MO HealthNet Division
Care Management Innovation and Expansion
Request for Information

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10. Managing the one-time costs of converting a FFS population to managed-care – Currently, capitation payments are made to MCOs at the end of each month that a person is enrolled. Health care providers can bill MHD for FFS enrollees up to two years after the date of service. Therefore, when people currently enrolled in FFS are moved to coverage by MCOs there will be a substantial period of time during which MHD is paying both the current capitation rate and the claims for services provided during the previous months when the person was still in FFS. This is referred to as "claims run out." MHD estimates the cost of the claims run out that will occur when moving the remainder of the low income custodial parents, pregnant women, and children covered in FFS to coverage by MCOs to be $114 million. What can be done to mitigate this one time claims run out cost? Page 127
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Dear Friends of MO HealthNet,

I am pleased to present for your consideration and feedback, summaries of the responses to the MO HealthNet Care Management Innovation and Expansion Request for Information (RFI). The responses are rich with insights into the Medicaid program generally and Missouri's approach to Managed Care specifically and offer good advice and new ideas for MO HealthNet's to improve quality of care and access to care in Missouri.

The RFI was released on September 11, 2015 with all responses due by October 9, 2015. The purpose of the RFI was to allow interested parties an opportunity to provide the State of Missouri with feedback regarding issues related to improving health care quality and increasing the efficiency of health care delivery for low income custodial parents, pregnant women, and children covered by MO HealthNet Managed Care. In addition to general questions about the transition to Managed Care, the RFI addressed the following topic areas:

- Care Management Organization Accountability for the Desired Delivery System Improvements
- Care Management Organizations Accountability for Improving the Health Care Delivery System
- Implementation of Local Provider-based Care Coordination Approaches
- Provider Responsibility for Quality of Care and Containing Costs
- Coordination of Care through Enhanced Use of Health Information Technology
- Participant Responsibility and Incentives for Healthy Behaviors
- Participant Access to Local Health Care Provider Appointments
- Integrating Behavioral Health Care with Physical Health Care
- Empowering Provider Change

Thirty-four responses were returned from a wide variety of interested stakeholders including: three advocacy organizations, seven associations representing different Missouri provider and physician groups, 11 provider organizations (including hospitals, federally qualified health centers, community mental health centers and small practices), seven managed-care companies, four healthcare technology service vendors, and two research organizations.
As much as possible, we attempted to let the words of the respondents themselves summarize the issues, recommend changes and improvements, or offer thoughts for consideration. For each issue, the responses were reviewed and summarized in the enclosed document with:

- Overall Recommendations,
- Recommendations to Increase Efforts in Areas we are Already Working,
- Recommendations to Innovate, and
- Additional Recommendations.

I have chosen not to have an executive summary written because in today's healthcare delivery systems there are no simple brief answers to get the high quality accessible care. For that reason any executive summary would be either misleading or not worth reading. I found reading your recommendations thought-provoking and believe they will be for all our stakeholders as well.

Respondent	Type	Response
Legal Services of Eastern Missouri	Advocate	comprehensive
Paraquad	Advocate	comprehensive
St. Louis University Center for Health Law Policy	Advocate	limited
Missouri Association of Rural Health Clinics	Association	limited
Missouri Coalition for Community Behavioral Healthcare	Association	comprehensive
Missouri Committee for Professional Counselors	Association	limited
Missouri Dental Association	Association	limited
Missouri Hospital Association	Association	comprehensive
Missouri Primary Care Association	Association	comprehensive
Missouri Psychological Association	Association	comprehensive
Aetna	MCO	comprehensive
Amerigroup	MCO	comprehensive
AmeriHealth Caritas	MCO	comprehensive
Home State	MCO	comprehensive
MCNA Systems Corp	MCO - Dental	limited
MissouriCare	MCO	comprehensive
United HeatlhCare Community & State	MCO	comprehensive
WellCare Health Plans	MCO	comprehensive
Harry S Truman School of Public Affairs - Dr Heflin	Other	limited
Missouri Health Connections	Other	limited
UMC - Lincoln Sheets, MD	Other	limited
University of Missouri, Center for Health Policy-OSEDA	Other	limited
Addition Awareness	Provider	comprehensive
BJC HealthCare	Provider	comprehensive
Cox Health	Provider	comprehensive
Jordan Valley Community Health Center	Provider	limited
Lakeland Behavioral Health	Provider	limited
Mosaic Life Care	Provider	comprehensive
Preferred Family Healthcare	Provider	limited
St. Luke's Health System	Provider	comprehensive
Truman Medical Center	Provider	limited
Alpha Maxx Healthcare	Vendor	limited
Case Management Technologies	Vendor	limited
MedExpert International	Vendor	limited
Family Facets		
UHS		

Question 1a: Care Management Organization Accountability for the Desired Delivery System Improvements:

1) Optimizing the financial and clinical value Care Management Organizations could provide to the citizens of Missouri
   a. What should care management organizations do to train and support health care providers to become better at care coordination, care management, disease management, and population health management?
   b. Should MHD require care management organizations to follow a defined prior authorization protocol to reduce the administrative burden on physicians and other health care providers? Describe the operational, financial, or clinical benefits and issues that a standard prior authorization protocol would present.
   c. Describe the obstacles to achieving an 80% or better compliance rate for Early and Periodic Screening Diagnostic and Treatment (EPSDT) and strategies which the State should consider in meeting or exceeding that goal.
   d. Describe the advantages or disadvantages of having any or all of the following benefits paid for through the care management organization:
      i. Dental;
      ii. Non-Emergency Transportation;
      iii. Behavioral Health; and
      iv. Vision.

Responses to 1a: 26 (MCO –7, Provider – 5, Association – 9, Advocates – 4, MCO-Dental – 1)

Overall Recommendations

MHD should require:

1. Continuing provider access to timely and accurate data to support clinical decisions and enable providers to meet performance expectations and reporting requirements;
2. The use of uniform, transparent care management standards, developed collaboratively between MHD**,** providers and CMOs,
3. Ongoing, technology-enhanced training between CMOs and providers around care management standards, MHD goals/performance expectations and desired client outcomes, specialized interventions, such as chronic disease management and wellness activities, and reporting requirements and formats; and
4. The use of more intensive locally-focused care management and health home strategies for individuals with chronic conditions or co-occurring disorders such as mental illness and chronic medical conditions.

Recommendations to Increase Efforts for System Improvement

MCOs:

1. In RFP responses, CMOs be required to demonstrate experience in training and supporting providers, including the implementation of comprehensive training plans utilizing multiple formats that provide provider feedback mechanisms. CMOs should also demonstrate an understanding of the current Missouri healthcare delivery system and the issues providers are experiencing.

2. CMOS should be required to create information-sharing platforms for timely communication that continually keep providers abreast of new information on care coordination, disease management and population health management, and that provides data for predictive modeling, ER utilization, hospitalization, readmission rates, HEDIS data, and health maintenance exams and immunization schedules.

3. At minimum, MCOs should:

    - Collect data from a variety of sources and produce reports that identify gaps in care;
    - Offer provider portals with access to preventable service activity, care gaps, drug and utilization patterns, clinical population profiles and other data sets;
    - Give providers actionable items for assigned members i.e., wellness screenings, access to medical devices and medication adherence for members with chronic conditions (asthma, diabetes, etc.);
    - Offer financial incentives to providers to increase member access to regular preventive screenings and health checks, recommended vaccinations, follow-ups to hospitalization, and more intensive care management for members with chronic disorders.

4. MHD should require CMO and network participation in the State's Health Information Exchange (HIE). Timely access to data through HIE can play a major role in population health management and reduce hospital readmissions and ER overutilization.

5. CMOs should implement a variety of mechanisms to support provider compliance to clinical practice guidelines, including performance incentives beginning in the first year of the contract, such as, incentive payments for closing gaps in care for agreed-upon HEDIS and other quality metrics. PCPs, and other general practitioners could earn enhanced payments for delivering high-quality and cost-effective care, member service and convenience, and accurate and complete health data.

6. Health plans should offer a variety of provider training resources including regional provider summits, committee participation and face-to face provider Visits, and should partner with providers for member education, ensuring member access to 24-hour nurse line, behavioral health crisis line, telemedicine, and provider and member portals, and making communication and exchange of provider and member information seamless. There should be collaborative business agreements and protocols established to resolve identified barriers, including social or economic.

***Providers*:**

1. CMOs should allow easier applications to become a provider and a central data system so that all providers are aware of who the client is seeing.

2. Many healthcare providers have highly developed platforms that may be instructive in creating better standards and developing quality outcomes. MHD should require CMOs to work collaboratively with healthcare providers in setting care management standards and objectives.

3. Standardized rules, expectations and trainings across all CMOs would be beneficial to support healthcare providers as well as set the tone for proper care and treatment. Current care management standards are poor or non-existent, and all CMOs operate by their own set of rules and expectations.

Associations:

1. There should be uniform, transparent standards to insure that services are accessible without unreasonable delay and members receive appropriate services.

2. To ensure robust provider participation, MHD should develop and enforce stronger standards regarding the following: prompt and accurate adjudication of claims and payment, education on proper submission of clean claims and appeals, acceptance of standardized forms through an electronic portal, clearly defined and adequate physician and provider network standards, including simplified, prompt

credentialing processes, uniform efficiency standards and requirements for submitting and tracking preauthorization requests, transparent CMO reports of the CMO's provider network retention rates.

3. The following language be included in CMO contracts: "In order to create seamless systems for public safety-net behavioral health services between federal SAMHSA block grant funding, the State's healthcare home services, disease management initiatives, and the function of certified community behavioral health clinics as defined in Public Law 113-93, MCOs shall contract with Administrative Agents and Affiliated providers, as defined by DMH."
4. In the mental health arena, the focus should be on recovery, rehabilitation, employment or education, rather than only the abatement of mental health symptoms. Behavioral health homes, developed and implemented for people with serious mental illnesses, make it possible for community behavioral health providers to coordinate and manage the integration of services over a full range of needs of clients, even when there are several caregivers and agencies involved.
5. MCOs should ensure that participating providers have ample opportunity to help craft the MCO's care management standards to ensure that they concur with those standards. At minimum, MHD should consider mandating that MCOs work with contracted providers to develop standards of care to provide common ground for providers and MCOs about what accepted standards of care are.
6. MHD should mandate that MCOs use standardized utilization review protocols and other treatment standards. Uniform standards generate administrative savings and simplify provider training. It is not effective or efficient for each MCO to establish its own treatment protocols and processes, with providers expected to implement multiple directives, some of them contradictory.
7. MCOs can best support delivery system redesign if they offer common methods for: Measuring population health outcomes; sharing timely patient data so that providers have a longitudinal record that spans care settings; offering payment structures aligned with desired performance results; and committing resources to assist Primary Care providers with practice transformation.

***Advocates*:**

1. MHD needs to let MCOs know that it takes care management seriously by enforcing all case management requirements, including EPSDT case management.
2. MHD must monitor MCO compliance with case management, particularly for special needs children.
3. MHD should review what has worked in its successful *Health Homes Program* and ensure that plans provide the same type of wide-ranging support, including social work support where needed, to Primary Care Providers to help them better coordinate their patients' health care. That program provides a comprehensive care management team approach to support PCPs.
4. MHD should support person-centered models of providing care coordination to individuals, including training for working with individuals with disabilities, providing reasonable accommodations/modifications when requested, how to establish integrated care plans, align available community resources, and why communication among providers is important for people with disabilities who receive a lot of specialty care. CMOs should pay for all the above services.

Recommendations to Innovate

***Provider*:** Provider organizations more often provide support and infrastructure to CMOs for these services rather than the reverse being true. Through recent CMS pilots of ACOs and ACO-like initiatives, healthcare providers are developing innovative ways to provide better care coordination and management. MHD should build on these initiatives in collaboration with providers.

***MCO-Dental*:** proposes a separate "carved out" dental model for Missouri that combines the advantages of dental managed care with a fee-for-service payment model, where the state places the dental benefit program manager "at-risk" for the provision of quality dental services and timely claims payment and pays providers on a fee-for-services basis rather than capitation.

***Association*:** Technology offers unique opportunities to providers to engage with experts they would otherwise not be able to access. This is especially valuable in underserved rural areas. For example, the University of Missouri's Echo program engages providers in Learning Communities to study evidence-based approaches. Telehealth technology can also be used for more short-term educational opportunities or consultations.

***MCO*:** CMOs should create an environment that encourages and incents the development of robust primary care medical homes and other subsets of health care delivery.

Additional Recommendations

***Provider*:** Assure that providers are familiar with the Case Management Society of America (CMSA) case management process. Require care managers to achieve certification in a nationally recognized credentialing organization. Educate providers on resource identification.

***Association*:** Experience from states with successful Medicaid programs indicates that a dedicated Medicaid Dental Program Director (assisted by a Dental Advisory Committee) is key to successful implementation and oversight of the program. Missouri should hire a Dental Director with expertise in requesting key analytical reports and reviewing data to effectively manage a Medicaid dental program.

Question 1b: Should MHD require care management organizations to follow a defined prior authorization protocol to reduce the administrative burden on physicians and other health care providers? Describe the operational, financial, or clinical benefits and issues that a standard prior authorization protocol would present.

Responses to Question 1b: 18

Overall Recommendations

1. Most providers, Associations and Advocates supported MHD standardizing Prior Authorization (PA) protocols across CMO contracts for consistency, simplification and reduction in provider training costs, more flexibility in clinical decisions, and to avoid CMOs utilizing the PA process to restrict member access to care to increase their bottom line profits.
2. MCOs opposed a uniform set of standardized PA protocols across MCO contracts, indicating their individualized PA protocols are central to their ability to manage utilization, assure best practice and contain costs. Some MCOs indicated that the savings projected by the state would have to be modified to reflect the limitations of standardization on their ability to achieve savings. Some MCOs recommended that MCOs work with MHD to limit the use of PA protocols for specified services.
3. MCOs recommended that MHD require contracting MCOs to utilize nationally recognized PA standards, and indicated that MHD requirements for timeliness, standardization of PA processes (not specific protocols), and utilizing electronic PA systems should be considered.
4. Providers and Associations requested that MHD require CMOs to allow providers input into the design of the CMO's PA protocols for transparency and buy-in by providers and members, for CMOs to provide ongoing training and establish regular feedback mechanisms for providers to react to a CMO's PA protocols, and for assertive MHD monitoring of the CMO utilization management processes.
5. Providers indicated that, in addition to standardizing PA protocols, other CMO protocols should be standardized, such as credentialing provider networks, claims submission, and covered services.

Recommendations to Increase Efforts to Improve the System

***MCOs*:**

1. CMOs continue to be required to use nationally recognized utilization management (UM) protocols and continue to require that all PA protocols to reflect consistent use of nationally-recognized, evidence-based criteria for determining medical necessity and appropriateness of care. Since MCOs take full financial risk for all members, they must continuously analyze claims and utilization data to determine medical spend trends indicating the need for intervention. If MHD standardizes PA protocols without any financial responsibilities for the actual medical spend, MCO savings projected in the capitation rate will be limited, thereby reducing savings to the state. Standard protocols remove a key tool that CMOs utilize to engage providers and manage utilization. Should the state adopt as standard protocol, it will need to adjust savings assumptions.
2. While providers now manage multiple PA protocols across payors, opportunities do exist to reduce perceived burdens with the process. MCOs should limit its list of services requiring PA to those procedures and services for which the quality of care or financial impact can be favorably influenced by medical necessity or appropriateness of care review, such as non-emergent inpatient admissions, out-of-network services and certain outpatient services. Under the direction of MHD, MCOs should work together to develop standard PA forms for the MHD program. CMOs should enable providers to submit PAs through a secure web-based provider Portal that allows providers to submit authorizations 24/7. MHD and CMOs should use several strategies to determine which services require PA and review and update the list of services at least annually. A system must be designed to protect the MCO from

increased utilization of services not included in the PA process, to manage outliers, to maintain state-of-the-art practice, and to capture necessary data to coordinate care.

3. MHD require documentation of what guidelines are used, and assure transparent provider and member access to the guidelines, and regular auditing of Interrater Reliability.
4. MHD should require MCOs to provide an online process for providers to complete authorizations and upload clinical information via a secure web portal with automatic and immediate approval for care as long as the information provided meets national guidelines for the care or service requested.
5. While there are substantial reasons for states to establish requirements for CMOS to adopt similar operational standards, these decisions should be carefully evaluated against the costs of doing so. While standard protocols will ease the administration for providers, it will require up-front administrative costs to customize CMO systems to support a standardized approach.

***Providers*:**

1. Uniform PA protocols, based on nationally recognized medical necessity treatment standards, would decrease duplication and fragmentation of services, reducing financial burden and the risk of impairing the physician/patient relationship. All CMOs should use the same authorization protocol.
2. A standardized PA protocol will allow providers to develop one process for working with various MCOs. It is important that MHD consider a standardized approach. The MCO will be looking to create margin for their shareholders (a requirement of their business model) and one way to do that is to increase the administrative burden on the providers as an effort to induce a higher denial rate. Denial of services is not an appropriate way to reform payment in the healthcare system. The MCOs will already be taking 15% or more out of the system for their margin and overhead.
3. Inconsistent use or absence of evidence-based interventions are key concerns expressed by stakeholders, including the lack of availability of key interdisciplinary services, effective education strategies for patients and family members of disease process and self-care strategies, regularly scheduled Primary Care Physician/provider appointments, and a process for inpatient management and discharge processes for targeted diagnosis. If the PA protocols are developed without input from those actually delivering the care, then providers are placed in an untenable position.
4. MHD should provide accountability and oversight regarding implementation of the PA protocols as they can vary widely.

***Associations*:**

1. MHD should require CMOs to follow a standardized PA protocol. MHD must provide clarity and stronger definitions regarding medical necessity and parity. MHD should encourage flexible PAs for services that will increase access, outcomes and cost savings for individuals with unique and complex needs. Some states have adopted different terminology in their contracts, such as “social necessity” or “psychosocial necessity”. Another technique to deal with narrow definitions for medical necessity is to require Plans to have a “keep-people-safe policy”.
2. MHD should require PA protocols to be clearly defined, grounded in medical evidence, transparent for providers and members and applied consistently.
3. Uniform standards should not be limited to PA protocols. MHD should establish uniform standards for claims submission and resubmission, auditing guidelines, pre-certifications, adjudication of denials, peer-to-peer reviews, phone and written requests for records. It could also mandate standardized credentialing processes and benefit plans/covered services. A transparency tool to explain the scope and extent of those covered services would be useful.

4. As providers who contract with multiple payers, FQHCs benefit from consistent processes across payers. Standard PA protocols, drug formularies and other policies will be essential for reducing provider abrasion and decreasing patient treatment disparities.

***Advocates*:**

1. Adopting a defined PA protocol would eliminate some of the complexity in the current system. An advantage of the MHD carve-out for prescription drugs is that it simplifies the criteria for members and providers. The prior system, whereby each of the Plans had its own PA criteria did not work well. It now works much better under the carve-out as MHD employs a single set of PA criteria.
2. Regardless of the decision, criteria must be transparent to consumers, their legal representative and providers. MHD must carefully review all plan utilization review criteria to ensure they are no more restrictive that Medicaid law allows and that such plan protocols do not impose administrative burdens and red tape that negatively affect providers and impose barriers to care.

***Vendor*:** Sometimes CMOs deny claims for pre-authorized services. A standard PA protocol based on current evidence-based clinical guidelines has benefits because most tests, treatments and medications can be provided more quickly; it would help cut costs because medical personnel do not have to be involved in PA requests for tests and procedures; it helps eliminate inconsistent or arbitrary CMO decisions and reduces costs in administering PA processes;

Recommendations to Innovate: Not applicable to this question

Additional Recommendations: None

Question 1c: Describe the obstacles to achieving an 80% or better compliance rate for Early and Periodic Screening Diagnostic and Treatment (EPSDT) and strategies which the State should consider in meeting or exceeding that goal.

Responses to Question 1c: 17

Overall Recommendations

1. ***Commonly Identified Barriers:***
    - The State's contact information on assigned CMO members is often inaccurate, making contact with the member impossible;
    - There is a major PCP shortage in Missouri and many providers do not accept Medicaid due to its poor reimbursement rates, thus reducing member access;
    - Long wait-times in physician's offices discourage members from preventive care;
    - members sometimes receive screening and services that could be billed or counted as an EPSDT service through other venues, resulting in EPSDT under-reporting and making it impossible for the CMOs to follow up with members; and
    - Poverty is a primary driver of unreliable access to phones, transportation problems and a lack of health literacy. Low-income parents have competing work, childcare, financial, and family priorities, and may only go to the doctor when sick, or distrust the medical system.
2. ***Strategies Recommended:***
    - Intensive member outreach and education efforts, developed collaboratively between MHD and CMOs;
    - Incentivize providers and members to meet EPSDT goals;
    - Develop timely and accurate information systems that capture all EPSDT screenings and services, even when performed by non-Medicaid providers and healthcare organizations;
    - Educate providers to use every opportunity to complete an EPSDT preventive health screen;
    - Make EPSDT goals a performance metric for CMOs and providers, and monitor closely; and
    - Carve-out EPSDT services to providers with on-ground case management expertise.

