed care program?

The division highly encourages the managed care health plans to contract with entities such as public health departments and federally qualified health centers. Since the health plans need the resources of the public health departments, the state has found that the health plans typically seek out health departments in their provider panels. There are good relationships between the health plans and health departments in other regions.

If managed care is driven by accessibility, availability, and willingness to provide services, why can't provider participation in health plan mental health panels be reviewed for adequacy first before proceeding?

Lack of availability of providers willing to accept MO HealthNet is currently experienced in the fee-for-service program; it is not discipline specific. A health plan's provider network is reviewed by the Department of Insurance, Financial Institutions, and Professional Registration (DIFP) prior to any contract award. If the health plan's provider network does not meet DIFP standards, a contract cannot be awarded.

Do the additional services offered by health plans, i.e., special classes, decrease reimbursement for other services?

The health plans use these additional services as marketing strategies. The overall cost is minimal, and it does not decrease provider reimbursement. These are wonderful benefits from the patient perspective. The health plan focus on prevention can offset higher medical expenses. Under federal requirements any Medicaid managed care program must be budget neutral when compared to the same services for the same population under a fee-for-service provision of service.

Have changes in emergency department utilization been seen in other regions?

The health plans, hospitals, and state align in their desire for appropriate emergency department use. Health plans are very focused on how to control emergency department use. However, inappropriate use still occurs. The most success has been seen by health plans who have built up urgent care centers and after hours access.

Is there an impact on hospitals from the realignment from the Federal Reimbursement Allowance to cover managed care programs? Will the managed care plans also pay hospitals for services?

The hospitals will negotiate per diem rates with the health plans, and the normal state add-on payments will remain. Per the Missouri Hospital Association (MHA) the hospital MO HealthNet managed care experience in other regions have not been negative. Hospitals with any concerns about managed care coming into the region are urged to contact MHA.

It has been found in other regions that disabled children are put into the managed care program. Are children who have been on SSI disability from birth included in managed care?

Those eligible for MO HealthNet in a category of assistance of permanently and totally disabled (PTD) will not be included in managed care. PTD tends to be those who meet the Social Security Administration definition of disabled. Managed care enrollment is driven by the category of assistance under which a participant receives MO HealthNet benefits. Children on SSI disability from birth can opt out of managed care.

If a family chooses managed care they are out of the Healthy Children and Youth (HCY) program.

Care coordination is much better under managed care than through fee for service. As a counselor with the family, an agency should think hard before advising family to opt out of managed care.

Is there a cap on mental health sessions within managed care?

There are limits of service on both sides; typically the managed care threshold is lower. It depends on the age of the individual and service being provided. In both cases they are appealable through the certification process.

Addendum:

MO HealthNet staff have investigated an expressed concern that transportation services are not covered for individuals seeking therapy services by LPCs or LCSWs. The state transportation contract for NEMT does not exclude transportation for these services. If participants are informed that this service is not covered, that is incorrect advice, and MO HealthNet Division requests that immediate report be made to Sandra Levels at 573/751-6926 or via email to Ask.MHD@dss.mo.gov.

An additional concern was expressed that managed care plans may not credential mental health providers with provisional licensure or with less than five years experience post training. A preliminary investigation has revealed that credentialing decisions are individual to each plan, and generalizations are not applicable. MO HealthNet Division suggests that any provider interested in serving patients within managed care regions contact plan representatives specific to that region for further detailed information. There are, in fact, plans that will credential provisionally licensed providers and those with less extensive experience.

Joplin, November 11, 2008 Public Comment	
Individuals who registered to give public comment will be called in the following order.	
1	Rudy Snedigar, CEO (or designee)
2	Jeremy Mitchell
3	Betty Ann Riggs
4	Laura Hurn
5	Brad Ridenour
6	Peggy Bryan

MO HealthNet Division Public Forums
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