Recommendations to Increase Efforts to Improve the System

***MCOs*:**

1. The address and phone number provided for members assigned to a CMO may not be accurate making it impossible to reach a member. MHD should consider an improvement initiative to increase the accuracy of member demographic information, such as the National Change of Address (NCOA) database which can automatically feed updated member information to MHD's system.
2. Missouri has a PCP shortage that reduces access to PCP services. Some members receive services that could be billed as an EPSDT service through grants or locally-funded programs. Health plans then do not have the claims data to show EPSDT services have been provided. MHD and CMOs should educate providers that EPSDT services can be provided when they see children for acute illness visits and sports or camp physicals, using the standard EPSDT forms as guides. MCOs should outreach members who have not received recommended EPSDT services and ask about exams performed by non-Medicaid

providers. CMOs should incent members to obtain screenings and providers to increase completion rates.

3. For Medicaid members who go to the doctor only when sick, poverty is a primary driver of social determinants, such as reliable phone services, transportation and lower health literacy, making it difficult to balance the importance of preventive care with other social needs. Providers sometimes have long appointment wait times that discourage and create barriers for members.
4. Additional barriers and obstacles: low-income parents have competing work, childcare and family priorities and experience limited provider hours or transportation challenges. Getting members to keep their periodicity schedule, lack of transportation and other access to care issues, member appointment "no-shows"; inability to coordinate referrals and medically necessary follow up treatment, and lack of member education on the importance of screenings and visits.
5. Members' lack knowledge on the importance of preventive care and are often non-compliant in following providers' recommendations. CMOs should demonstrate an understanding of the importance of educating providers to the need to not only meet EPSDT requirements during visits but to appropriately code for the care and screening provided, as well as develop a comprehensive outreach campaign to member families, to collaborate with key community organizations on education and community events that encourage and even conduct necessary screening.
6. Other Solutions: Before an EPSDT visit, CMOs should place 1-2 appointment reminder calls to ensure the appointment is kept and transportation is available. CMOs should focus on educating parents/guardians on available services, including transportation services and same-day services at the pediatric or PCP offices. CMOs must track and monitor program performance for rates of adherence by members and providers. CMOs must generate reports for members and providers. Recommend mailings, partnership outreach programs with providers, digital outreach (text reminders, member Portal) outbound calls, and inbound calls to discuss EPSDT. Care gap alerts should be incorporated in the member service and care management systems. Payment models to incent improvements may also improve compliance and health outcomes.
7. MHD should consider a multi-year approach to meeting the EPSDT goals, using year-over-year percentage improvement targets to be included within CMO performance standards rather than a flat benchmark. MHD should require CMOs to propose new and creative ways to increase screening completions and require MCOs to develop targeted member and provider incentive programs.
8. CMOs should employ a local approach to care management, hiring staff from within the communities served and establishing relationships with key community agencies to assist them to remove obstacles. It is essential that appointment availability for covered services fall within MHD-specified timeframes. CMOs should provide care gap reports for EPSDT services to providers and must partner with them to ensure compliance with appointment access and wait times.
9. EPSDT measurement methodology for compliance should be consistent with the CMS measurement age range 0-5 years old. The eligibility criteria should be expanded to a minimum of 6 months and allow a 6-month claim run-out to be consistent with claims filing allowances. The measurement period should be calendar year.
10. MHD should require and provide incentives for all providers to participate and file claims for EPSDT services. Like the immunization registry, a centralized database would assist health plans and medical homes to coordinate member care. We also suggest a data sharing policy that allows health plans to update MHD's contact information for members when CMOs have more accurate data.

***Providers*:**

1. Parental awareness is a barrier.
2. MHD must align incentives for this quality metric.

3. The form is outdated and cumbersome—last revision in 2007.
4. Low provider participation in Medicaid hinders access to EPSDT for children. Anecdotal evidence indicates that primary care providers may be utilizing Evaluation and Management documentation rather than EPSDT, as there is higher reimbursement.
5. Improvement strategies: reminder and recall systems, improved transportation services, access to providers during non-traditional operation hours and on-site care at schools and child care facilities.
6. MHD could mandate strong network requirements for the MCO but the math for these requirements will likely not work. If access issues are based on current reimbursement rates, how will the MCO take the same or less state funding, remove their 15+% for overhead/margin, and still be able to entice participation in the network by providers who already feel under-reimbursed? There are inherent financial incentives for MCOs to limit access to these services. Given that members can move from one plan to the next, it is in the MCO's interest to focus on short-term financial gains rather than the long term benefits realized by increasing access to EPSDT services. Local providers will see these patients regardless of which plan they choose, and likely will see them later in life as part of a commercial insurance plan. Providers are better equipped and have better aligned incentives with finding innovative ways to fund these services and address long term needs.

***Advocates*:**

1. The new RFP should: 1) specify the responsibilities of the MCO, contracting providers, and MHD for conducting outreach and informing; 2) require MCOs to provide each enrollee with information, in writing and orally, about the availability of help scheduling appointments and providing transportation; 3) require plans to document when enrollees decline EPSDT services and deem the rejection as specific only to that particular service; and 4) require MHD, health plans and providers to use appropriate means to communicate with persons who do not speak English, who do not read or are hearing or vision impaired. CMOs should clarify who has responsibility for informing enrollees of transportation assistance and arranging it.
2. MHD should focus on both screening and treatment requirements. The state's current contract includes beneficial language on EPSDT but these provisions are not adequately enforced, with sanctions for screening but not for treatment.
3. MHD could improve Plans' performance by including a prohibition on waiting lists, monetary caps, upper limits on hours or units, or limits on the number of visits to a physician, therapist, dentist or other clinician as long as the provider documents medical necessity.
4. MHD should clarify that there are to be no "magic words" or special procedures required for requests for services under EPSDT, and the right to continued services pending appeal, regardless of whether the original authorization period has expired. MHD should specify protections against denials of services and the applicability of EPSDT to HCB Waiver programs.

***Vendor*:** Members lack information, transportation and distrust the medical system. Information technology is needed to track members to allow Plans to conduct outreach. Provide neediest communities with local testing at community sites, such as schools. Use mobile medical units. Use community education campaigns (PSAs, internet ads, and flyers/brochures at hospitals, government buildings, libraries, churches etc. Work to overcome distrust and provide culturally competent services.

Recommendations to Innovate

***MCO*:** We recommend member Incentive Programs to provide education and promote EPSDT compliance, and Provider Incentive Programs, in which providers receive an incentive for completing specific preventive services, including well child visits; We also recommend Nurse Practice Advisors Program - providing nurses in the offices of practices to assist providers identify care gaps and the reasons why visits are not captured in

claims/encounter data, as well as educating providers on capitalizing on routine visits (i.e. sports physicals, sick visits, etc.) to complete well child visits, and help overcome member barriers, such as a transportation benefit available to most members at no cost; We recommend Care Gap Reports identifying members who are due for, but have not yet completed, well-child visits. Further Recommendation: Collaboration between MHD and all CMOs to provide consistent promotional messaging on the importance of EPSDT.

***Provider*:** FQHCs, Comprehensive Substance Abuse Treatment and Rehabilitation (CSTAR) providers and Community Mental Health Centers (CMHCs) and their Affiliates should be the primary providers for this effort. Establish a regional effort. Otherwise promote adoption of this initiative by all CMOs through the Local Community Care Coordination Program (LCCCP) as referenced in the state's current contract.

***Association*:** Missouri's EPSDT compliance is woefully low. An obstacle is the shortage of Medicaid providers, especially in rural areas. Rural Health Clinics understand rural patients and are uniquely positioned to develop strategies to improve healthcare benchmarks in these areas. MHD should consider incentive payments to CMOs based on meeting evidence-based standards such as EPSDT. We strongly recommend provider incentives for EPSDT care coordination. Missouri's behavioral health homes would provide an excellent opportunity to help the state achieve EPSDT compliance.

***Other*:** If MCOs and their provider networks were incentivized to participate in Missouri's SDE for medical record exchange, capturing EPSDT and other quality measures would be expedited, much less costly and more thorough.

Additional Recommendations: None

Question 1d. Describe the advantages or disadvantages of having any or all of the following benefits paid for through the care management organization:

i **Dental;**

ii **Non-Emergency Transportation;**

iii **Behavioral Health; and**

iv **Vision.**

Responses to Question 1d: 22

Overall Recommendations

1. All MCOs, with the exception of a Dental MCO, strongly advocated for the inclusion of all four services in the MCO's plan, stating the importance of a fully-integrated plan for care coordination and cost containment.
2. Opinions among providers, Associations and Advocates varied somewhat, with the majority supporting the delivery of non-emergency transportation and vision services inside MCO Plans, but carving out dental and behavioral health.

Recommendations to Increase Efforts to Improve the System

***MCOs*:**

1. The advantages of incorporating all of the benefits (dental, non-emergency transportation, behavioral health, and vision) through the CMO model far outweigh any disadvantages. When services are carved out of the managed care benefit, CMOs lose the ability to fully manage these services as part of an integrated care management approach. This leads to less-effective overall health outcomes and limits the cost containment that could be impacted by the Care Management Organization.

    i. ***Dental:*** Dental health ties into individuals' overall health outcomes. Systemic conditions, such as cardiovascular disease, diabetes and AIDS often first become apparent as mouth lesions or other oral problems. Studies show that patients with severe periodontal disease incur much higher health care costs than patients who have good oral health Diabetic patients undergoing dental preventive treatment incur on average $2,500 (23%) less in health care costs per year than patients with periodontal disease. For many low- income children, lack of access to dental services means expensive ER visits are the first and last resort for treatment. The cost of treating young children for decay-related ailments in hospital ERs or ambulatory surgery centers jumped from $18.5 million to more than $31 million (2004–2008). Including dental benefits in MCO plans allow health care providers to more easily share information and consult with one another in a systematic/sustained manner, increasing the likelihood of members receiving appropriate preventive care, as well as providers identifying disease precursors and underlying conditions in members. Integration also raises members' awareness of the importance of oral health, potentially encouraging them to seek dental services sooner rather than later. A recent report indicates that patients enrolled in MCO dental networks saw dentists more often than those enrolled in traditional Medicaid FFS. The report also found that about 40 percent of children and 29 percent of adults in traditional Medicaid saw a dentist in 2009, compared to 51 percent of children and 40 percent of adults enrolled in Medicaid managed plans. A Rhode Island access and utilization study of dental care found a 28% increase in overall participation in dental care between 2005 and 2010, a 33% increase in preventive visits and 50% increase in treatment visits after introducing its managed *Rite Smiles* program.

ii. **A Comment Regarding Dental Carveouts:** States using carve-outs for Medicaid dental programs have found issues with processing dental claims and other administrative processes, including a lack of consistency in Plan administration, creating confusion within the dental office. Carve-in dental programs utilize fully integrated medical-dental electronic health records which can facilitate sharing of health information between medical and dental care providers. Waste, fraud and abuse is a significant issue with in the dental program, a carve-out dental program adds to the complexity and administrative burden of monitoring this issue. Including it in the MCO program eases the administrative burden on the state while adding to its ability to monitor waste, fraud and abuse.

iii. **Non-Emergency Medical Transportation (NEMT):** including NEMT in the MCO's responsibilities creates overall efficiencies, including better coordination of care and lower program costs. The CMO may be best prepared to oversee and coordinate non-emergency transportation services as well as to resolve issues such as "no shows" or timing the transportation with the medical appointment. In addition, the inclusion of NEMT services in the MCO's scope of responsibility alleviates issues related to their provider networks and member access requirements. In some regions of Missouri, the RFP should mandate that CMOs provide additional trips to the pharmacy, Lamaze or birthing classes, and other appointments for members who have transportation as a covered benefit.

iv. **Behavioral Health (BH)**: According to the Kaiser Family Foundation, as of 2012, Medicaid had become the largest source of financing for BH services in the United States. 35% of Medicaid members live with a chronic mental illness and 61 percent are more likely to experience a co-morbid medical condition. An integrated system that coordinates members' physical and behavioral health is essential to meeting members' needs and reducing overall health care costs.

v. **Vision:** Vision benefits are an essential component of a fully integrated model. Millions of Americans live with visual impairment and many more remain at risk for eye disease and preventable eye injury. A visit to an eye care professional for a comprehensive dilated eye exam can help to detect common vision problems and eye diseases. Early detection of these vision problems increases the likelihood of successful treatment and helps maintain a higher quality of life. Early detection also allows CMOs to provide the most cost-efficient, effective treatment options possible.

vi. **MCO-Dental:** MHD should consider carving-out a full-risk dental model that combines the advantages of dental managed care with a fee-for-service payment model. Keeping dental separate from medical care is paramount for program accountability. When dental is administered by health plans as a carved-in service, the ability of the dental community to influence clinical guidelines and policy development is severely compromised. Most MCOs subcontract with dental managed care plans to administer their dental benefits, resulting in duplicative administrative costs. Dollars appropriated for dental care risk are diverted into medical plan cost categories. Forcing Dental providers to deal with the varying requirements of multiple MCOs creates a significant administrative burden, increases dentists' reluctance to participate in Medicaid, and stresses their already thin resources. MCOs have minimal experience in administering dental networks, managing the utilization of dental treatment services, or increasing quality of care measures such as the use of preventive services. This dilutes the State's efforts to increase the effectiveness of its financial commitment to dental services. A separately managed dental model can make a dramatic difference in the number of children receiving care. Dental managed care focuses on getting children back on the road to good oral health by increasing the appropriate utilization of covered services and decreasing fraud, waste, and abuse. A statewide competitive procurement to select a Dental Benefit Program Manager (DBPM) would permit Missouri to implement a focused quality dental program for its Medicaid Beneficiaries and Dental providers.

***Providers*:**

1. Lack of dental care often results in emergency treatment through hospitals at much higher costs. Requiring the MCO to provide such services may reduce the incidents of ER visits. Including NEMT as an MCO benefit removes the concern of patients who often lack reliable transportation to get to their appointments. However, this issue is also tied in with the reliability of the transportation provider. Both the MHD and the MCO should have the ability to reward and penalize non-emergency transport vendors who don't meet specified criteria. Behavioral health (BH) is essential to overall physical health. MCOs should be required to include BH consultation services. Referral paths for BH should be similar to other medical specialties and coordinated with primary care providers for on-going maintenance. When a BH diagnosis is made, MCOs should be required to compensate the provider for the service. The possible exception is when there is diagnosis of a serious mental illness as defined by the Department of Mental Health (DMH) which would direct care to Missouri's Health Care Home model. BH Health Homes exists to provide high level care in the community settings to improve health, reduce overall costs and move the patient toward recovery.
2. We note the number of ER visits we receive from Medicaid recipients as a result of poor dental hygiene. MCOs should have responsibility for these costs, otherwise they are left with few incentives to find meaningful alternatives and will shift the burden for these services even more heavily to the providers. Regardless of the solution pursued by MHD, behavioral health must be a focus in Medicaid reform. Behavioral health extends beyond the commonly thought of areas of mental health to include social work, behavior modification, wellness, and self-management education. While not a health benefit, per se, NEMT is a major factor in compliance with required testing and keeping regular appointments with providers. MHD should consider a mandated benefit for these services. There are inherent financial incentives for MCOs to limit access to non-standard services such as those above. If MHD can develop solutions that require MCOs to provide these services while avoiding additional financial strain on providers, it would be beneficial for members.
3. MCOs seem to do a decent job managing physical health, but we find them ill-equipped to manage mental health or set up networks to deliver adequate supportive services. MHD's Fee-For-Service system allows for actual treatment in an inpatient setting, whereas CMOs push for medication and discharge instead of assessment, treatment and having a solid discharge network in place. Denied days with the MCOs far outweigh denied care for Fee-For-Service, which force facilities to provide additional treatment without reimbursement. Missouri has seen this play out countless times in regard to mental health. We would advocate for a carve-out for all mental health services.
4. It would be an advantage to have all benefits paid by CMOs instead of carveouts to multiple entities.

***Associations*:**

1. Dental, BH, and vision are unique services often best provided under a specialist umbrella. Payments for these services should use the same methodology as the larger CMO contracts. Incentives should be aligned so that providers, payers, and members are working toward the same goals to achieve better health outcomes and reduce costs. MHD can use the new RFP as an opportunity to offer more services, such as dental, through Rural Health Clinics (RHCs). RHCs operate under a cost-based payment structure, but the actual cost of providing services exceeds the payment limit in many instances. MHD should consider different funding streams, such as supplemental incentive payments or grants, for additional services to reimburse RHCs beyond the current per-visit limit.
2. Certain intensive services, like community support as defined by DMH, should not be included in the CMO model, in part due to the negative history of MCOs in managing care for vulnerable populations (chronic mental illness and addiction disorders). MHD should pay for behavioral health services through a separate capitated payment to BH providers. MHD's current Health Homes and Disease Management initiatives have proven that provider-driven care coordination and quality measurement improves

health outcomes, and drives down healthcare costs. A provider-led care management strategy allows care responsive to individual member needs and values that guide clinical decisions, not just containing costs. All care management, whether provider-driven or traditional MCO, must be held accountable for quantifiable outcomes. Quality measurement also serves as a check on the temptation to produce short-term savings by limiting care. Care management must be tailored to the needs of Medicaid's beneficiaries, many of whom have multiple chronic health, BH and social challenges. Placing responsibility in the hands of providers, who have established relationships in the community and who directly provide care to consumers, correctly balances the incentives to improve quality and reduce costs.

3. In terms of the dental component, the current complex system for dental Medicaid services could be administered differently (carved out), with one central system of management and one set of rules that apply to all participants and providers. We feel it would streamline billing operations in dental offices and expand the number of providers in the state.

4. Lack of access to dental care is the impetus for a notable number of hospital ER encounters. If Medicaid HMOs do not have the capacity and responsibility to manage the delivery of Medicaid dental services, they will have an incentive to deny payment for those ER services or minimize payment to temporary pain relief without addressing the enrollee's underlying dental problem. This is a poor outcome for both the hospital and the patient. If some alternative mechanism can be found to ensure adequate access to Medicaid dental care and minimize associated emergency department visits, a role for the MCOs may not be necessary. Until then, Medicaid MCOs should not be allowed to ignore their enrollees' oral health. Also, if a Medicaid enrollee needs diagnosis or treatment services, getting them to those services is a prerequisite. Non-emergency transportation would seem to be an integral function in the MCOs' obligation to manage the care so that the patient gets the right treatment at the right time. Behavioral health is an important contributor to Medicaid spending. Without a role in influencing how and when mental health care is delivered, MCOs will be forced to be purely reactive to the adverse consequences of a mental health delivery system that struggles to meet the demand for services. Experience in the MO HealthNet health home program emphasizes the cost and outcome benefits of ensuring that patients have ready access to both behavioral and medical services.

5. FQHCs have long been one-stop shops for underserved populations. Many of our clinics offer medical, behavioral and dental services in addition to co-location and collaboration with the community-based services needed to address social determinants of health. We have seen the power of integrating clinical services to provide more accessible and better health for vulnerable people. We encourage payment reforms and other policy changes that enable primary care providers to help underserved populations access needed care to improve their health outcomes. Most of our CMO partners understand the value of our integrated care models and should have broader latitude to reimburse primary care providers in ways that align incentives for integrated, timely access to dental, vision and behavioral health care in one-stop shops like FQHCs. Thus, maintaining such services within the MCOs should foster coordination. For example, dental is a high need for much of the safety net population and has many long-term consequences to overall health if not managed well. Additionally, many ER visits are directly connected to oral health issues. CMOs should be active partners with providers at the local level, and incentivize providers to encourage appropriate usage of such services. Behavioral health is an area that also presents opportunities for CMOs and providers to collaborate at the local level. CMOs should incentivize providers and assist providers in identifying high-cost/at-risk populations for intervention.

6. Many BH providers believe that our Medicaid system would best be served by having BH services remain under the state-run system. Managed care has had a difficult history nationally and in Missouri supervising behavioral health care services. In Missouri in the managed care areas there have been complaints voiced as to phantom providers lists, unfair paneling practices, preauthorization difficulties, particularly of psychological testing, failure to reimburse providers at all or in a timely way, and difficulty

with complaint resolution. Nationally there are numerous lawsuits and fines levied against managed care for failure to provide adequate care.

***Advocates*:**

1. While this question asks about four designated services, MCOs will likely seek to have other carved out benefits included in MCO Plans. Missouri's MCO capitation rates now cover the basic acute care services that members use: physician services, diagnostic services, and inpatient and outpatient hospital services. Nearly all of the high cost, specialized care is carved out and paid on a fee-for-service basis, including transplant services, psychiatric rehabilitation services (CPR), comprehensive substance abuse treatment and rehabilitation services (C-STAR), Home and Community-based Waiver services for persons in the Developmental Disabilities, therapy services (physical, speech or occupational) included in children's individualized family services plans (IFSPs) or Individualized Education Programs (IEPs), mental health services for children in foster care, and pharmacy. Missouri's experience indicates that these carve outs should continue to be exempted from MCO risk-based contracts. Pharmacy services have worked far better since being carved out. Our clients are far more likely to access medically necessary prescription drugs now than under prior MCO Plans. The MHD PA and clinical edits system functions much more smoothly than the Plans' systems did. Another health service that did not work well under managed care was comprehensive substance abuse treatment and rehabilitation services (C-STAR). Plans simply failed to provide the services required by the contract and CSTAR had to be carved out not long after Missouri implemented Medicaid managed care. Each designated area in the question is addressed below:

    i. ***Dental:*** MHD should consider carving out dental services. There is evidence that dental carve-outs have been effective in other states. Among the current system's problems are that members are unable to find dentists in their area and specialists are not available or members have to travel long distances to see one. A the National Academy for State Health Policy report indicates that a number of states have combined dental carve-outs with provider reimbursement rate increases and achieved success in improving dental service utilization. For example, Michigan, Tennessee, and Virginia increased provider reimbursement rates and collaborated with state dental societies to reach out to providers and pinpoint concerns and established advisory committee mechanisms for providers to give program design input. MHD could improve services and eliminate a layer of administrative costs by carving out dental services. There is also no requirement that these services be capitated. The State can simply pay a dental contractor an administrative fee for managing dental benefits. A dental carve-out must ensure clear due process protections and lines of responsibility for determinations of care approvals or denials. A positive feature of the current system is that the MCO is responsible for the dental subcontractor's decision and can reverse erroneous denials of care, and the MCOs' contracts. Any carved out dental contract must include all such protections and must be aggressively monitored and enforced by the State agency. Whether MHD carves out dental care or not, it should use the same dental care system for all Medicaid members.

    ii. ***NEMT:*** MHD's NEMT program (contracted through LogistiCare) has been problematic for participants and health care providers. NEMT seems to work better under MCO control. We do not recommend carving out NEMT services from the managed care contract.

    iii. ***Behavioral Health****:* The current system is confusing in that BH is included in MCO Plans for most enrollees but excluded for children in state custody, even though they receive their medical services from the Plans. Thus, children living in the same household may receive their BH services in different ways and from different providers. It is difficult for families to keep this straight. It would seem that children in state custody ought to have the option of receiving both their behavioral and their physical health care services from the same Plans as other children in their household.

iv. ***Vision:*** Vision services work reasonably well under the current managed care system and should not be carved out from the MCOs.

2. Dental, non-emergency transportation, behavioral health and vision are essential services necessary to ensure all health needs are met. If CMOs did not provide all these services directly, people will have to utilize a much more complicated system to get their needs met, increasing the likelihood that people will go without care, causing additional health issues and increased costs.

Summary of Recommendations to Innovate: See respondent comments

Additional Recommendations: None

Question 2: Care Management Organizations Accountability for Improving the Health Care Delivery System Requiring Care Management Organizations to be accountable to MHD for improving the health care delivery system: What should MHD do to improve care management organization accountability for improving the health care delivery system?

Responses to Question 2: 24

Overall Recommendations

1. Make the new RFP transparent and accessible to all interested parties and the public.
2. Increase MCO Accountability by:
    - Moving to a value-based care management system focused on desired health outcomes that require standardized protocols recommended by national guidelines, evidence-based treatment practices, and data driven performance metrics measuring the desired health outcomes and required practices;
    - Clarifying and strengthening MHD's monitoring processes and capabilities; and
    - Making all MHD expectations and MCO performance data fully transparent and easily available to members, providers, advocates and the general public.
3. Create new payment models that incentivize Member access to quality services, performance expectations and desired Member outcomes. Use data for benchmarking, evaluating and allocating performance payments to achieve the three goals of improved population health, greater Member satisfaction and lower per-capita costs.
4. Include health outcomes that include population wellness, the use of outpatient services, improved health markers for members with chronic medical, behavioral and co-occurring conditions through disease management strategies, and patient medication adherence.
5. Include consumer satisfaction measures focused on the ease of access to services, how care was managed, transitioned and delivered, as well as satisfaction with Member health status.
6. Include cost measures that include reduction in inappropriate or repeated hospital ER visits, inpatient readmissions, and reductions in healthcare costs for high-risk patients.

Recommendations to Increase Efforts to Improve the System

***MCOs*:**

1. That MHD establish clearly defined expectations endorsed by national performance authorities (NCQA, NQF, AHRQ, CHIRPA, and Adult Core measures), and add regionally-focused expectations, such as the engagement of community organizations, use of community advisory boards and inclusion of community stakeholders on the CMO's board or quality improvement committees, and partnerships with regional community organizations to address local health disparities.
2. MHD should establish dialogue forums for MHD and CMOs to discuss barriers and challenges to achieving performance goals.
3. Include RFP questions designed to evaluate a CMO's experience in creating strong provider networks, incentivizing and holding providers accountable for services and working collaboratively with providers through shared information, jointly designed care management tools, and pay-for-performance methodologies to meet program goals.

***Both MCOs and Providers*:** The need for timely access to accurate Member health data, including historical patient encounter data, to identify unique patient needs and health care gaps.

Providers, Associations and Advocates:

1. MHD's ability to adequately monitor MCO performance given its shrinking staff resources.

2. The adequacy of MCO provider networks statewide, particularly in rural areas, with strong recommendations that network compliance be vigorously enforced through "secret shopper" and other monitoring mechanisms to ensure that network directories are adequate and accurately reflect practitioners willing to serve Medicaid enrollees. There were numerous citations of studies in Missouri and nationally documenting the inability of MCO networks to meet the access needs of Medicaid members, as well as on-ground anecdotal stories of network coverage problems
3. The inconsistencies of MCO Prior Authorization processes, claims denial/partial denial rates, complaints, grievances, appeal processes and dis-enrollments. It was recommended that MHD routinely review delays, denials and dis-enrollments and other terminations of services as part of annual external quality assurance reviews, publish the results and sanction MCOs if care is being improperly delayed, denied or terminated.
4. MCOs' willingness/ability to meet federal Behavioral Health Parity standards and the adequacy of MCO BH provider networks. MCOs should be required to use standard measures of level of care for behavioral health, such as CALOCUS/CASII. MCOs should be required to include Missouri's CMHCs and FQHCs in their networks, and that care management be provided locally for members with co-occurring chronic medical and behavioral conditions through more intensive, on-the-ground provider-driven programs. Recommended quality measures for dually diagnosed individuals include A1c in control for diabetics, blood pressure in normal range for consumers with hypertension, medication adherence for Individuals with chronic mental illness, prompt access to outpatient services following hospitalization, assessment and treatment for alcohol and other drug use, screening and follow-up for clinical Depression, and suicide risk assessments.

Advocates, Providers and Associations:

1. The RFP be directly published and accessible on the MHD website, and include both an index and table of contents to make the document less confusing to consumers and the public;
2. MCOs should be required to provide MHD and publicly report data on service denials, partial denials, dis-enrollments, grievances and appeals.
3. That network adequacy reviews and performance metrics on service access and utilization, complaints, denials grievances and appeals, quality and consumer satisfaction measurements be widely published and available to members, providers, advocates and the General Public;

Advocates:

1. The RFP's accountability measures should require strong due-process protections that prohibit MCOs from denying services by adopting short authorization periods and then requiring unnecessary additional paperwork for providers to appeal. Under traditional due process requirements, individuals are entitled to continue to receive health services when they appeal a decision to terminate those services.
2. Members should be allowed immediate access to the state's fair hearing process to obtain a decision on their claim for medical assistance in all instances, including when the MCO is not making decisions in a timely manner as opposed to requiring numerous appeal steps before reaching the fair hearing process.
3. Care management contracts be tightened to require that written notice be given to a Member for any denial of services, including any partial denial. Any evidence of verbal or telephone denials or discouragement of requested services should subject MCOs to automatic sanctions.

Research vendors:

1. "Provider Numbers" be included on managed care claims and linked to the provider name and NPI in the provider file.
2. "Cost of Care" variable should be created because they believe cost data for managed care claims is currently unreliable.
3. Prescription provider numbers on pharmacy claims be tied to the provider's name and NPI in the provider file.

Recommendations to Innovate

1. Nearly all respondents recommended that MHD increase its current efforts to create new incentive and performance payment models that support a value-based healthcare system.
2. Many respondents stressed that Plans using incented payment models should be required to provide raw monthly claims feed to its providers to allow quick serviced adjustment and enable providers to do their own evaluations. MHD should require a standardized format to be used by all CMOs to provide such information. If the data is incomplete or inaccurate, the CMO should be subject to financial penalty and the provider exempted from the performance requirement.
3. Some provider and Association respondents recommended that MHD consider withholds from MCO Payments tied to achieving performance expectations, citing examples in other states: Texas withholds 5% of Medicaid Health Plans' total premium revenues until quality outcomes are achieved; Arizona withholds 1% of Medicaid Plan premium revenues and uses relative quality rankings to reward high performing Plans by letting them earn up to 5% of their total premium revenues in quality bonuses; New York offers significant bonuses for quality and sanctions for underperformance, including decreasing enrollment in poorer performing CMO Plans.

Additional Recommendations

1. Every Member, on their medical card, should have a number they can call if they have a complaint about their services. It should be allowed for both members and providers to make anonymous complaints. Currently providers are at risk from losing referrals from MCOs if they complain. Mental health services, in particular, need to be protected.
2. Supervision of MCO service delivery should be placed under the Department of Insurance, who is organized to better provide oversight than is MHD.
3. The public health care system represents a broad and diverse stakeholder network. Given this and the experience of Missouri public network, MHD should establish goals and expectations of CMOs and public health entities for interagency collaboration and corresponding outcomes reporting.
4. Require MCOs to include provisionally licensed professional staff under state-supervised plans, as allowed in FFS Medicaid. Presently 2800 provisionally licensed clinicians in Missouri cannot practice under MCOs. Preventing agencies from allowing provisional clinicians to serve on the MCO provider panels will further the crisis in rural areas that already experience shortages.
5. Disallow MCOs carving out of behavioral health management to a subcontracted specialty MCO. Ensure that each MCO has Network providers that include specialists in behavioral health inpatient and outpatient to meet the demands of the population.
6. Continue to require NCQA accreditation for any Health Plan awarded a contract. NCQA oversees both clinical performance and consumer satisfaction, releasing standards and performance measures each year that are focused on validating clinical and performance measures.
7. Require MCO Plans to publicly report medical loss ratios (MLRs), as well as those of subcontractors. The MLR is the share of the premium an MCO spends on health services vs. administration, marketing and profits. Plans should be required to maintain MLRs of at least 85%. If the MLR falls below that level, the Plan should be required to refund that portion of the capitation rate paid equal to the difference between the Plan's MLR and 85% of the capitated payment. Administration, marketing expenses and profit margins of subcontractors should not be counted in the MLR.
8. An MCO-dental respondent recommended that MHD should convene regular meetings with the dental benefit program manager to review report results, discuss improvements to the reporting guidelines, and other operational components of the program such as clinical guidelines, benefits and limitations, provider manuals, network adequacy, and quality initiatives.

Question 3: Leveraging local innovations by engaging local, provider-based care coordination and care management approaches Many Medicaid participants respond more positively to requests from their healthcare providers to change health-related behaviors when the request is made by a healthcare provider with whom they have a personal, face-to-face relationship. The healthcare provider the participant sees most often has the most frequent opportunity to coordinate and manage their care and influence their health behaviors. Missouri seeks to increase care coordination and care management provided to MO HealthNet Managed Care participants by their local health care providers. Describe the model (primary care medical home, Primary Care Case Management, accountable care organization, Health Home, or others) that is the most effective, from both clinical and cost perspectives, in achieving the goal of increasing care coordination and care management, and how that model can be implemented.

Responses to Question 3a: 24 total

Overall Recommendations

1. Respondents felt that the most effective models have the following characteristics:
    - Integrate all aspects of care for all member-facing services with co-location of as many services as possible (physical, behavioral, dental).
    - A close member relationship with PCP and patient-centered team.
    - *Capitated, fully-integrated statewide care management system where a single, accountable CMO manages all services provided to enrolled members.* There was disagreement on this characteristic. Some respondents felt a single CMO should manage all member services while others believed providers should be allowed to manage outside the MCO structure.
    - Accommodate geographic area and size and practice structure as key model determinants.
    - Urban, larger practices, especially those that are hospital-owned and that include primary care and subspecialty practices, and offer care management and shared financial risk for their patients, may more easily lend themselves to an ACO model. The Health Home model may provide the best foundation for these objectives at the level of the group practice.
    - Fully integrated care management in Missouri includes developing relationships with local, provider-based entities, such as Patient-Centered Medical Homes (PCMHs), ACOs and Health Homes. Model combinations create the best opportunity to impact member health.
2. Considerations in how to implement the model included:
    - <u>Financial Considerations</u>:
        a. Need financial and other incentives to support transformation at provider levels to engage in care coordination activities.
        b. Must provide financial and other incentives for PCPs to engage in care coordination activities, which are not typically reimbursable under traditional fee-for-service reimbursement models.
        c. Physicians and care providers should be intimately involved in the construction of the delivery model and should have incentives that motivate them to strongly pursue increasing the health and well-being of their Medicaid patients.
        d. Implement up-front care coordination payments to support new health information technologies and new provider-based skills and competencies required to conduct care coordination and population health management to improve clinical outcomes.
    - <u>Logistical/Model Considerations</u>:

a. MHD should seek ways to work with providers that build on existing CMS plans, which will lead to significant synergies that will allow providers to more quickly innovate and provide new and efficient ways of delivering care to Medicaid recipients.

b. Need to consider geographic area and size and structure of the practice--the model should vary based on unique practice characteristics.

c. Require team-based care and a focus on quality.

d. Any model MHD employs must include significant oversight to assure that "care management" is not just a paper requirement but is implemented by the MCOs/ PCCMs.

e. Any model considered should demonstrate its effective use of evidence-based population health and care coordination practices to improve patient outcomes. MHD can encourage these efforts by constructing contracts centered on the benchmarks that CMOs are expected to meet. These benchmarks should include measurable health outcomes and the delivery of population-appropriate services. We believe local providers are best equipped to encourage patients to engage in healthy behaviors.

f. Encourage the State not to limit itself to specific preferred delivery models.

g. Allow providers, regardless of resources or geography, to engage with the support of CMOs, to take a more active role in supporting the needs of their patients.

- <u>Contract Considerations</u>

  a. As MHD develops the RFP for managed care, all considerations of care models should be reviewed. Entities that contract with MHD should be expected to embrace goals of improving the experience of care, improving member health, reducing healthcare costs and accepting responsibility for creating partnerships with providers to achieve success. It is important to note that this is not the traditional capitated contract model.

  b. MO HealthNet must have contractual provisions establishing the goals and financial incentives rewarding growth of innovations. Success cannot be achieved without active provider participation and continuously open lines of communication with the MCOs.

  c. While cost savings appropriately accrue to Payers, shared savings with providers will be required to support the care delivery changes needed for success and should accrue from achievement of a standard set of consensus performance metrics. MO HealthNet should build on existing models whenever possible.

  d. MHD should encourage collaboration between MCOs to standardize value-based contracting approaches and share related population health management capacity-building investments.

  e. The RFP should require information from CMOs on their approach to implementing each of the models and the outcomes achieved where implemented

- <u>CMO/Provider Considerations:</u>

  a. Hold CMOs accountable to engage with providers– regardless of size, experience, or sophistication – to expand investments in care coordination and care management at the provider level, and enable them to be successful through access to robust data and understanding of how data should be utilized to improve outcomes.

  b. MHD should select CMOs with demonstrated experience in implementing a variety of local, provider-based care coordination approaches tailored to the characteristics of the providers' community and the members served.

  c. CMOs should have a demonstrated capability to collaborate with providers who can perform within these models and deliver effective care coordination and management.

d. CMOs should have a proven ability to support providers wherever they are along the care management continuum from both a clinical and administrative perspective.

e. MHD should implement processes that clearly define responsibilities between the provider and CMO, promote open communication and prevent duplication of services.

Recommendations to Increase Efforts to Improve the System

***MCO*:** PCMH or Primary Care Health Homes, in particular in large urban practices, could play role of an ACO and provide growth opportunities in both rural and urban areas

***Providers*:**

1. Contract with providers to so that front-line staff can provide case management face-to-face.
2. Align MHD goals with patient needs and incentivize providers to assure access to services.
3. In-home case management should be used for high-level co-morbid cases. Manage their inpatient use through a 3rd party and not through the MCO. The 3rd party would be reimbursed by the MCO for case management and incentivized when they reduced the episodes ER or inpatient care.

***Advocates*:**

1. Because Missouri has had success with the "health home" model, that model should be replicated to the greatest extent possible as the state extends "care management" across the states.
2. Provide a PCMH for each individual in need of primary care.
3. MHD should implement methods to periodically assess provider networks to determine if providers listed as in-network are actually participating and are actually taking on new patients.

Associations:

1. Co-location of behavioral and physical health services.
2. Create a fully integrated Health Home so that physical and behavioral health are managed through a team approach with at least virtual, if not physical, co-location, where case managers are fully integrated and able to address all of the patient's needs.
3. Local providers are best equipped to encourage patients to engage in healthy behaviors. CMOs must have incentives to work closely with RHCs and other providers to implement care coordination strategies for specific populations.
4. A "behavioral health home lite" version of care coordination could be implemented in addition to the existing health home program for those that do not have that degree of need, including populations that are currently being served that are still sick and costly. This health home-lite model could be a less intense version of the already successful CMHC Behavioral Health Homes, allowing for better care coordination for individuals who do not the current Health Home criteria.
5. Establish dental health homes. Have a primary care dentist serve as a member's dental home.
6. MHD should maintain the existing Local Community Care Coordination program in the next RFP so that it may be implemented for any new regions included.

Recommendations to Innovate

***MCOs*:**

1. Provide financial and other incentives for PCPs to engage in care coordination activities, which are not typically reimbursable under traditional fee-for-service reimbursement models.

2. Models are not mutually exclusive. Use different models that may be best suited to specific members and provider capabilities, or to a specific geographic area.

3. Avoid a one-size-fits-all approach to improving care coordination and care management – likely, a combined approach in which CMOs work collaboratively with various models is effective.

4. Embed case managers within PCP offices when appropriate and welcomed.

5. Require practices to become PCMH before coming health home.

***Providers*:**

1. Physicians and Care providers should be intimately involved in the delivery model construction and have incentives that motivate them to strongly pursue increased health and well-being of patients.

2. As MHD develops the RFP for managed care, all considerations of care models should be reviewed.

3. The ACO model should be developed.

4. Embed care managers within the Primary Care Medical Home.

5. Models should seek to establish a Medical Neighborhood that has specialty care providers and ancillary social support systems encircling the primary care system. The New England Journal of Medicine published a report in April 2014 detailing the concept of weaving the Patient-Centered Specialty Practice model with the Medical Home model and pulling in safety net providers to achieve a fully functional Medical Neighborhood. The per-member-per-month rate is pooled and shared amongst Medical Neighborhood providers to reach the common goal of care management.

6. At a minimum in care coordination, the primary care provider should be notified if a patient is admitted or discharged from the hospital.

7. Mandate In-home case management for cases with a high level co-morbidity and frequent inpatient use. This could be done through a 3rd party, not the MCO. The 3rd party would be reimbursed by the MCO for case management and incentivized to reduce episodes in the ER or inpatient facility.

***Advocates*:**

1. MHD should consider a model that ensures robust networks, sufficient payment of care coordination services and retains use of fee-for-service payments for people with disabilities.

2. PCCMS and ACOs must have hospitals within their groups.

***Associations*:**

1. CMOs must have incentives to work closely with RHCs and other providers to implement care coordination strategies for specific populations.

2. There should be contract clauses calling for dental and medical contractors to work together on primary care education programs and other initiatives (such as the fluoride mentioned above) to improve dental care for children and to ease the referral between medical and dental providers.

3. Dental Emergency Department diversion programs- Contractors should assume responsibility for all members seeking care in the emergency department by establishing an emergency department diversion program, helping to ensure the establishment of a dental home.

4. Shared savings with providers will be required to support the care delivery changes needed for success. Shared savings should accrue from achievement of a standard set of consensus performance metrics.

5. MO HealthNet should build on existing models whenever possible.
6. Recognize that there are multiple ways to access mental health services is crucial. Working in a primary care setting is one option, but it should not be our only method for making mental health services available.

Additional Recommendations

Association: Given the successes and national recognition of the MO HealthNet health home program, it might be tempting to compel that particular model but MHD should not as ACOs also are active in Missouri.

Provider**:** The state should consider options for contracting directly with ACOs.

MCO: Any model is e best supported when CMOs act as an umbrella organization managing the full continuum of care for any type of provider. A single, accountable CMO manages all services provided to enrolled members. As the Primary Care Case Management (PCCM) model has evolved in most states, including Missouri, to either focus on more intensive, care coordination or to a fully integrated, capitated model a basic PCCM model will not meet the State's clinical and cost containment goals.

Advocate: Models should be tested first as the state expands "care management" geographically across the state. We strongly recommend against MHD paying providers a capitated rate for provision of Medicaid services to people with disabilities. MHD should consider a payment system that pays PCPs for time spent on care coordination activities, particularly for people with disabilities.

Question 3b. How can ACOs be utilized through a Managed Care Organization (MCO)? What are the advantages and disadvantages? How should MHD hold care management organizations accountable to contract with existing ACOs in Missouri in a way that includes the ACO performing the functions of care coordination, care management, and disease management? Describe financial, clinical, and operational issues for the care management organization which MHD should consider when developing the RFP.

Responses to Question 3b: 18 total responses

Overall Recommendations

The response to the creation of ACOs was mixed:

1. Most MCOs recommended that MCOs not be forced to contract with all ACOs. If ACOs exist independently, they should meet the same State requirements as MCOs and that there should be a clear delineation of roles and responsibilities for ACOS.
2. Providers and Associations were more supportive of an ACO model, with some reservations.
3. A number of respondents recommended detail on structure, required elements for success, relationships with providers and MCOs, information technology and reporting/evaluation requirements, and payment models and financial incentives for prospective ACOs.
4. Advocates stressed the need to protect patients in any new model and urged exploration of opportunities within more traditional models, e.g. Health Homes or Primary Care Medical Homes.

Recommendations to Increase Efforts to Improve the System

***MCOs*:**

1. Define clear roles and responsibilities between CMOs and ACOs including alignment of financial, quality, and clinical/care management processes.
2. ACOs must be ready to manage their members using data (claims, HEDIS, utilization, etc.) that are fed into their electronic health record (EHR) and payment systems.
3. MCOs should share predictive modeling data, claims data, and HEDIS reports to be sure the ACO is identifying and engaging members who could benefit most from care management and to provide oversight and assistance with care management processes.
4. Require that MCOs engage with certain existing ACOs and support the development of new ACOs.
5. Recommend MHD not require Missouri Medicaid MCOs to contract with all ACOs, as each are different in terms of their capabilities, sophistication, goals, interest in contracting with Medicaid, and their ability to take financial risk and manage patient risk.
6. Recommend MHD not to require the Care Management Organizations to contract with all ACOs for all functions including care coordination, care management, and disease management.
7. MHD should not designate which specific functions should be included in MCO contracts with ACOs.
8. Recommend against holding CMOs accountable to contract with entities that label themselves ACOs. To be successful as an ACO, an organization must have a structure that supports ACO providers as they implement new care models, transform their practices, and adapt to new payment methodologies.
9. Recommend that the CMO strategy focus on provider partnerships and advanced incentive programs to emphasize value-based payments and reinforce multi-stakeholder alignment in order to transform the

health care system from one that is primarily fragmented care to a system that is value-based, accountable, integrated, and in which data is standardized.

10. The same safeguards should apply to every entity looking to provide services to MHD members using Missouri taxpayer funds.
11. ACOs should be required to comply with the same taxpayer safeguards and consumer protections as MCOs.
12. If an ACO cannot meet CMO Contract requirements, recommend the entity partner with a CMO.
13. Recommend that ACO's be required to enroll with the SDE.
14. MHD should not limit the participation of MCO health plans in Medicaid ACOs.
15. Prevent Anti-Trust Issues: The anti-trust laws must assure that providers involved in the formation of ACOs are precluded from obtaining and wielding market power in an anti-competitive manner. ACOs cannot be allowed to implicitly or explicitly exclude Medicaid managed care plans from a health care market.
16. If ACOs are utilized in a managed care context, and CMOs continue to bear both up and downside risk, the CMOs should be able to contract with ACOs in whatever manner is agreed upon between the two. If ACOs are offered as an alternative to Medicaid CMOs, there must be a level playing field including both up and downside risk, licensing or certification and quality measurement.

***Provider*:** Focus on improved quality measures and outcomes.

***Advocate*:** It's preferable for the State to develop primary care case management (PCCM) or health home alternatives that offer intensive case management and other supportive services, rather than more risky ACOs. A PCCM or health home program that rewards organizations that provide meaningful case management should also be explored.

***Associations*:**

1. Since provider groups generally have direct control over care decisions, their accountability for a consumer's costs may be more accurately reflected in health outcomes and costs. Most "quality" metrics do not gauge quality; rather, they are process measures that capture compliance with practice guidelines.
2. Create provider incentive programs for disease management, to be implemented by a CMO or a MCO. The program should focus on certain chronic diseases, such as: diabetes, asthma, depression, hyperlipidemia and hypertension in conjunction with high emergency room and hospital utilization.

Recommendations to Innovate

***MCOs*:**

1. Linkages to community and social supports, the coordination of medical and behavioral health care by an interdisciplinary team, aligned incentives and accountability, and appropriate provider, member and staff education should be an ACO requirement.

2. Complete and timely sharing of data is essential to the success of care coordination and care management. Any independent ACO model would need to meet these requirements.

3. Value Improvement and Quality: ACOs and CMOs providing care to hard-to-serve populations should be rewarded for the delivery of high quality care. Quality metrics applied to Medicaid ACOs must be consistent with the quality metrics applied to Medicaid health plans. This will ease implementation, provide continuity of care and ensure accountability.

4. Beneficiary Assignment and Out-of-Network Access: MHD should allow for 12 months of continuous eligibility to limit churn between Medicaid (whether ACO or CMO) and other programs.
5. Network requirements (access to in- and out-of-network care) should apply to both CMOs and ACOs to assure continuity of care, cost containment and accurate data reporting. MHD should allow CMOs the flexibility to determine the best models to providing care for our members. ACOs can be a valuable tool but they are not a one-size-fits all.
6. MHD should develop meaningful incentives in the RFP to encourage CMOs to present a strategy to engage with ACOs as well as a track record of developing relationships in other programs.
7. MHD should encourage CMOs to support development of a broad spectrum of capabilities within ACOs, and be able to demonstrate experience in practice transformation and ACO engagement.
8. Establishing a financial model that encourages payment that supports ACO development and incentives will be key to the success of integrating ACOs into CMO delivery. State should develop a model that allows CMOs to report all types of payment models – ranging from incentives, to shared savings, to full sub-capitation through encounters—to avoid adversely penalizing CMOs for creating payment methodologies that do not rely entirely on traditional claims payment.
9. Consider how savings can be shared amongst the CMO, state and ACO providers.

***Vendor*:** MCOs can contract with ACOs to provide better regional coverage and for specialized services such as pregnancy, pediatrics, geriatrics, etc. MCOs can award contracts based on ACOs' proven ability and evidence-based outcomes. ACOs should have transparent accountability backed by reported data.

***Providers*:**

1. MHD should broaden the requirements so that more providers can assume responsibility for care coordination, care management and disease management, as larger organizations don't have the personnel or the personal relationships that smaller providers would be able to provide.
2. ACOs should be able to contract directly with MHD for the care of defined populations. Not only would this approach maintain lower capitation rates, but it would take advantage of the care coordination and management systems that were developed and are currently utilized for ACO patients.
3. In places were the ACO's and ACO-like structures already exist, it would be in MHD's best interest to work directly with providers who have established these structures to build on prior successes in innovating and reducing costs.
4. We are better poised to address this issue without the intervention of MCOs than with them.
5. MCOs contracted with MHD should be required to recognize and work within the existing payment innovation and care management structures that have been put in place by some progressive providers, and not be allowed to force their own models on providers who are already dealing with change at an alarming rate.
6. MCOs contracted with MHD should be held to a minimum Medical Loss Ratio (MLR). We suggest the minimum should be set at no less than 90%. Accounting for and reporting MLR should be standardized so that there are no incentives for MCOs to creatively account for costs in their overhead structure.
7. ACOs must focus on improved quality measures and outcomes, financially incentivize, and have robust technology for data reporting.

***Advocates*:**

1. Test ACOs first with the "healthier" population" of children, families and pregnant women already covered by Medicaid managed care rather than on people with disabilities.

2. MHD should address how the ACO will interact with the state's existing medical [health] home models; the scope of services that will be provided through the ACO's network;, how the ACO will be different from managed care (e.g., how risk will be allocated); and if providers are at financial risk, how their health care decisions will be affected and monitored.
3. ACOs' financial incentives should be tied to quality improvement rather than financial savings.
4. It will be crucial to have quality measures that truly safeguard against limitations on care, as well as having robust grievance and appeal systems. Because of these concerns, it would be preferable for the State to develop primary care case management (PCCM) or health home alternatives offering intensive case management and other supportive services, rather than more risky ACOs.
5. Care management organizations should be rewarded for performance on quality measures, including getting people into medical homes and coordinating their care, rather than cutting costs – which may well be accomplished by denying care.
6. Any ACO structure must comply with all Medicaid and all due process requirements, including notice and an opportunity for a state administrative hearing when services, are denied, delayed, suspended or terminated, as well as internal grievance within the ACO and/or MCO.
7. The system must be clear who is making decisions about coverage of services, who is making a medical judgment, and who is making a fiscal decision for an ACO. Any system that's established must provide the treating provider the ability to exercise independent medical judgment, and the member the right to receive notice and opportunity for a hearing for any denial of care.

***Associations*:**

1. A problem with ACOs is that some hospitals (not in KC and St. Louis) have used exclusive contracts to block participation of private mental health providers in a variety of commercial insurance companies. Open enrollment is crucial and active involvement in any referral system as well.
2. Without strong State direction, MCOs seem reticent to share significant accountability with providers, especially safety net providers. Any ACO model should prohibit hospital-based systems from locking out independent primary care providers; especially FQHCs. MHD should encourage the development of primary care-led ACOs, especially primary care providers like FQHCs, since such PCPs have no incentive to refer patients to a specialist or hospital that may be higher cost.
3. The contract bid document should provide for significant incentives for vendors to propose and execute ACOs and other care delivery models that engage providers in setting care delivery standards and collaborating with other providers and insurers in implementing them.
4. The MCO could serve as an administrator for payment of claims and analysis of utilization. The ACO model could be designed to be at-risk or shared savings.
5. Explore the possibility of a delivery system model that was provider-driven with a focus on driving quality and demonstrating outcomes and thereby reducing cost.
6. The eventual goal of many Medicaid ACO models is for providers to manage more risk and perform utilization management functions, which are traditionally performed by payers, such as MCOs.
7. Focus incentives on reducing costs, improving quality, and getting chronic conditions under control.
8. A well-designed prospective payment system directly encourages and supports integrated teams and high-value care.
9. Valued-based payment in addition to a base perspective payment system (PPS) to reward providers for meeting or exceeding performance benchmarks and/or well-defined metrics.

10. Care coordination and disease management initiatives could be incentivized with higher reimbursement rates or value-based payments for consumers with high-cost utilization history or high-risk using evaluation models.
11. Regardless of the mechanism of payment, there needs to be a movement based on flexibility in clinical decision-making instead of utilization controls. Clinical rules that are in the best interest of the consumer should be established.
12. Give consideration for a higher-reimbursement for evidence-based practices that are proven to reduce costs and improve quality.
13. A financial consideration is the multiple funding streams that are utilized to fund the BH safety net.

Additional Recommendations

***Provider*:** We would be remiss if we did not note the challenge of statewide managed care as it relates to the FRA. We fear that MCOs will use funds from the hospital provider tax to underwrite the administration of their programs, thereby reducing the funds that are used to treat patients.

Associations:

1. Consider an "ASO" type model where the MCO serves as an administrator for payment of claims and analysis of utilization for those ACOs that need administrative support.
2. The ACO model could be designed to be at-risk or shared savings; an at-risk model may not make sense in initial years until baselines and actuarial sound rates could be developed.
3. Explore delivery system model that is provider-driven with a focus was on driving quality and demonstrating outcomes and thereby reducing costs.

MCO: We oppose the segregation of patient populations into specialty plans, whether ACO or CMO. A substantial proportion of beneficiaries suffer from multiple chronic conditions. The creation of "specialty ACO's" results in segregating members by condition rather than addressing their holistic care.

***Vendor*:** MCOs could contract with ACOs to provide better regional coverage and for specialized conditions and services such as pregnancy, pediatrics, geriatrics, etc.

Question 3c. How should MHD hold care management organizations accountable to facilitate and support more Missouri healthcare providers to develop the capacity to function as and to meet the requirements of primary care medical homes, Health Homes, ACOs, Primary Care Case Management, and similar models? Describe the financial, clinical, and operational issues for the care management organization which MHD should consider when developing the RFP.

Responses to Question 3c: Total =18 (MCO- 6, Provider- 5, Association- 4, Advocate- 2, Vendor- 1)

Overall Recommendations

1. Overall, the responses recommend that MHD set clear expectations and requirements, and hold the MCOs to them, including enforcements like sanctions and withholds. They also recommend avoiding being too prescriptive and stringent in the RFP, and allowing the MCOs to work through details with local providers.
2. Providers recommended that MCOs differentiate in their models for providers who have achieved certification. Mechanisms to do so could include different reimbursement rates, incentives for the providers and requiring CMOs to encourage transformation to a patient-centered model, including providing the necessary tools and supports to do so. Methods suggested include:
    - Increasing reimbursement rates to providers that are providing care coordination services.
    - Incentivize CMOs based on quality of services/degree of transformation achieved.
    - Deploy different reimbursement models that encourage comprehensive care and care coordination for fully functioning ACOs. These could include models that begin with pay-for-performance could progress to sharing upside risk, and ultimately offer full-risk to those practices that are fully functioning ACOs.
    - Provide financial support for ACO and PCMH operating margins.
    - CMOs should collaborate with providers to develop value-based programs.
    - MHD and CMOs should collaborate to engage providers and assist with transformation efforts.
3. Financial, clinical, and operational issues that should MHD should consider in the RFP are:
    - Infrastructure requirements, data capture and sharing challenges and alternative financial solutions, such as value based purchasing plans.
    - Models that begin with pay-for- performance, progress to sharing upside risk, and offer full-risk models to those practices that are fully-functional ACOs.
    - MCOs should be accountable and rewarded for evidence that they facilitate providers to progress along a continuum of care models (PCMH, Health Homes, ACOs), and that they provide a spectrum of contractual and payment methodologies to motivate and reward the providers.
4. The RFP should be written to reward CMOs with experience in supporting practice and system transformation.
5. CMOs should be required to describe their current reimbursement models and effectiveness in other markets in the RFP.

Recommendations to Increase Efforts to Improve the System

***MCOs*:**

1. MCOs should provide analytics and member data (i.e., claims, utilization, and HEDIS) and predictive modeling data needed by provider's and practices to fully manage their members, and should assist providers in understanding and utilizing the data.
2. With respect to care management integration and oversight, MCOs should help practices who want to drive care management processes by providing education and mentoring to practice-based case managers.
3. MCOs should deploy a progressive array of reimbursement models that provide "stepping stones" for all providers to move further up the spectrum of increased responsibility for the health management of whole populations in a community, increasing their ability to provide comprehensive care and service coordination. These could include models that begin with pay-for- performance, progress to sharing upside risk, and offer full-risk models to those practices that are fully- functional ACOs.
4. MCOs should be accountable and rewarded for evidence that they are facilitating providers to progress along the continuum of care (PCMH, Health Homes, ACOs), along with evidence that they are provide a spectrum of contractual and payment arrangements to motivate/reward providers.
5. MHD should query CMOs on their experience and innovative solutions to support providers in developing capabilities to meet the requirements of PCMHs, Health Homes, and ACO models. MHD could incorporate transformation support components as a requirement for CMOs. In doing so, CMOs can then provide resources to help providers achieve, maintain and enhance their effectiveness for these models of care.
6. MHD should include a scored question in the RFP that asks CMOs to describe their experience in operating Plans that promote improvements in quality and cost, and their proposed initiatives to facilitate and support providers in transforming their practices.
7. MHD should hold CMOs accountable for collaborating with providers to implement value-based programs designed to address the overall needs of a Medicaid population, while allowing for variations by market and individual provider delivery systems.
8. A CMO's portfolio of value-based programs should be specifically designed to improve the capacity of the health system to deliver high-value care and increase provider accountability for high-risk Medicaid populations facing multiple health and social challenges.
9. Facilitation and support for providers to transition to accountable care models, including primary care medical homes, Health Homes, ACOs, etc., requires a reimbursement model that aligns incentives, as well as a strategy for provider transformation to an effective value-based model. The most effective strategy will include core components that address quality, utilization and total cost of care, and will be tailored to address specific populations and providers and, where feasible, include a shared savings component. CMOs should be required to describe their current reimbursement models and examples of effectiveness in other markets.
10. CMOs should be required to develop a work plan to assess its provider networks' readiness and desire to achieve advanced care management models, and to offer multiple levels of support, training and education to providers wishing to implement such models. Because providers contract across multiple CMOs, we propose a CMO work group, under the direction of MHD, to deploy activities, prevent duplication of efforts and define associated performance measures.
11. MHD should establish its goals and objectives for its Medicaid beneficiaries and CMOs. It then should allow the CMO to utilize its creativity and innovation to meet them. The benefit of CMOs is the flexibility and innovation that can be achieved through them. That ability should not be mandated or limited. CMOs should work with providers to develop a model that best serves their patients and achieves the MHD goals. Holding CMOs accountable should be limited to achieving clearly defined goals and objectives that are measured through outcomes not processes.

12. Financial, clinical, and operational issues that should be considered by MHD when developing the RFP are infrastructure requirements, data capture and sharing challenges and alternative financial solutions such as value based purchasing plans.

13. MHD should establish expectations that CMOs play a pivotal role in expanding the number of providers who transform to more progressive practice models. Without dictating the preferred approach – i.e. ACO, PCMH, or HH – MHD can establish the expectation that CMOs are responsible for engaging with providers and assisting them to transform from fragmented, volume-based practices to integrated delivery models that are rewarded based upon improvements to outcomes and quality. While there are multiple ways MHD can establish these expectations, it should ensure that the RFP is written in a way that rewards CMOs with experience in supporting practice and system transformation and specific plans to address the State's goals.

***Providers*:**

1. Provide free training and guidance to new providers with a consistent application for all providers and all CMOs to keep everyone on the same page and the communication consistent.

2. MCOs should be required to do all quality and economic reporting, and, most importantly, MHD should own the data from those reports.

3. MCOs should provide a bonus or higher rates to providers who achieve NCQA Level 3 Patient- Centered Medical Home (PCMH) status to drive adoption of this transformational model. Minimum standards of provider incentives should be used to ensure provider engagement so that the benefits for patients actually materialize.

4. Provider organizations should also be encouraged to integrate with other MHD programs, such as Behavioral Health Homes for Medicaid beneficiaries, to create integrated care delivery systems.

***Advocate*:** CMOs should implement field case management in all regions as part of their care management programs.

***Associations*:**

1. The bid contract should be structured to provide significant incentives for bidders who propose and implement, or collaborate with, provider-sponsored or other alternative models of care deliver, and should include components to verify that successful bidders implemented these initiatives. Bidding standards should ensure that the MCOs have the capacity to accommodate necessary data collection and analysis, and health information needs of these provider-sponsored and other care models.

2. MHD can help speed progress toward meaningful financial alignment between CMOs providers by driving common standards around quality measurement (especially measures that require clinical data to ascertain performance), data sharing and attribution methods. Along with significant quality incentives for CMOs, we encourage MHD to set measurable targets for participation in value-based arrangements. MHD should consider a requirement to share utilization and claims data, consistent attribution reporting, and common risk adjustment tools. Ensuring that providers are not just trying to find healthier patient groups to care for to meet metrics is key in ensuring access. Having different performance expectations for different segments of populations that are based on social determinants of health rather than disease states is a mechanism that may be important to ensure equity for patients.

Recommendations to Innovate

***MCO*:** A pass-through incentive or stipend for smaller/rural practices could be helpful to support practices that may not be able to afford the cost of this transformation. The common goal of these programs is to align financial incentives for accountable providers to improve the quality of care and curb costly and avoidable hospitalizations of Medicaid members, particularly those with multiple chronic conditions and BH needs. CMOs typically employ several mechanisms to coordinate information and services with the medical/health home to

optimize effectiveness and avoid duplication of services, including a robust Provider Portal, community care management teams and community health workers that connect members to the right care at the right time. MHD should facilitate CMO efforts for assertive outreach to the provider community, its commitment to financial investments in health home providers, and deployment of targeted incentives and value-based purchasing models, in order to integrate health homes into a holistic system of care coordination to ensure identification and effective management of complex high-needs members.

***Advocate*:** Person-centered care that is carefully coordinated by a provider can lead to better outcomes and higher quality care that controls levels of cost. MHD should consider a model that ensures robust networks, sufficient payment of care coordination services and retains use of fee-for-service payments for people with disabilities. These key elements could be found in a Primary Care Case Management model or in an ACO. The care delivery model must include a sufficient number of PCPs, specialists and hospitals, whether a PCCM or ACO model. One of the problems with expanding Managed Care across Missouri is inadequate provider networks. MHD must create policies and payments to providers that attract and keep providers in the PCCM or ACO. PCCMS and ACOs must have hospitals within their groups or care coordination will not be as effective or achieve a primary goal of controlling costs. We advocate strongly against MHD paying providers a capitated rate for provision of Medicaid services to people with disabilities. However, the traditional FFS model is missing payment to providers to provide care coordination. If MHD contracts with MCOs, strict accountability measures must be in place, including assessment of provider networks and monitoring of wait times. To successfully coordinate care for people with disabilities in all areas, but particularly rural areas, it is essential that MHD demand that any Provider Network adhere to certain time and distance standards that ensure timely access to necessary providers, and without significant barriers. More detailed policies and standards may be required to ensure that PCPs, who coordinate care in rural areas, have tools to address patient needs. MHD should consider paying a higher rate for care coordination in rural areas because it may take more work to coordinate care across a wider area with fewer specialists and hospitals than in urban areas.

***Association*:** Practice Support Payments are an option that a CMO could utilize to support growth of clinical care management staffing and systems.

***Vendor*:** Supports CMS recommendations for a pre-payment for services as an incentive for ACOs. CMS is encouraging providers to participate in ACOs through the Medicare Shared Savings Program, which creates financial incentives for ACOs that lower growth in health care costs while meeting quality of care performance standards and putting Medicare beneficiaries first

Additional Recommendations

Provider: MCOs should be required to recognize the work done by providers who have obtained certification under these models, and should be required to reimburse them differently. In addition, MCOs should be required to provide financial support from their operating margin to those providers who have or are developing internal resources to better coordinate care. This support should come out of any overhead reimbursement the MCOs are retaining and should not be part of the Medical Cost Ratio (MCR). In exchange, MHD could allow MCOs who contract only with providers certified under one of these models (PCMH, ACO, etc.) to have different Plan designs and marketing restrictions.

Association:

1. Psychologists should be included with physicians that receive bonuses who serve a high percentage of Medicaid patients. We need to encourage psychologists to serve Medicaid patients, particularly if we place BH on the same level as physical health. Because treatment alliances in health-care are fundamental to compliance and outcomes, especially BH, MCOs should be required to provide:

- Any-willing-provider participation for the patient's provider of choice, especially in any prior existing provider relationship;

- Interoperability of EMRs and an EMR portal for all providers; and
- A standard for continuity of care to stop the pattern of short-term underpaid employee turnover at the expense of the patient and the State.

MCO: We do not encourage the use of withholds for dental providers. This often has the unintended consequence of creating a barrier to care because the approach is viewed as punitive by the provider and can impede participation. Likewise, the clinical aspects of dental care do not lend themselves to "episode of care"-based payments other than for multi-step procedures such as root canals which are paid by us using a comprehensive approach that includes exams, radiographs, and the root canal procedure in a single payment. In terms of performance-based payments, we would encourage the State to authorize the dental benefit program manager to implement a pay-for-quality program to incentivize increased utilization for key preventive dental measures. In Texas, MCNA's Stellar Treatment and Recognition Reward (STARR)™ program provides bonus payments to dentists based on their compliance with key dental care metrics such as timely access to care, routine and recall visits, sealant application, fluoride application, and early care intervention.

Advocate: MHD can hold CMOs accountable by ensuring that they actually provide the "case management" services they are supposed to provide. Financial sanctions for failing to provide such case management, as required in the current RFP, is a good start. The new RFP must not only continue these requirements but must strengthen oversight of Plans' compliance with case management requirements, especially for special needs populations, who are being shortchanged in the current program. Performance withholds for failing to provide case management must go beyond case management of pregnant women and children with elevated blood levels (as provided for in the current contract) and must extend to other individuals whose care is managed by the MCOs, including special needs children.

Vendor**:** Incentivize MCO network providers for joining the SDE, which can result in cost savings, reducing duplicative treatments and improve medication management capabilities of the PCHM, ACOs, and PCCM.

Question 3d: How should MHD hold care management organizations accountable to implement "episode of care" payment methodologies or other bundled payment methodologies over an entire episode of care in order to improve coordination and quality? Describe financial, clinical, and operational issues which MHD should consider when developing the RFP.

Responses to Question 3d: 16 total responses

Overall Recommendations

1. Respondents recommended considering episodes of care payment methods with great caution, or preferably as a pilot effort with certain disease conditions, like joint replacements, or not implementing EOC at this time.
2. If MHD proceeds, it should only do so with major input from CMOS, providers and stakeholders, and should limit its efforts to models already deployed through Medicare or other payors.
3. Respondents noted that EOC requires significant investment of administrative, IT, and financial reprogramming along with intensive training. A robust and validated evaluation would be needed.
4. Respondents emphasized the need for transparency, clarity and consistency of rules, expectations, definitions and terminology.

Recommendations to Increase Efforts to Improve the System

***MCO*:** EOC payment should not be required while the field is yet so immature; opportunities to pilot this payment model could be considered as part of the overall value-based approach.

***Vendor*:** EOC or bundled payments place emphasis on quality of care rather than quantity of services.

***Providers*:**

1. MHD will have to find new and innovative ways to create incentives for the Medicaid member to improve compliance, and should consider appropriate incentives for the Patient, provider, and MCO when developing its RFP.
2. It's important to note that removing a margin from these bundles and returning it to the MCO's corporate structures and shareholders who lie outside of Missouri only hinders the ability of providers to succeed under these bundles, or to have any incentive to participate and provide access to Missouri Medicaid recipients.
3. MHD could easily work directly with existing ACO and ACO-like providers to develop alternatives to capitated managed care models across the state.
4. Incentivize for timely care, follow up and outcomes. Penalize for failure to meet the standards.

***Advocates*:**

1. Hold MCOs accountable to provide the care they say they will provide and for their performance on appropriate quality measures, not the extent to which they achieve additional cost-savings – they are already incentivized to deny care.
2. MHD should not assume that EOC strategies can be easily applied to the Medicaid population.
3. Missouri should be wary of applying bundled payment methodologies to its Medicaid program and should certainly not rely on this unproven approach to achieve significant cost-savings or quality improvement.
4. It is uncertain whether providers are equipped to participate in a bundled system and how such a system would interact with existing payment arrangements employed by Missouri MCOs.

***Associations*:**

1. It has been difficult in Missouri and nationally for behavioral health (BH) professionals to work with MCOs. Moreover many BH patients, particularly certain children's groups, are already carved out of managed care (e.g. residential patients, state custody and foster children). Continuity of care would be better if these children were under a single system.
2. Managed care is rewarded for using medication rather than counseling for children. They do not pay for medication. Pharmacy has been carved out. This cost shift would not exist if BH was entirely carved out. Managed care creates problems with increased administrative time.

Recommendations to Innovate

***MCOs*:**

1. The uncertainties of what should/should not be included in such models, or what exceptions should apply for services rendered during such episodes remain significant and raises the risk of poor financial performance by providers. This could significantly undermine the collaborative efforts between providers and Payers necessary for the larger goals of MHD to be realized.
2. Opportunities to pilot this payment model should be considered as part of the overall value-based approach rather turning on broadly.
3. MHD should not hold CMOs accountable to implement "episode of care" payment or other bundled payment methodologies.
4. Episode of care payment models require a high density of patient volume and involvement of large sectors of the health care marketplace in order to be effective in driving providers to engage in the infrastructural and operational transformation needed.
5. These models require significant administrative investments in systems and reporting, along with a high degree of analysis, transparency, data-sharing, and cooperation from broad sectors of providers working collaboratively together.
6. Initiate EOC pilot programs for specific conditions.
7. Transition to this type of payment model will require transparency, education, and input from the full provider network.
8. MHD should collaborate with a CMO to implement an episode-based payment methodology, including improving the current inpatient and outpatient reimbursement methods and a Diagnostic Related Group (DRG) payment methodology for hospital care for members.
9. MHD should carefully consider its ability to implement "episodes of care" given its current reimbursement systems for inpatient and outpatient services. It would be a significant challenge for all providers, including CMOs, to go from a charge-based to an EOC system.
10. "Episodes of Care" or bundled payment methodologies are generally most effective for health care events that present with a distinct beginning and ending such as joint replacements, Coronary Artery Bypass Grafts or maternity care.
11. Targets are set prospectively and should include the full spectrum of care including hospitalization, post-operative and necessary home or follow up care.
12. Consideration may be needed for a "true up" of costs when the episode concludes to account for risk factors and functional status. This is particularly important for the populations we serve as they tend to also have behavioral or socioeconomic challenges that may impact recovery.

13. Recommend the state limit "episodes of care" reimbursement methodology as described and endorse that such arrangements be developed and administered by the CMO.
14. Recommend clarity from the State in terms of payment expectations, episodes, and affected providers.
15. Need transparency in expectations and sufficient planning time to ensure that systems can be configured to support the State's model, and a clear understanding of CMO reporting requirements, with clear expectations in advance of any reporting timelines to ensure successful system and reporting configuration.
16. Any alternative payment methodology should have a collection process that allows for tracking of expenses to be used for rate setting. Adoption of alternative payment methodologies should not serve as a penalty for CMOs and all costs –both medical and administrative expense should be reportable and supportive of ongoing rate development to avoid unintended penalties to CMOs.

***Vendors*:**

1. Standardized terminology is necessary.
2. Effective episode definition requires problem-resolution skills and a consensus building process.
3. Clear and uniform criteria, in clear and uniform language, must be part of all episode definitions and included in all contracts that call for bundled payment.

***Providers*:**

1. Include a central payment program as well as approval program.
2. These models should mirror those already in operation by CMS, allowing MHD to build on the work already performed by providers to implement these models.
3. Models should be consistent with other care payment models, including those in Medicare.

***Advocates*:**

1. To the extent that these approaches are tested, they are more applicable to certain conditions than others. They work better with common conditions that have "easily identifiable start and end point" such as joint replacement, or labor and delivery.
2. Consider that this approach may negatively impact care provided to people with disabilities.

***Associations*:**

1. Assign value to enabling services (case management, WIC, insurance navigation, care coordination, health workers, and cooking classes).
2. Allow multiple episodes of care to be billed in one day.
3. Episodes of care definitions should be standard and be defined in a similar manner in other programs, such as Medicare. Align standards with already established programs to reduce the administrative burden on providers.
4. Episodes of care for behavioral health should be viewed in a similar lens to chronic disease, instead of an acute physical health condition.
5. Standards used for episode of care payment methodologies should be consistent with the standards of other episode of care models operating in the Medicare or commercial markets.
6. It is notable that most EOC and bundled payment models are part of Medicare and commercial fee-for-service delivery models. It may be difficult to apply them as a component of capitated MCOs.
7. Quality of care metrics used in evaluating performance should also mimic what is used in comparable models in other markets and have gone through a process of review and validation.

8. MCOs should ensure that their networks of post-acute or other appropriate providers are actively participating and sufficient to accommodate the demand created by these models.
9. The MHD should establish, monitor and enforce standards to ensure that the patient receives services at a level commensurate with his or her medical condition and situation.
10. Recommend robust stakeholder involvement from the provider community to ensure that design and implementation is successful.
11. Need clarity regarding episode-of-care definitions and rules; behavioral health is different than primary care and acute medical conditions.
12. Recognize that services that require a high degree of care coordination across many providers make calculating episode of care rates very difficult and must be carefully constructed.
13. Once episodes are defined, technology to support cross-functional implementation and management of bundled payment will be important for achieving efficiencies. Strong analytics are essential for setting up and monitoring the program. The technology to support bundled payment must be capable of integrating and executing multiple functions in an integrated care environment. For example, it must be able to define and manage contracts as established by the episode definition and then consistently apply the contract terms.
14. The complexity of bundled payment demands automation of the contract so that claims can be auto-adjudicated; otherwise, manual adjudication costs will escalate, payments will be inconsistent, and the bundled payment strategy will fail.
15. A system must have the intelligence and flexibility to monitor the contracted episode and payment as defined, recognizing that a claim is for an eligible service in an eligible facility. It must be able to determine consistently that component services are included/excluded according to contract terms. The system must integrate contract management with claims auditing for EOC payment success.

Additional Recommendation

Association: Rural providers, who can barely keep their doors open at times, will be hurt. They would do better under the state-run program with its lower administrative costs. When the state bids out a new program and a new company wins the bid, providers are hurt by having to re-enroll; there are delays in getting paid. BH providers, particularly in the rural area, have poor cash flow. They a system that guarantees immediate payment, as is the case now under the state-run system.

Question 4: Holding providers responsible for improving quality of care and containing costs:

a. When and to what extent should Care Management Organizations offer an upside bonus or other additional payment for meeting good performance goals and how is it best to decide the amount of the bonus for performance payment?

Responses to Question 4a: (MCO-6, Providers-4, Association-5, Advocate-2, Vendor-2, Other-1)

Overall Recommendations

1. Performance measures used in pay-for-performance generally fall into these categories:
    - **Process measures** assess the performance of activities that have been demonstrated to contribute to positive health outcomes for consumers;
    - **Outcome measures** refer to the effects that care had on consumers, for example, whether or not a consumer's diabetes is under control based on laboratory tests. Additionally, outcome measures should include cost savings; and
    - **Consumer experience measures** assess the consumer's perception of the quality of care they have received and their satisfaction with that care experience.
2. Be aware of the cumulative effect of other risk-sharing programs in non-Medicaid markets. The implications of risk-sharing, even at a modest level, are magnified when it is being done across the spectrum of Payers, each of whom may be unaware of the others.
3. MO HealthNet Division (MHD) should ensure that any incentive models are consistent across managed care organizations (MCOs), and that they are simple and easy to administer to reduce the amount of resources necessary to administer those incentives.

Recommendations to Increase Efforts to Improve the System

***MCOs*:**

1. Endorse upside bonus programs to providers for achieving specific quality improvement targets and in some instances, for cost efficiency performance goals.
2. We believe that pay-for-performance models are paramount to ensuring that providers and CMOs are aligned in improving outcomes for consumers and transformation the broader Medicaid system.
3. Setting up financial incentives with upside payment potential is essential to promoting an environment where providers will want to engage with MCOs on value-based contracting
4. Upside bonuses and additional payment incentives reflect important components of an effective provider payment innovation strategy, one that accommodates all providers at various levels of capability and readiness for quality incentives and payment reform.
5. There should be significant focus on shifting providers from volume-based payment methodologies to those that invest in value and have made significant investments nationally to transition providers to payments that align with the goals of improving care.
6. The amount of the bonus in a shared savings program should be determined by the actual financial results and the clinical improvements of meeting the established goals.
7. The amount of the incentive payment should be a function of the following four factors:
    - Amount should be sufficiently large that it captures the attention of the provider and acts as a meaningful motivator of improvement.

- CMOs should constantly evaluate external data points to determine the appropriate "market rate" for various incentive programs.
- Amounts must not conflict with any applicable rules and regulations regarding "market rates" for medical services or anti-kickback statutes.
- Amounts must align with overall health plan medical cost objectives to ensure a long-term sustainable managed care program.

8. Demonstrated upside incentive bonuses align best with providers who have a sufficient panel size, strong performance management capabilities, and a high degree of system integration.
9. The development of proprietary payment mechanisms requires extensive state-specific claims information, other data analysis, and close work with providers and the State to identify the best approach, including the methodology for setting performance benchmarks and the amount of a bonus or incentive payment.
10. Quality payments for achieving performance goals can take many forms, from care coordination fees up to and including shared savings. Taking an initial "upside" approach would promote providers' adoption of value based payment methodologies as an initial step towards more risk-based arrangements.
11. What is needed is a continuum of payment models that allow providers to participate in a manner that is comfortable for them to take on more risk and begin building core competencies around value-based contracting.
12. Models to consider:
    - *Pay-for-quality (P4Q)* - An additional payment made to providers who achieve a specific quality target for quality metrics for their attributed population - for example, HEDIS quality metric. Payment can be set based on a PMPM that accounts for the members being served.
    - *Shared Savings Upside* - Set a performance target for an attributed population tied to the population's Medical Benefit Ratio (MBR) and meeting certain quality metrics (e.g., HEDIS). If a providers can reduce the total MBR for their attributed membership and improve quality, then a bonus payment may be made for a percentage of the savings.
    - *Patient Centered Medical Homes (PCMH)*- For practices that can demonstrate they are improving quality through tracking of cost, utilization, and quality metrics, and that this can be linked to specific transformation efforts (such as investment in patient-centered medical home/health homes), payments can be offered to support that transformation.

***Vendor*:** Two-sided or upside-down models require individualized shared-savings arrangements because there are many diverse approaches, including the populations and services covered, the assignment of providers, the use of risk adjustment, and how savings are calculated and distributed.

***Providers*:**

1. Not in favor of performance payment or decreasing pay for poor performance.
2. We support the idea of incentives and penalties based on clearly delineated performance goals.
3. When provider risks and/or reward incentives are aligned with desired outcomes, providers are able to better align models with expected outcomes – including outcomes, cost, and patient satisfaction.
4. Keep incentive models simple and easy to administer to reduce the amount of resources necessary to administer those incentives.
5. Urge MHD to coordinate, or require contracted care management plans to coordinate these incentives with already existing criteria from CMS. Failure to do so could put providers in a position where they are simply not capable of complying with diverse incentive plans.

6. It is important that any incentive payments for performance be delivered in a timely manner to tie the incentive as closely to the performance as possible.
7. A Pay-for-Performance program should be administrated by a 3rd party or oversight board.
8. MCOs should provide a bonus or higher rates to providers who achieve NCQA Level 3 Patient Centered Medical Home (PCMH) status.
9. Recommend tying incentives to the size of population a provider serves, usually by counting member months, is common for these types of programs.
10. Bonuses should be provided based on the provider's quality of care and documentation of that care and service provided to the client.
11. Provider organizations should also be encouraged to integrate with other MHD programs, such as Behavioral Health Homes for Medicaid recipients, to create comprehensive integrated care systems.

***Advocates*:**

1. It makes sense to offer positive incentives to plans that do a good job of providing case management and other medically necessary health care services, as well as plans that achieve demonstrable improvements in health care quality. It does not make sense to reward providers who merely reduce costs without improving health.
2. MHD must develop adjustment mechanisms and/or incentive systems that do not penalize the organizations providing the bulk of the care to the Medicaid and uninsured patients. For example, "pay-for-performance systems" tend to penalize safety net providers because they do not take the socioeconomic status of patients into account.

***Associations*:**

1. Offering payment bonuses to CMOs for meeting certain standards, and reducing payments for failing to meet them, is a powerful mechanism to encourage CMOs to engage in best practices to improve care. This payment structure gives CMOs financial incentives to actively pursue the state's goals for the Medicaid program.
2. Providers should be held accountable for the services and treatment they provide. It is our perspective that performance measures drive quality and that providers should be rewarded for high-quality care that improves the health and behavioral health of the individual and reduces costs to the state and federal government.
3. To alleviate the administrative burden and fragmented care associated with inconsistent care standards among payers, we recommend that MHD's Vendor contracts reinforce the importance of using bonus methodologies that mirror federal or other widely accepted national standards, such as models used in the commercial and/or Medicare Advantage markets.
4. Payment bonuses or withholdings must be tied to standards that are clearly defined, quantitatively measurable, and evidence-based providers should have input into the development of the benchmarks and the means of measuring them.
5. Be aware of the cumulative effect of other risk-sharing programs in non-Medicaid markets. This is especially true if the standards are inconsistent. In setting the amount of the bonus, providers should be consulted.
6. Payment systems must be changed to reward value rather than volume, the compensation of individual physicians and other providers will also need to be changed to align with the structure of the new payment system, rather than with fee-for-service payment.
7. Supports the use of payment bonuses based on progress towards performance goals.

8. Ensure that the measurement data are used to assess healthcare equality and to generate an action plan for quality improvement programs in the following year.
9. MHD could set standards for CMOs relating to network adequacy, increased primary care visits, medication compliance, decreased emergency care, etc. MHD could evaluate care quality through evidence-based health outcomes, such as reduced BMI or controlled A1C levels. MHD should tailor these healthcare benchmarks for specific patient populations, such as pregnant women or diabetics.
10. While bonus payments based on efficiency seem appropriate, we urge caution and restrictions on allowing MCOs to award bonuses for reduced lengths-of-stay for inpatient care. Coupled with emerging and growing emphasis on penalizing readmissions, hospitals are set up to be penalized for keeping patients too long or not long enough, with no clear standard of demarcation.
11. Rural Health Clinics cost-based structure has been essential for clinics, but the per-visit cap is below actual costs for the majority of RHCs. RHCs also serve many uninsured or underinsured patients and receive little or no reimbursement. Incentive payments must be delivered outside the per-rate visit to supplement RHCs' existing reimbursement.

Recommendations to Innovate

See above

Additional Recommendations

Vendor: MCOs could be incentivized to participate with the SDE health information exchange and accordingly, support their Provider Network to join as well.

Question 4b: Holding providers responsible for improving quality of care and containing costs.

When and to what extent should care management organizations offer a downside decreased payment for poor performance against goals? What is the best way to decide the amount of the downside decreased payment for poor performance?

Responses to Question 4b: 17 (MCO-6, Provider-4, Association-4, Advocate-2, Vendor-1, Other-1)

Overall Recommendations

1. Many providers are still developing the core competencies to truly manage an attributed population in an upside/downside shared savings model that stretches even the most advanced accountable care-minded entities. Downside risk should be reserved for those provider organizations that have experience with value-based models and the necessary existing clinical leadership to take on the responsibility for managing all aspects of members' care under a risk-based model.
2. Pay-for-performance programs should be offered to providers, or networks of providers, that have demonstrated a commitment towards quality. For example, attaining level 3 PCMH recognition should be a threshold that all participating providers should meet to enter into such arrangements.
3. Downside risk should be introduced only if MHD and the managed care organizations can provide meaningful data to support the determination of poor performance.

Recommendations to Increase Efforts to Improve the System

MCOs:

1. MHD should include a question in the RFP asking CMOs to describe their provider incentive program(s), including any downside decreased payment for poor performance against goals as well as the methodology for determining the amount.
2. Juggling provider and Insurer roles while simultaneously learning how to generate shared savings will naturally stretch even the most advanced accountable care-minded entities. Introduction of downside risk for providers, who are still learning how to generate shared savings, will introduce additional challenges.
3. Downside payments for poor performance against goals are not an effective way to motivate provider behavior or influence practice patterns. Our Medicaid experience has taught us that many Medicaid provider organizations struggle on a daily basis to simply get through their flow of patients. Further undermining these already challenging situations with potential reimbursement shortfalls, only serves to further distract them from the primary objective of provider quality care to patients and may exacerbate existing Medicaid access and availability challenges by creating a disincentive to join CMO networks.
4. Any CMO that offers downside risk to providers must have an extensive vetting process to make sure that providers are well informed and appropriately positioned to assume financial risk.
5. As the financial stakes are quite high for the providers in these relationships, it is important to assess their capacity to assume risk on the front-end to ensure they are positioned to succeed. This upfront evaluation should include an evaluation of their operations and infrastructure (e.g. EMR system; analytics capabilities) as well as analyses of the size of the membership pool and historical claims data to ensure that the size and risk burden of the patient population is properly considered in the funding arrangement.

6. Downside risk should be reserved for those provider organizations that have experience with value-based models and are truly invested as an organization, and with the clinical leadership to take on the responsibility for managing all aspects of member care under a risk model.
7. Downside payments or risk for providers should be limited to those providers or systems that have sufficient resources, experience, and desire to assume such risk. Should downside relationships be established prematurely or with providers who are not sufficiently prepared to assume the risk, there is increased potential of negative outcomes to members and potential instability to the program.
8. CMOs should be given the opportunity to negotiate a deal and model that works best in each individual case. Prescribing set models or percentages will likely not work; as we meet provider-to-provider and assess their strengths and weaknesses, each will be at different level of capability for taking on risk.
9. There are several factors involved in the ability of both Care Management Organizations and providers to enter into an arrangement involving financial risk:
    - There must be an upside bonus before any downside payment can be considered.
    - CMOs must also have sophisticated systems to accurately track, measure, calculate, and report associated claims and financial data to the provider risk-taking entities.
    - Providers must fully understand what is involved in assuming any type of financial risk and be prepared to undertake the risk.
10. MCOs must be careful to balance a downside decreased payment with their own capabilities to help providers be successful.
11. Methods used to accomplish two-way incentive approach include minimum quality “floors” required to access the earned surplus, as well as reductions to target funding or sharing rates.
12. The amount of decreased payment should start out small enough so as not to completely deter the provider organization from making changes, but also large enough to gain their attention. Typically, an amount equal to 10% of reimbursement should be used as a way to capture attention in an upside rewards scenario. For a decreased payment scenario, the amount should be smaller.
13. Downside risk can be adjusted based on the population complexity, the carved-in services that the provider is accountable for, and the number of members. It can be adjusted to increase over time so that a provider who is still learning to adjust to a risk model has time to learn how to manage the population effectively.
14. To ensure access as well as limit the risk that providers may attempt to demand payments well above the State’s established Medicaid fee schedule, CMOs should be afforded the opportunity to pay 10 – 15% below the State’s fee schedule after three documented attempts to contract with a provider. This incentive ensures providers are encouraged to participate in CMO networks and limits unnecessary financial burden placed on CMOs or the State as CMOs develop networks.
15. In order to implement a process that places reduced administrative burden on CMOs, we recommend processing the decreased payment on the front end, at the time of claim processing, by withholding the applicable payment amount from the provider’s fee schedule. For providers who have had payments withheld, those withheld funds would be issued to providers upon successful performance against predetermined threshold quality standards.

***Vendor*:** A downside payment should be not be used in obstetrics - providers should be encouraged to provide maximum care.

***Providers*:**

1. Shared risk, especially among emerging ACOs or similar risk-based arrangements, is a challenge. Until the MCOs provide standardized data that can be used to provide better care, and thus better outcomes, it will be difficult for the providers to fully engage in risk-based models.
2. Downside risk should be introduced only if MHD and/or the MCOs can provide meaningful data to support the determination of poor performance.
3. MHD should standardize the criteria by which these determinations of increased and decreased payments are made.
4. There should be an expectation provided for the expected care to be delivered to each client. If the provider is not performing well, additional training should be provided before decreased payment.
5. Reduced payment should be a zero-sum game, with reduced payments from one provider going to support increased payments to another provider for superior performance. No financial incentive should be created for MCOs to reduce payments to providers based on criteria they track.
6. All providers for the client should have a central system to access mental and physical conditions, addictions, etc.

***Advocates*:**

1. CMOs should have their payments decreased when they fail to meet specific requirements of the contract, including provisions on EPSDT, network adequacy, case management, due process, and failures to provide medically necessary services.
2. When performance and ongoing metrics are so poor that it indicates no attempts have been made to improve, no bonus for not meeting the measures.

***Associations*:**

1. Almost without exception, providers are reimbursed well below the cost of treating Medicaid patients. In that environment, "up-side" bonuses are likely to be sufficient incentive to achieve performance goals. Penalties may engender practitioners such as dentists and physicians to forego Medicaid rather than risk further losses from treating Medicaid patients. This should not be interpreted to insulate providers from consequences for substandard performance.
2. Penalties are not practical. Behavioral health providers are paid poorly to begin with, access is poor, and it would be foolish to discourage providers from participating in the Medicaid system. Our auditing system and poor pay, as well as problems with the excessive administrative time in managed care already discourage participation.
3. Parameters should be established that limit the amount of downside risk providers assume.
4. A risk-bearing MCO should be allowed to address those provider Network management matters, within the confines of MHD quality of care standards, by curtailing or ending network participation.
5. Ensure that the incentive program does not limit access to care for patients requiring extraordinary levels or types of care, nor provide a disincentive for practitioners to treat complex or difficult cases because of concern about performance ratings.
6. Systems should not interfere with the doctor-patient relationship by injecting factors unrelated to the patient's needs into treatment decisions.
7. It would be imprudent to have penalties for working hard to change behaviors, but not be successful immediately.
8. Efforts to measure and improve quality of care should be separate from the traditional utilizations management activities of the contractors.

9. States typically use HEDIS and CAHPS to assess quality however, for some specialties (e.g., dental, behavioral health) these tools lack comprehensive dental specific measures. For example, for dental providers, quality should be measured by using a nationally recognized measure such as those developed by the Dental Quality Alliance (DQA) or endorsed by the National Quality Forum (NQF).
10. Behavioral health providers, not just physicians, should be included in any bonus system.
11. Bonuses should go directly to providers, not to administrators. Rural area, in particular, would benefit from bonuses as it could encourage more participation in Medicaid. Guaranteeing parity requires that we reward both physical and mental health providers. Unlike physical healthcare, a majority of mental health providers are non- physicians.
12. Ensure that measurement data are available to all stakeholders in order to allow the Medicaid system (Medicaid office, contractor, provider association and patient groups) to participate in improving program administration and patient health.
13. Ensure that the measurement data are used to assess healthcare equality and to generate an action plan for quality improvement programs in the following year.
14. Bonus payouts should be on a scale, so that meeting benchmark performance provides some payout, with higher levels of performance paying out additional amounts. Payouts will likely be capped at 3-5% of the total capitation payment. Payouts should be measured vs. previous three years performance and be judged against national or regional NCQA percentiles.

Recommendations to Innovate

***Advocate*:** The existing 7/1/2015 RFP has some performance withholds but they need to be extended to additional areas of performance besides those that are specifically included in the existing RFP.

***Associations*:**

1. Under the current system the patient is required to fill out paperwork to switch their PCP. It would be helpful if the provider reaches out to the patient, and the patient states they are seeing provider “x”, that a form could be completed by the provider to switch the PCP. The plan would have access to claims information to determine where the patient was seeking care most often for primary care.
2. Patient contact information including phone, address, and e-mail addresses should be updated regularly and shared with providers to assist with patient outreach and engagement by providers.
3. Improve attribution methodology so that the provider seeing the patient most often for primary care is the provider that the patient is attributed to, otherwise providers are penalized under the current system for patients that seek care elsewhere. Complete attribution lists should be provided no less than monthly.

Additional Recommendations: None

Question 4c: Holding providers responsible for improving quality of care and containing costs.

How should care management organizations decide the extent to which to include containment or reductions in the cost of care as a performance goal for providers?

Responses to Question 4c: 15 (MCO-6, Provider-4, Association-2, Advocate-2, Vendor-1)

Overall Recommendations

1. There must be a common belief that quality should not be placed in jeopardy in order to reduce cost, but stakeholders should understand the connection between cost/quality/utilization.
2. MHD should establish the detailed framework of the program (e.g., criteria; utilization thresholds) for providers and MCOs; MCOs should not be allowed to independently determine the extent to which containment or reduction in cost of care as a performance goal is included in any incentive.
3. Payers and providers need discretion, latitude and flexibility to negotiate an arrangement that makes sense for all parties involved. Each MCO and provider relationship will be unique and require unique considerations in setting a quality payment model and corresponding performance targets.
4. MO HealthNet should consider the implications of new downside risk-sharing obligations on the continued willingness of practitioners to participate in Medicaid.

Recommendations to Increase Efforts to Improve the System

***MCOs*:**

1. As healthcare costs continue to increase, find a way to marry quality care with appropriate utilization and cost containment. There must be a balance—not too much emphasis on cost to the exclusion of quality/utilization and vice versa.
2. All incentives must be designed to encourage the appropriate level of care and use of services, and should never allow for the withholding of necessary services.
3. CMOs should have appropriate processes in place to monitor and to make sure providers are not withholding medically necessary services, and that members are receiving appropriate care.
4. CMOs should perform extensive upfront due diligence to validate the group's ability to perform successful population health management, including an evaluation of its operations (e.g. EMR systems, data / analytic capabilities) and historical claims analysis.
5. The extent to which cost of care should be included as a performance goal should be related to the provider's span of control and/or ability to impact the various components of the total cost of care.
6. MCOs have a duty to develop models in which there must also be some level of understanding within the provider community around the connection between cost/quality/utilization. If not, education must take place at the grassroots level to assure a level of competency.
7. CMOs should include containment or reductions in the cost of care as a performance goal for providers only when implemented in tandem with quality performance measures.
8. Cost-efficiency measures are often focused on:
    - Avoidance of inappropriate use of emergency room services;
    - Potentially preventable hospital admissions;
    - Potentially preventable hospital readmissions; and

- Risk adjusted actual and expected utilization measures including ancillary services.

9. Quality metrics should form a threshold that providers must pass through before cost containment or reductions in cost should be considered.
10. Recommends that MHD request Care Management Organizations to describe the extent to which containment or reductions in the cost of care are included as a provider performance goal.
11. Offer bonuses for achieving certain utilization thresholds like reduction of inpatient readmissions, reduction in inappropriate hospital days, reduction in inappropriate ER utilization etc.
12. Including cost containment or reductions in contracts as performance goals largely depends upon the structure of the CMOs value-based contracts and the goals of the State.
13. When a CMO enters into a contract that includes a capitation, the provider is automatically incented to contain costs and eliminate unnecessary utilization.
14. These relationships should be limited to providers who appreciate the complexity of doing so as well as the tools and resources to successfully manage comprehensive or partial benefits.
15. By focusing on the most impactful quality metrics and aligning incentives with providers results in overall improved performance and, more often than not, also results in cost containment.
16. Quality indicators should target specific improvement, using State quality goals and performance measures as a starting point, and then further refined through analysis of the Health Plan's data and discussions with PCPs.
17. A thorough analysis will be needed to establish the complexity of the population including: risk-adjustment, the services to be provided, the attributed panel, strength of the primary care network, commitment to PCMH, EHR adoption and use, as well as any other incentives that the health plan may have. Considering all of these factors will be important in setting the right payment reduction on a provider-by- provider basis.
18. Reductions in cost of care is a likely outcome of focusing on performance improvements and any such reductions can become a part of the available pool for rewarding high-performing providers (e.g. shared savings models).

***Vendor*:** Only when there is no reduction of benefits and care for members.

***Providers*:**

1. MCOs should not be allowed to independently determine the extent to which containment or reduction in the cost of care as a performance goal is included in any incentive model because of the inherent perverse financial incentives that are present for the MCOs.
2. MHD, with guidance from provider partners, should determine if and when reductions in total cost or containment of care should be incentivized. MHD and the providers have the best interest of Missourians in mind when making these decisions.
3. We support MHD working with providers to decide on criteria rather than having set performance goals or reductions in the cost of care. As providers, we are already tasked with national standards and goals and have been able to identify those areas where improvement has been made and other areas that need adjustments.
4. Based on clinical authorizations that provide the necessary information.

***Advocates*:**

1. Reduction in the cost of care should not be a performance goal for providers whose responsibility is to provide the care that their patients need. Providers should be rewarded based on their performance on health quality indicators and on providing medically necessary health care services, not the extent to which

they save money for the MCO, which may or not be a positive outcome. Such savings may well be achieved by denying care, which benefits the MCO's profits and bottom line but not the participant or the state.

2. Based on patient panel.

***Associations*:**

1. Medicaid pays virtually all providers well below the cost of care. Provider reticence to accept the risk of further eroding those payments, even potentially, may be adverse to the delivery system.
2. Providers who are sharing risk with insurers lack insurers' capacity to reduce spending by the blunt instrument of denying payment through utilization controls. Their cost savings must be achieved by better management of care, which has traditionally been defined for them by corporate MCO decisions, or by limiting supply chain costs. Providers have only indirect control over the latter and cost containment pressures have already subjected this area to close scrutiny.
3. Providers should not be expected to share downside risk without some direct level of control over care management standards.
4. Unlike the Medicare Advantage and commercial insurance markets, Medicaid managed care has limited risk-adjustment for factors such as patient health status, acuity, etc. This makes it more challenging to predict and manage the risk of financial loss.

Recommendations to Innovate: None

Additional Recommendations: None

Question 4d: Holding providers responsible for improving quality of care and containing costs. When and to what extent should care management organizations contract for shared medical risk with providers?

Responses to Question 4d: 17 (MCO-6, Provider-5, Association-2, Advocate-2, Vendor-1)

Overall Recommendations

1. MCO respondents are fairly united that successful shared-risk models require entities which are highly prepared and that it is difficult to prescribe a model which will work for all.
2. The model requires a well-established MCO evaluation process to validate that providers or systems have sufficient experience and resources. Evaluation of resources should include clinical experience and capabilities of assessing and managing the needs of members; data analytics to support identification and management of member needs; technology resources to support clinical and administrative functions; and sufficient financial resources commiserate to the risk that the provider is bearing.
3. Provider groups want MHD to define the methodology used in the shared-risk models.
4. This question is also addressed with other responses (4a-c).

Recommendations to Increase Efforts to Improve the System

MCOs:

1. Each MCO should determine their own appetite for taking on shared-risk and engaging their Network in full-risk models.
2. Supports the development of shared medical risk with providers when and where appropriate.
3. Recommends that MHD request in the RFP that CMOs describe the extent to which they have shared medical risk with providers and their vetting process to make sure that providers are well informed and appropriately positioned to assume financial risk.
4. To be successful, a CMO must "meet providers where they are" on the continuum of payment arrangements, and not have a prescriptive strategy to encourage migration to specific points along such continuum, particularly into arrangements involving financial, risk for which they may not be ready. Each provider situation is unique, and developing payment arrangements and financial incentives tailored to each group is essential to a sustainable, successful partnership.
5. Contracts that share medical risk should be limited to providers who are well prepared to assume risk. Evaluation of this preparation is vital to ensure program stability and avoid unnecessary consequences to individual members.
6. CMOs should have an established evaluation process to determine that providers or systems have sufficient experience and resources. Evaluation of resources should include:
    - Clinical experience and capabilities of assessing and managing the needs of consumers;
    - Data analytics to support identification and management of consumer needs; technology resources to support clinical and administrative functions; and
    - Sufficient financial resources commiserate to the risk that the provider is bearing.

7. Key elements to evaluating when contemplating shared risk include:
    - Leadership and governance;
    - Partnering with (all) stakeholders;
    - Gain and/or risk-sharing arrangements;
    - Data analysis and IT;
    - Improving care delivery;
    - Quality improvement;
    - Community acceptance
8. Increase the likelihood that partner provider ACOs achieve their cost and quality improvement goals by aligning payment incentives and implementing the necessary infrastructure changes.

***Vendors*:**

1. Payers and providers must agree on how to determine whether savings were achieved so that there is both a meaningful incentive for the provider and reasonable protection that calculated savings do not reflect random variation in healthcare costs. This balance is difficult to achieve, especially in the case of smaller provider organizations.
2. Allows for CMOs to control costs and, as a result of assuming responsibility for managing service utilization, costs, and quality outcomes, offer providers greater autonomy.

***Providers*:**

1. Shared medical risk is a challenging model which should only be considered when MCOs can prove that they are able to deliver accurate and meaningful data to help the providers track and improve their performance under such a model. These models should be used sparingly when MCOs are involved as they allow the MCO to shift much of their risk to providers, and so after they have guaranteed their operating costs much of the margin is already covered.
2. Any provider involved would be held accountable if there was a central information system.
3. We strongly endorse the recommendations of the NQF Report on Risk Adjustment for Sociodemographic Status or other Sociodemographic Factors. Risk adjustment improves the quality measures by controlling for differences in outcomes attributable to factors that are not under the control of providers in order to illuminate those that are. Shared medical risk with providers and managed care organizations should be delayed until MHD can adjust risk based on the significant sociodemographic disparities that exist within Missouri.
4. Medical risk should be shared with CMOs who are dictating the length of stay and telling providers they no longer meet medical necessity. This would lend to more accountability at the CMO level.

***Advocates*:**

1. Unless the provider has the necessary infrastructure in place and a history successfully taking and managing risk, the CMO should be prohibited from contracting with that provider under a risk model. If they force a risk model and the providers are unable to make it work they simply won't contract to take Medicaid.
2. We disagree with such models of sharing medical risk with providers if it means sharing financial risk because such models could place the treating providers in conflict with their patients, given that this "shared risk" gives the provider an incentive to deny health care rather than provide the care that the patient needs.

***Associations*:**

1. Providers must think about overall population health and should be reimbursed based on value and outcomes and not volume.
2. Downside or penalties are not needed to improve quality. However, if properly structured, standardized, and with significant transparency regarding expectations and data, our providers would be open to moving forward on risk on an incremental basis, since the way our system is currently designed, we are already at-risk to a certain extent.

Recommendations to Innovate: N/A

Additional Recommendations: None

Question 4e: Holding providers responsible for improving quality of care and containing costs.

Which clinical and operational performance measures should MHD mandate for use by its contracted care management organizations? What would be the advantages and disadvantages of doing so?

Responses to Question 4e: 17 (MCO-6, Provider-5, Association-3, Advocate-2, Vendor-1)

Overall Recommendations

1. Value-based payment, performance standards, goals and outcomes desired should be established by the state with input from all stakeholders.
2. Align all health plans with the same measures and where possible, utilize nationally standard measurements – which can be measured more easily, are known to providers, and are truly measures of a critical domain of quality. Doing so will reduce the fragmented care and administrative burden of multiple submissions, allow for year-over-year comparisons and allow MHD, providers and health plans to design, implement and operate programs that show results over time. The advantage of using standard measures is the ability to compare Health Plans within the State and also compare Missouri to other Medicaid States.
3. Both clinical and operational performance measures are critical for MCOs to utilize when improving quality of care and containing costs.
4. Many respondents referred to their answer in Question 2.a.

Recommendations to Increase Efforts to Improve the System

***MCOs*:**

1. The administrative costs associated with monitoring large sets of metrics does not equate to improved performance, so the choice of metrics should be carefully chosen to demonstrate performance that is most meaningful to the State.
2. Recommend that MHD select clinical and operational performance measures designed to strengthen the Medicaid program with the overarching goal of selected performance measures promoting greater health outcomes, member and provider satisfaction, and system efficiency.
3. The performance measures should be:
    1. Reasonable and attainable,
    2. Reflective of the maturity of the program,
    3. Represent all aspects of achieving the Triple Aim: improved clinical outcomes, reductions in unnecessary cost and utilization, and improved member engagement.
4. The advantage of mandated clinical and operational measures is the reduction in the administrative burden for the partner providers, but the disadvantage is that this may discourage CMOs from developing innovative individual solutions.
5. Recommended clinical or operational measures:
    - HEDIS (MHD already mandates NCQA accreditation, which includes 88 HEDIS measures across 7 domains of care)
    - ED visits/1000

- Readmission rates
- Percent of members with a PCP visit
- Standard priority HEDIS measures (such as Well Child Visits and Immunizations),
- EPSDT rates
- Network adequacy
- Responding to the needs of members, providers, accrediting bodies and regulators
- Claims processing
- Reduction in potentially preventable events

6. Potential advantages of a mandated program-wide performance management system include providing CMOs with a "level playing field" of quality measures against which performance is measured. Potential disadvantages include a decrease in innovative quality management solutions offered by CMOs resulting from a mandated performance management system.
7. A disadvantage of using national measures is that they may not always address circumstances unique to our population in Missouri. The disadvantage of keeping measures stable year-over-year is that CMOs are not incentivized to address other measures.
8. Non-standard measures often cannot be properly administered because providers do not know how to impact the measure. In these cases, the measure is truly not applicable or cannot be measured and may only apply to such a small subset of the population, so as to render any measurement meaningless to the overall quality goals. Further, payers and providers have invested millions of dollars in EHR and other quality systems that are often aligned with specific measure type such as HEDIS and cannot as easily report on non-standard measures.
9. Consider using percent improvements as the metric when the baseline data shows that the current status of a particular measure is significantly below the ultimate benchmark in order to provide attainable targets and appropriately incent health plans.
10. Performance measures should be related to sharing/integration of actionable data at the point of care.

***Vendor*:** As it relates to pregnancy there should be at least a 10% reduction in NICU admits and infant mortality.

Advantages:

a) There would also be a reduction in the rate of emergency room usage and a reduction in average length of stay, and readmission rates;

b) a healthier population.

There are **no disadvantages**.

***Providers*:**

1. Standardization will be a large challenge when there are multiple CMOs involved.
2. Need a strong measure of accountability provided by MHD, or an independent oversight board, to ensure CMOs are not taking advantage of our Medicaid recipients.
3. Access to care and measures have been proven to improve the wellness of the population should be the primary considerations for MO HealthNet Division to mandate for use by any managed care company.
4. Submission of treatment plans for whatever care the client needs in a centralized treatment plan for effective whole person treatment.

***Advocates*:**

1. Replicate Medicare performance measures.
2. The performance measures should demonstrate compliance with a) EPSDT, b) case management (for all populations, including special needs populations), c) network adequacy requirements, d) due process provisions, e) improper denials of service and f) the provision of medically necessary health care services.

***Associations*:**

1. MHD's MCO contracts should compel standardized metrics for all vendors that are consistent with federal CMS or other widely accepted national standards to alleviate the administrative burden and fragmented care associated with inconsistent quality and outcome measures.
2. Focus on the standardization/alignment of performance measures and targets across all Plans to allow providers to have the same requirements for all patients participating in MHD Managed Care. Having different performance measures and targets for each plan makes it difficult for providers to conduct quality improvement to improve their systems and patient care.
3. Any performance measures implemented by MHD should be standardized across all care management contracts. Care benchmarks and health outcomes should be based on standards that are evidence-based with clearly defined measurement mechanisms.
4. Too many measures dilute focus. For this reason, our providers would endorse fewer clinical measures focused around the common chronic conditions like asthma, diabetes and hypertension that drive the majority of spending in health care – especially if left undertreated and managed.
5. MHD can measure the CMOs' quality of services through standards based on reduced ER visits, increased primary care visits, network adequacy, etc. Care quality can also be measured by patients' healthcare outcomes and/or CMOs' success rate at delivering certain services. Standards for health outcomes and services should be tailored to specific patient populations.
6. Cost containment alone is an insufficient performance measure for CMOs because CMOs who are rewarded for reducing costs will meet this target by restricting network access and limiting services. Instead, success should also be measured by the services offered and patient health outcomes. If these benchmarks are met through effective care management, savings will also accrue.
7. Require the development of systems that can accept clinical data from electronic health records and practice management systems in addition to use claims based data for the determination of provider performance on the established standardized performance measures. Use of clinical information in addition to claims-based information will allow the use of performance measures that show patient outcomes without the burden of time consuming chart audits versus relying solely on process measures that can be evaluated with claims based information.
8. Establish and enforce contractual standards pursuant to section 208.950, RSMo, related to Vendors' need to work with their enrollees to prevent avoidable ER encounters, and to set financial penalties for failure to do so.
9. The challenge is the delivery system - the business model - not the individuals operating inside that business model. The model must shift from paying for volume to paying for value. Additionally, providers must be held accountable for the health and well-being, as well as the healthcare costs, of the population they serve. Therefore, we support specific process and quality improvement requirements that are rewarded with value payments.
10. As much as possible, align with federal SAMHSA and other guidelines established in the Section 223 demonstration:
    - Follow-up after hospitalization for mental illness (adults),

- Follow-up after hospitalization for mental illness (child/adolescents),
- Adherence to anti-psychotics for individuals with schizophrenia,
- Initiation and engagement of alcohol and other drug dependence treatment,
- Adult major depressive disorder (MDD) suicide risk assessment, and
- Child and adolescent major depressive disorder (MDD) suicide risk assessment.

11. For behavioral health, vendors should be expected to use the same instrument to assess level of care, i.e. LOCUS/CALOCUS.

Recommendations to Innovate

***MCOs*:**

1. Regarding the current clinical and operational performance measures being applied to Care Management Organizations:
    - Some current measures leave room for subjectivity, which could affect measurement consistency and validity;
    - Measurement methodology should be reviewed with all relevant stakeholders to determine the most appropriate and robust methods for obtaining accurate measures;
    - Current benchmarks for some measures are very aggressive and may not be reasonable for existing or new entrants in the market; and
    - Any capitation withhold amount should be factored into the actuarial soundness review of Care Management Organization rates.
2. The transition to "75th percentile" levels for a Medicaid population is challenging and can take many years – material movement on 10 key measures for Missouri may be more advantageous than minimal movement on 30 or more measures.
3. MHD should invest in a comprehensive education of its own staff in NCQA, HEDIS, and all standard measures included in the managed Medicaid contract in order to ensure state and MCO staff are aligned in understanding, implementing, and interpreting these national measures.
4. Where there is underperformance in caring for the CHIP population in areas such as improving EPSDT scores, having the state recommend standard metrics they would like to see improve population health and outcomes would be welcomed.

Additional Recommendations

Association: Commend MHD for developing successful clinical and operational performance measures that Care Management Organizations can use in their service provision. We appreciate that MHD has adjusted measure selections and benchmarks for new entrants to the program and believe this approach should be preserved in the upcoming RFP. We also appreciate that the contract currently supports collaborating with health plans on the performance metrics, populations, and individual measure withhold percentages.

Question 4f: Holding providers responsible for improving quality of care and containing costs.

Describe any geographic areas or particular provider types in Missouri for which a provider incentive program might be easier or more difficult to implement or be more or less successful.

Responses to Question 4f: 13 (MCO-6, Provider-5, Association-2, Advocate-1, Vendor-1)

Overall Recommendations

1. The factors for a provider to succeed in a provider incentive program are a) provider type, b) size of the provider's membership panel, and c) provider's ability to assume coordination of care responsibilities and improve quality metrics rather than where they are geographically located.
2. Resources, technology, and infrastructure are critical success factors for provider incentive programs. Therefore, providers who do not have access to those resources, especially in smaller or rural communities may not achieve the same levels of performance as those who have such access.

Recommendations to Increase Efforts to Improve the System

***MCOs*:**

1. Geography becomes a factor if it impacts the ability to reach a credible panel size for measuring performance and outcomes.
2. It is much more challenging to implement effective provider incentive programs in the following scenarios:
    - There is an insufficient attributed member population to effectively measure outcomes; and
    - Clear clinical guidelines or national standards for quality outcomes have not yet been established.
3. The best way to design a system for rural communities, particularly those with single practitioners or lack of specialists, is to work directly with the providers, social service agencies and members to determine the care gaps and how to meet them. There is no one-size fits all.
4. MHD should ask MCOs to describe their experience implementing provider incentive programs across a broad range of provider types, including successes or barriers to implementation and associated mitigation strategies in the forthcoming RFP.
5. Incentive programs tend to be most effective and easily implemented with PCP practices. PCP practices generally have the ability to control the greatest number of preventive or chronic condition measures – and because members are "assigned" to PCPs, it creates the ability to foster an ongoing patient or provider relationship with clear and direct accountability for patient care.
6. Incentive programs for specialists are the most challenging to design and implement due to fewer standard national measures, difficulty in establishing member-to-specialist accountability (requires attribution), and challenges related to specialist shortages, particularly in non-urban areas. The optimal structure for incorporating specialists into an incentive payment model is through an integrated delivery system where the PCPs, specialists, hospitals and outpatient facilities are all part of a single entity where the need and desire to align incentives is inherent.
7. Certain subspecialties or certain ancillary providers may be more difficult to implement due to lack of standard guidelines or quality outcomes.
8. Provider Groups should be brought into the fold whereby a value-based payment model can be incorporated into arrangement where the entire continuum is engaged and where true accountability is aligned.

9. From our experience, systemic improvements result from the development of value-based approaches with providers that have the broadest impact on the population to be served (e.g., aligned incentives for primary care providers with an extensive volume of Medicaid beneficiaries will have more significant impact on program performance than models that are focused on targeted specialists).
10. CMOs should have extensive experience in developing value-based solutions for a broad set of traditional and non-traditional providers. This experience, as well as a plan specifically designed for Missouri, should be considered as part of the procurement process to ensure that the State is able to capitalize upon the ability of CMOs to support comprehensive system improvements.

***Vendors*:**

1. Obstetrical providers should be incentivized for the first prenatal exam to occur in the first trimester of pregnancy in rural as well as urban areas.
2. Provider incentives would typically be more difficult in urban communities where medical residents from academic hospitals provide the majority of care.
3. Provider incentive programs have the potential to be seamlessly implemented and successful regardless of provider type or a provider's geographic location, as long as incentives are tailored to account for variables such as the provider's position on the capabilities continuum for achieving quality measures, and health system affiliation.

***Providers*:**

1. Provider incentive programs are beneficial to patients, MHD, and providers in Missouri.
2. Establishing a broad provider network for mental health services will be a challenge in Missouri's rural areas.
3. Provider incentive programs will be most successful in those practices that have already demonstrated results with CMS pilots, and those that use an integrated model to serve a specific population.
4. It may be an easier to provide incentive programs starting with some of the national models where such programs are currently provided. Results are still fairly new and every year the models are adjusted to meet the concerns of providers. The ability for MHD to make similar adjustments should be considered for the duration of the contracts.
5. Shared risk may not be appropriate for all settings, even within the same provider organization. For example, the financial realities of our critical care access hospital that serves the Barry and Lawrence County areas are different than those faced by an inpatient facility in Greene County, and the solutions considered for patients in these counties should be tailored based on those realities.
6. Providing proper discharge planning with a patient returning to the extensive rural areas surrounding Springfield is a challenge now and will be a bigger challenge with CMO system.

***Associations*:**

1. Because the federal government has created cost-based reimbursement systems for many of the traditional providers in isolated rural areas (critical access hospitals, FQHCs, rural health clinics) establishing effective provider incentive programs may be more challenging there.
2. Ensure that providers have the minimum number of cases needed to provide statistical reliability and protection from the effect of outliers.
3. Coalition providers have implemented behavioral health homes and disease management initiatives and we do not anticipate there would be any barriers to implementation of care coordination or provider incentives.

Recommendations to Innovate

***MCO*:** The existence of national behavioral health measures is a helpful design feature for behavioral health Community Mental Health Centers (CMHCs), but the key challenge is that members are not assigned to CMHCs, making the patient or provider relationship and direct accountability more difficult to establish.

***Provider*:** It is harder to provide services in the more rural area due to lack of available services and transportation for the client to receive the services.

***Association*:** Transportation is always an issue for our population regardless of geographic location. Ensuring that services provided through telehealth are included in an incentive program will also help address geographic issues.

Additional Recommendations

MCO: Suggested provider incentive models:

1. **Pay-for-Performance** – Program designed for smaller PCP practices with less than 50 assigned members. Additional reimbursement for offering services such as after-hours care to increase member access.
2. **Pay-for-Quality** – Program designed for PCP practice with greater than 50 assigned members. Additional reimbursement is available for improving quality outcomes such as addressing gaps in care that impact HEDIS scores.
3. **Patient Centered Medical Home** - Program designed for PCP practice with greater than 100 assigned members. Payment of a monthly care coordination fee for providers who meet PCMH recognition based on criteria for person-centered, team-based, and coordinated care criteria.
4. **Shared Savings** – Model designed for integrated providers with greater than 5,000 assigned members. At the end of each performance period, providers who meet quality measures and whose risk is adjusted per members costs share in a portion of savings.
5. **Risk Sharing** – Model designed for large integrated providers with greater than 5,000 assigned lives to share in the upside/downside of the performance, based upon meeting quality measures and risk-adjusted per members costs to a benchmark.
6. **Full Risk** – Model designed for large integrated providers with greater than 5,00 assigned lives to accept a paid portion of the capitation and assume accountability for achieving quality and access targets to continue in the model.

Question 5: Incentivizing coordination of care through enhanced use of health information technology:

5a: What should care management organizations do to make a participant's health care providers aware as promptly as possible of a new hospital admission or ER visit?

Responses to 5a: 20

Overall Recommendations

MHD should require:

1. The proactive use of analytics and Health Information Technology (HIT), including Electronic Health Records (EHR), telemedicine, Health Information Exchange (HIE) via standard HL7 transaction, and mobile technology to increase efficiency and coordination of appropriate care, reduce cost, increase health care quality, improve outcomes and expand access to patients, especially those in rural areas.
2. CMOs to contract with all provider networks and hospitals to transmit patient data using a standard format and secured common delivery method. Such data includes records of hospital admissions, discharges, transfer data (ADT) and ER visits in real time to the patient's various providers. Providers must also have the technology to support seamless exchange with the HIEs, enterprise data warehouses, and individual provider EHRs.
3. CMOs to establish common workflows for providers around transitions of care. Once ADT notifications are received, they can then be easily integrated into clinical workflows that then promptly initiate actions between care management teams which can then be tracked and used for more effective population health management.

Recommendations to Increase Efforts for System Improvement

***MCOs*:**

1. CMOs should require timely admission and ER notification from hospitals through their contracts. CMO initiatives to improve hospital compliance could also include:
    - Tying hospital incentives to timely notification of ER visits and inpatient admissions to improve reporting compliance rate; and
    - Using CMO information and technology to support sharing health information data (such as pushing frequent notifications of patient activity to providers and supporting access to comprehensive information through provider online inquiry tools.)
2. CMOs should work with local HIEs and the provider community to interface directly with HIEs. This will allow receipt of ADT data feeds from hospital systems in near real-time to providers/ care managers to facilitate better discharge planning, appropriate and timely follow up care and implementation of readmission and care transition protocols.
3. CMOs could use an organization that operates like a HIE but is a "network-of-networks" (NON). This would build a common place where providers could share common patient data including member demographics, care plans, medications, diagnoses, and assessment information. The NON component is used as a pass-through whereby assessment and other patient data are packaged in a HL7/CCD-A format. Notifications for inpatient and ER visits are fed through the system.
4. System interoperability is a challenge to sharing data between organizations, primarily due to provider and small organization resource limitations. Therefore, MHD should provide incentives or other technological support for managed care organizations and providers to directly interface with each other to establish common ADT file formats and delivery channels.

5. MCOs need to be prepared to use different delivery mechanisms to share data including: HISP/Direct secure messaging, using HL7 and CCD-A architecture, Secured FTP site, Web services, and XML, XCA. MCOs with this capability will be able to send/receive ADT data to multiple systems, overcoming the interoperability barrier.
6. CMOs should work collaboratively with MHD and fully participate in all Missouri statewide Health Information Exchange (HIE) initiatives, especially those related to Admission, Discharge, and Transfer (ADT) data. CMOs need the flexibility to accept ADT data in the manner, frequency, and format prescribed by the HIE. They should then leverage their respective information technology capabilities to support MHD and deliver information directly to providers through multiple channels. While it is preferable to exchange this data via a standard HL7 transaction, CMOs should also be able to accommodate proprietary formats.
7. MHD should require that CMOs fully describe their capabilities for prompt provider notification of hospital admissions and ER visits as part of their RFP proposal. CMOs should be required to detail best practice initiatives, show results, and describe how they will leverage their experience and IT capabilities to assist and support MHD and providers with this requirement.
8. CMOs should be equipped with a scalable, interoperable, and secure Management Information System (MIS) to receive, store, analyze, and promulgate actionable intelligence through multiple provider channels (such as secure Provider Portals). Today, large hospital systems play active roles in supporting Missouri's Health Information Network, Missouri Health Connection (MHC). Hospital systems are able to securely send and receive health information, such as ADT and ER visits, to MHC on a daily basis. To ensure alignment, MHD should require CMO access to MHC.
9. The State should evaluate CMOs on their experience in providing feedback to providers on a variety of metrics including hospital admissions and ER visits and the plans to inform providers of vital information in the State of Missouri. This is particularly important for providers who have executed value-based contracts with CMOs.

Dental MCO:

1. The best way to reduce costly and inappropriate emergency dental visits is to maximize the delivery of comprehensive preventive care, outreach and education based on American Academy of Pediatric Dentistry (AAPD) guidelines, Dental Quality Alliance (DQA) quality of care indicators, and the CMS Oral Healthy Strategy and Healthy People 2020 objectives.
2. Assign members to a dental home to establish a patient/provider relationship that enables coordination of care with primary care physicians and dental specialists is a key strategy in preventing unnecessary ER utilization.
3. MHD or CMOs should share ICD-10 diagnosis codes related to dental utilization in the ER with the Dental MCO to trigger an alert to the member's dental home provider. The dental MCO could also use the information to collaborate with the member's health plan to facilitate dental care counseling, care coordination, and help avoid preventable ER visits.

***Providers*:**

1. Ask the hospital social worker to send an e-mail or call and leave a message for the provider.
2. CMOs should have access to the providers of services. It should be easy to pinpoint and communicate with the providers via a secure e-mail connection.
3. Use automatic notifications to providers through the EMR when patients are admitted or seen in the ER.
4. Notify PCP and assure follow up appointment is achieved within a designated time frame.
5. CMOs should utilize the Missouri Health Connection (MHC) HIE network developed through the American Recovery and Reinvestment Act (ARRA). Over 70% of Missouri health providers subscribe to

MHC, enabling hospitals, labs and other providers and organizations to share timely patient records. MHC's network has provided electronic health records exchange since January 2014, giving more than 7,000 physicians in hundreds of ambulatory facilities quick, secure access to patient health records during treatment. MHC's network covers more than 75% of inpatient care delivered in Missouri. It improves communication, efficiency, patient safety and quality of care by giving doctors immediate access to a patient's comprehensive health record. MHC has effectively worked with hundreds of stakeholders (hospitals, healthcare providers, experts in HIT, state officials and consumers) to develop a private non-profit organization whose mission is the inclusive participation of all providers, regardless of size or rurality.

6. MCOs have little or no ability to make a participant's provider aware of hospital admissions or ER visits in a timely manner. The MCOs rely on claims for this information and the timeliness and accuracy of claims data used to improve population health is limited at best. Even if MCOs indicate they will use pre-certification to be aware of these admissions, it will not fully capture all services. Integrated providers are much better suited to capture this information in a way that is timely and accurate, and use the information to develop and deploy interventions to reduce utilization when appropriate.

***Vendors*:**

1. Obstetrics physicians have a call group to notify the doctor when a patient comes to the hospital. HIPAA laws, designed to protect patient privacy, limit the use of an automated system to notify the HMO or ACO. Vendor team members should make daily rounds at local hospital ERS, hospital maternity wards, and clinics to insure receipt of daily information on the patient status. When patients are at the hospital or ER, this information should be added to the vendor's system on site using tablet computers equipped with specialized apps.
2. Use a proprietary system with automated Artificial Intelligence (AI) based Evidence Based Medicine (EBM), along with a patient record system and advanced telecommunications. This system identifies the most-appropriate care for individuals regardless of condition. This information is then communicated directly to patients by a staff of in-house physicians.

***Associations*:**

1. HIT systems are the most efficient means of sharing patient information across providers. HIT implementation is a tremendous challenge for Rural Health Clinics, given their small size and limited human and financial resources. MHD should support the use of innovative technology without punishing smaller organizations unable to make the investment. Grants or other supports for smaller providers should encourage the proliferation of HIT in low-access areas.
2. CMOs should be responsible for transmitting ADT information as soon as it is available. Behavioral Health Coalition providers are required to follow-up within 72 hours of being notified, conduct patient outreach, schedule follow-up appointments with their agency, and provide medication reconciliation. ADT information has helped CMHC providers drastically reduce readmissions, discourage inappropriate utilization, and ensure receipt of quality care.
3. In the near-term, MHD's CyberAccess program delivers the best patient status data to providers. As the emerging HIE system develops, MHD should ensure its vendor contracts allow insurers and providers to take advantage of its promising opportunities. CMOs should use HIT and analytics to reduce cost, assist with care coordination, improve patient outcomes, and to reduce duplicative procedures, ER re-visits and re-hospitalizations. CMOs should use HIE, predictive risk algorithms, and real time alerting to reduce expensive care in inappropriate settings. The Hospital Industry Data Institute has done significant work developing predictive modeling and analyzing the implications of "super-utilizers" on Medicaid costs, and would be pleased to explore collaborations with MHD and its contracted vendors to create a real-time data system to support care management.

4. All providers, including behavioral health providers, should receive immediate electronic notification of a patient's ADT, and all providers participating in care for the patient should be able to acknowledge and respond electronically, as part of the patient's treatment team.

***Advocate*:** CMOs should seek providers with a high commitment to technology and information sharing. Timely, accurate and meaningful information is necessary to provide cost effective quality care within a managed care system. Ideally, if the hospitals and providers within the CMO use the same EMR system, then the ER or hospital could immediately note the ER visit or hospital admission in the patient's medical record. Since this is not yet common practice, alternatives include faxing information to the PCP or assigning hospital care coordinators to be responsible for facilitating data sharing.

***Other*:** CMOs should share data, like inpatient census information, with providers in a timely manner. PCPs like those in FQHCs use this data to ensure timely follow up after patient discharge. The ability for MHD/CMOs to electronically share patients' assigned PCP/Practice information with hospital EDs would facilitate care coordination between care settings. Requiring that CMOs share claims-based administrative information with accountable PCPs/Practices would facilitate follow-up and reduce future ER encounters.

Recommendations to Innovate

MCO: Work with partners to support HIE solutions designed to facilitate data sharing across health care settings. Enable connectivity with existing provider EHR systems to access and aggregate patient data; combine CMO administrative claims data with clinical data (lab tests, lab results, diagnosis codes, and other encounter data) to identify care gaps; show care gaps to providers at the point of care through a provider portal or through a provider's EHR system; enable provider quality reports that aggregate cost and quality information and include care gaps for a provider's entire member panel, relative costs based on episode treatment groups (ETGs), and quality measures that include HEDIS; and offer providers a cost-effective EHR solution that is meaningful, compliant and enables connectivity to state-based HIEs. Offer technology that uses an extensive library of evidence-based guidelines enabling member-specific recommendations and care gap alerts at the point of care. Use solutions that are built to meet industry standards such as Health Level (HL7), Continuity of Care Documents (CCD) and Clinical Document Architecture (CDA). Integrate data from any hospital or provider EHR or HIE system and make that data immediately available through a MHD's HIE to better ensure that providers are timely aware of their patient's hospital admissions and ER visits.

Question 5b: Describe how states or health plans in other markets make a participant's health care providers aware as promptly as possible of a new hospital admission or ER visit.

Responses to 5b: 14

Overall Recommendations

MHD should make timely ADT and ED visit notification a requirement in contracts with CMOs and providers. State-sponsored activities to facilitate and increase provider data sharing could include:

1. HIE initiatives to enhance notification of ADT and ED visits (models already in place in Georgia, Kansas, Maryland, and Indiana) and HIE providers participation to facilitate prompt data exchange.
2. Using a centralized connection point like an HIE rather than establishing a multitude of connections to individual providers and health systems by a CMO (to enhance data quality, consistency, and interoperability as well as reduce administrative burden and increase efficiencies).
3. Requiring timely notification of hospital visits as a component of state-sponsored hospital quality improvement initiatives. When contracting with hospital providers, most CMOs include timely notification requirements for all admissions and emergency room visits.
4. Tying hospital incentives to timely notification of ER visits and inpatient admissions to improve reporting compliance rates; and using CMO information and technology capabilities to facilitate sharing of health information data (including frequent notifications of participant activity to providers and supporting access to information through provider online inquiry tools.)

Recommendations to Increase Efforts for System Improvement

MCOs:

1. One CMO in Florida is working with state agencies and a large national interoperability technology company to provide online, secure HIPAA compliant access to EHR information, using ONC standard HL7 transactions for prescriptions, lab orders, ancillary services, hospital and physician utilization information. The same organization's Washington CMO is working with state agencies and fellow CMOs to support an ED Information Exchange (EDIE). This program focuses on reducing inappropriate ER use and associated hospital costs, improving patient health status, and increasing capacity and integration of safety net services. The program targets patients who overuse the ER by developing individualized Plans of Care (POC) for the ER and coordinating care with PCPs. The POCs are posted in hospital-based software systems or in EDIE for use by ER physicians and are shared with PCPs and other providers. PCP's can also electronically send patient-specific clinical information that is incorporated into the POCs.
2. A Georgia CMO participates in the Georgia Health Information Network (GaHIN) to allow data sharing for hospital admissions, discharges, transfers and ER visits. This CMO also uses a contracted proprietary hospital census template to communicate member hospital utilization that will continue to be used until all hospitals participate in GaHIN. When the CMO receives notification of a patient's ER or inpatient activity, their Medical Management Platform (MMP) sends a secure email to the patient's PCP and automatically posts the information in their provider portal account. The automated, real-time notification is also sent to the care management team for follow-up. In addition, contracted providers (including ERs and hospitals) can use the CMO's secure provider portal to look up a member's PCP contact information to facilitate referral for follow-up.
3. States and health plans use a variety of mechanisms to provide information to providers. It is important to appreciate that there is not a one-size-fits-all approach to ensure that providers receive vital information. While certain providers may have access to robust IT systems that allow them to access systems that store information, other providers may not have the IT infrastructure or resources to

manage such technology. As such, health plans should be able to provide timely information in meaningful ways regardless of the sophistication of the provider. Furthermore, CMOs should have systems that support providers in managing their members including access to plans of care and direct access to care managers and other members of the care team.

***Provider*:** In a centralized information system a provider can log in as a health care provider for a patient and get an encrypted message that there is an update to their patient's care.

Associations:

1. In Minnesota's IHP program, a group of ten FQHCs reduced emergency department encounters by over 20% within two years using claims information provided by MN DHS. Despite the age of these encounters, they were still useful in following up with patients and coordinating post-visit care. In summary, daily notification of patient prior authorization for admission and discharge notification from the hospital inpatient and ER visit notification including discharge/visit summary and current telephone number of the patient should be encouraged and likely required. Ideally notification could be provided via e-mail with all attributed patients on one list because not all hospitals or primary care organizations are connected to the various Health Information Exchanges.
2. Web-Based Provider Portals with Patient Data: Allow providers to sort their patients by the number of recent hospitalizations and ED visits so they can consider utilization patterns (primarily ED versus primarily inpatient) and develop interventions to meet their needs.
3. A state health information exchange (HIE) delivers real-time data to programs on a daily basis. HIEs can include utilization data such as ED visits and inpatient admissions as well as clinical data such as discharge summaries, prescriptions filled, and laboratory and radiology results. By aggregating utilization data across hospitals, HIEs can create daily reports of current hospital inpatients classified as super-utilizers. Programs can use these daily reports to identify and engage potential clients during ED visits and hospitalizations, when they are most receptive to the intervention.
4. Decision Support Tools: Decision support tools can help care managers identify and prioritize high risk individuals. Some tools identify high risk individuals based on patterns such as frequent hospitalizations. Other tools can identify individuals with gaps in care, such as severe asthma without a controller medicine like inhaled corticosteroids.

Vendor: A West Tennessee contract with several health plans involved the vendor's nurses and social workers making daily rounds at hospitals and clinics, making phone calls, and sending emails and texts. All of this information was entered into a secure automated system that updated patient information instantly and was available for viewing in real time.

Question 6a: How should a case management organization work to improve the healthy lifestyle behaviors of its participants, such as improving smoking cessation rates and reducing the incidence of obesity? Are there other states or health plans in other markets that have a good model to improve healthy lifestyle behaviors? What have they done and what are their outcomes?

Responses to Question 6a: Total=29 (MCO- 7, Provider- 8, Association- 6, Advocate- 2, Vendor- 3, Researcher-3)

Overall Recommendations

1. Most of the responses encouraged the use of the following to improve the healthy lifestyle behaviors of the participants:
    - Member incentives
    - Pay-for-performance for providers
    - Care Management and Care Coordination Programs
    - Disease Management Programs
    - Wellness Programs
    - Partner with the community to host programs/health fairs
    - Partner with local providers to assist with behavior modification
    - Offer access to Nurse Advice Lines
    - Promote health literacy programs
2. MCOs should evaluate and score CMOs' innovative healthy lifestyle programs and demonstrated outcomes across other markets/programs in the RFP process.
3. Care management programs should provide more intensive case management for its members, and model their programs similarly to the health home model.

Recommendations to Increase Efforts to Improve the System

***MCOs*:**

1. We promote disease prevention by informing members about good health practices and encouraging their use of available health promotion, education and preventive services. Wellness and prevention program progress is regularly monitored and evaluated utilizing several methods.
2. CMOs should offer programs that target obesity, diabetes, high cholesterol, asthma, safety/injury prevention, and the appropriate use of the emergency room (ER). Customized programs should be developed according to the member's needs.
3. CMOs should support a culturally and linguistically sensitive care model for members that include the combined innovations of Health Plans, providers, and community resource agencies. Approaches include establishing Wellness Programs and assessing a member's individualized barriers to determine the best method to empower him/her to make healthy lifestyle choices.
4. CMOs should offer nurse advice lines and disease and care management programs, and provide member and provider incentive programs. CMOs should leverage technology to communicate, both with members and each other.
5. CMOs should educate themselves on the different services each entity can support and leverage these services to encompass the entirety of the individual members' needs. Also, CMOs should partner with providers and with community organizations/agencies to provide wraparound support. Additionally, CMOs should create collaborative partnerships with existing provider delivery mechanisms to coordinate member care and avoid duplication of services.

6. MCOs should increase outreach to members needing dental care. From partnering with community agencies and faith based organizations for health fairs, to using social media and text messaging to reach members lost to care. Assigning members to a dental home to establish a patient/provider relationship that enables coordination of care with primary care physicians and dental specialists is key to preventing unnecessary ER utilization.
7. CMOs should utilize a multi-faceted approach that includes the following activities:
    - Implementing rewards programs that incent participants to pursue healthy behaviors;
    - Connecting members to local community-based resources focused on helping people achieve healthy lifestyles;
    - Partnering with providers to guide/encourage participants' improvement of healthy behaviors;
    - Designing and deploying enhanced benefits that make healthy behavior related services available to members above and beyond the basic Medicaid covered services;
    - Developing educational and outreach initiatives to promote the importance of health behaviors;
    - Implementing rewards program that rewards members who complete specific preventive health, wellness activities, healthy behaviors and engagement milestones;
    - Connecting members to Local Community-Based Resources;
    - Collaborating with providers through provider orientations, handbooks, and portals; and
    - Conducting educational outreach activities with members, providing timely information to bring awareness of available Plan benefits and resources and drive healthy lifestyle behaviors.

***Vendor*:** Get patients involved, use a patient-centered conversational style approach, and capitalize on teachable moments. Utilize behavior modification components with teaching and education.

***Providers*:**

1. Provide seminars for clients to attend to learn about the benefits of not smoking and living a healthy lifestyle.
2. CMOs must manage population health by improving care delivery before a healthcare crisis occurs. Working with other providers and MCOs to develop community health programs would vastly improve the health status of the communities served.
3. Provide accountability through care coordination and relationship development. Monetary incentives for those who are successful in stopping smoking or reducing obesity would be helpful.
4. Provide coverage for tobacco cessation treatment, incentivize healthy behaviors, and provide nutritional programs.
5. Use a multidisciplinary team approach and more intensive case management. The focus is to teach self-management and familiarize the members with resources available to them.

***Advocate*:**

1. The state should provide more intensive case management and access to necessary social services as is the case in the health home program, which focuses on healthy lifestyles among its program goals, and has achieved success in reducing ER visits, improving adherence to medications, and improving health outcomes.
2. Making routine and preventive medical care easily accessible through physically and geographically accessible providers in robust networks is another clear way to reduce unnecessary hospital stays.

3. Carefully designed care coordination systems that include hospitals in their networks can reduce unnecessary hospital stays by addressing problem situations before they become emergencies.

***Association*:**

1. Interventions to improve patients' lifestyle behaviors should be localized and population-specific. MHD should support non-traditional methods for providers to develop a rapport with patients in order to more effectively influence their lifestyle behaviors.
2. Consider additional reimbursement for innovative practices and services that encourage healthier patient behaviors. MHD should structure RHC reimbursement outside the current per-visit rate. If payments are folded into the existing limit, RHCs will not be adequately reimbursed for the services.
3. Utilize a "whole-person" approach with evidence-based models to change member behaviors. Our providers have found it helpful when Medicaid has paid for some administrative procedures such as outreach, health education, or care coordination. Some states encourage providers to offer and promote wellness services through additional payments for health risk assessments and preventive services. Medicaid providers should be rewarded by using pay-for-performance incentives.
4. Responsibility for education and outreach lies with the both the Contractor and the State. Make sure Contractors work with existing Missouri oral health programs and the variety of other state-run programs, such as Women's Infants and Children (WIC) on establishment of a dental educational component. Care/case management personnel should be well versed in dental and medical outreach. MHD could consider mechanisms to track missed/late/cancelled appointments in order to conduct targeted outreach to members with repeated occurrences. The State or Contractor should monitor network use and assist members in finding providers that accept new patients.
5. The population-based health improvement models adopted by the CDC and other broad public health initiatives are based on a socio-ecological model that includes policy, community/organizational, family unit and patient components. Any number of interventions are available: community health workers, employee incentives, community educational session, etc. However, experimentation and rigorous evaluation should be used as the standard. The data from these evaluations should be readily accessible to allow the rapid dissemination of best practices.

***Researcher*:** Require MCO's to submit provider numbers and cost variables for better data analysis.

Recommendations to Innovate

***MCOs*:**

1. Consider a CMO's ability to develop innovative programs as well as its understanding of Missouri residents, the behaviors impacting health in the State, and how these proposed programs align with MHD's goals.
2. MHD should draft the RFP in a manner that encourages selected CMOs to work to improve the healthy lifestyle behaviors of members by:
    - Engaging members/families in members taking responsibility for their health care and healthy lifestyle decisions through incentive programs;
    - Educating members to make healthy lifestyle choices on nutrition and substance use, and to manage their chronic conditions through routine preventive care and medication adherence monitoring and education;
    - Educating providers on how to engage members in their health care decisions;
    - Partnering with community organizations and advocates who understand and share a healthy lifestyle vision to act as an extension of the Health Plan promoting healthy member behaviors;

- Using innovative care management, outreach, and education programs that empower members and their families to choose and maintain a healthy lifestyle; and
- Providing health and wellness resources and tools to members.

3. MHD should ask CMOs to propose and describe their innovative healthy lifestyle programs/incentives in their other markets/programs as a scored component of the RFP, including how they track/report activities, progress and outcomes.
4. Minimize unnecessary regulatory barriers to the development of consumer incentives and look to partner with CMOs that have innovative approaches and effectively use tools to engage with consumers to improve their own health. The State should evaluate CMOs' ability to create innovative engagement strategies to address issues that are pertinent to the population being served as well as any unique geographic variances that would influence quality and outcomes.

***Vendors*:**

1. Contract with CMT to utilize Missouri's Health Homes' tool to identify clinical indicators and care gaps, assign risk stratification levels, and improve care by analyzing data on population health.
2. Contract with MedExpert for population health services.

***Providers*:**

1. MCOs are not well suited for this type of behavior modification. MHD should partner with local providers on innovative ways to address this. It will require new delivery models and significant investment on MHD's part, along with patience, as a return on this investment will take years.
2. Develop relationships with the member and provider. Possible solutions include more community gardens, fruit and vegetable vouchers, cooking classes to educate on extending the food dollar, nicotine replacement provided, and access to more organized exercise.

***Advocate*:** Be careful with using incentives for healthy behaviors. The literature is not supportive. Idaho's incentive program (financial assistance with CHIP premiums) improved the proportion of children who were up-to-date in well-child visits. Missouri legislative initiatives proposed direct cash payments to individuals who choose lower-cost health plans or engage in healthy behaviors.

***Association*:**

1. Improve member responsibility by rewarding BH providers, like psychologists, for targeting patient habits that undermine physical and behavioral health. One difficulty is the problem of a physician and a psychologist billing for the "same" service on a given day. Each profession targets a different aspect of the problem, but must often use the same code when billing.
2. Enlist professional organizations to help design programs to encourage patients to change destructive behaviors. MCOs should use licensed professionals instead of poorly-trained paraprofessionals, or use them under direct supervision of a licensed behavioral health specialist.

Additional Recommendations

***Provider*:** All denials and appeals should be mainstreamed. The MCOs should be required to include provisionally licensed professional staff. Carved-out for Managed Care should be disallowed.

***Association*:** The lack of definition of an appropriately credentialed rendering provider could prevent provisionally licensed professional counselors from qualifying.

Advocate: Attend to the needs of people with disabilities, using incentives to promote healthy lifestyles, with MHD policies in place to provide modifications to any incentive program that allow all members can take advantage. In the event MHD considers including people with disabilities into a MCO system, create policies ensuring that CMOs don't discourage necessary hospital stays for people with disabilities.

Question 6b: How should a care management organization reduce inappropriate emergency room utilization for nonemergency conditions? Are there other states or health plans in other markets that have a good model to reduce inappropriate emergency room utilization? What have they done and what are their outcomes?

Responses to Question 6b: Total =21 (MCO- 6, Provider- 7, Association- 5, Advocate- 2, Vendor- 1)

Overall Recommendations

In general, Respondents focused on:

1. Patient education and behavior modification regarding ED use (including incentives and disincentives like co-pays) and alternative settings of care for non-emergent issues;
2. Increased patient responsibility for utilization patterns;
3. Enhanced care coordination/care management including transportation to get to primary care;
4. Real time information regarding ED use, high utilizer populations, etc. by CMO and providers made available to CMO by the ER, and ER admissions notification to providers;
5. Enhanced access to primary care and 24 hour nursing line at the CMO;
6. Empanelment to a PCP;
7. Shared information with providers for population health management—particularly for high utilizers;
8. Provider incentives for population management;
9. Inclusion and enforcement of contractual standards for CMOs; and
10. Payment options such as tiered payment, depending on the level of service provided in the ED.

Recommendations to Increase Efforts to Improve the System

***MCOs*:** MCO recommendations

1. We have developed a comprehensive approach for evaluating and monitoring ED over/under and inappropriate utilization including:
    - Reviewing claims and other relevant data to monitor utilization patterns;
    - Providing providers and members information about the appropriate use of the ED;
    - Referring to case management;
    - Evaluating and monitoring members in intensive case management;
    - Ensuring BH crisis intervention services are provided in the most appropriate setting;
    - Ensuring members understand the importance of routine dental care to prevent dental emergencies;
    - Monitoring the accessibility of PCPs whose members have a high ED utilization trend;
    - Monitoring providers who may be driving inappropriate use of ED services; and
    - Observing members who are frequent utilizers of ED services for non-emergent conditions and situations and informing PCPs about their patients' utilization of the ED.
2. Inappropriate ED utilization for nonemergency conditions can be reduced through consistent quality management metric reviews, engagement and support of members who are inappropriate or frequent utilizers of ER services, collaboration with community partners, and development of provider incentives.

3. Identification of frequent ER utilizers and outreach to help them find open-access.
4. Increasing the number of PCPs in the community who are available after normal business hours and increasing the number of health homes.
5. Increase the use of telehealth services.
6. In addition to improved access to care, shifting non-urgent ER visits to CHCs may also reduce the uncompensated care costs hospitals incur from caring for the uninsured.
7. Educate members on the availability of local urgent care centers.

***Vendor*:** Information technology can play a key role such as tracking frequent ED patients, contacting the primary care provider while the patient is in the ED and disseminating educational materials about appropriate settings for health care.

***Providers*:**

1. Encourage well visits and educate members on how to access services without ED use.
2. Intense care management and open access to medical providers and their PCMH are imperative.
3. Transportation and assistance in establishing with a PCP is required.

***Advocates*:**

1. MHD should adopt "health home" strategies.
2. MHD could reduce ER use by doing a better job of holding the MCOs accountable to provide the health care and case management services they are legally bound to provide.
3. MHD should avoid implementing additional co-pays or other negative incentives for members that utilize the ED inappropriately.
4. Carefully designed care coordination systems that include hospitals in their networks and making routine and preventative medical care easily accessible in robust networks.

***Associations*:**

1. Offer after-hour clinics, however, the provider reimbursement are insufficient to justify their existence in many instances. MHD will have to consider how to structure reimbursement to make after-hours operations financially sustainable for us given their cost-based structure.
2. There are several approaches including:
    - Expanded after-hours primary and urgent care options;
    - Care coordination and data sharing through health homes;
    - Identification and targeting of high-utilization members;
    - health navigator programs;
    - Supporting post-discharge care transitions into the community; and
    - Implementing a streamlined and integrated care model; and
    - Face-to-face interactions with members and hospital staff in order to facilitate follow-up appointments and linkage to community services.
3. Sharing inpatient and ED claims based information with PCPs.
4. MO HealthNet should establish and enforce contractual standards pursuant to section 208.950, RSMo, related to HMO's need to work with their enrollees to prevent avoidable ED encounters and to incur financial penalties for not doing so.

Recommendations to Innovate

***MCOs*:**

1. MHD should include in its RFP a scoring element around CMO's abilities and demonstrated experience with strategies to reduce unnecessary ED use, as well as specific plans for deploying and adapting these to address Missouri members and the Missouri provider landscape. Strategies may include disease management, ER alternatives, provider incentives, outreach and education, pharmacy interventions, case management, and use of Health Homes.
2. MHD should request CMOs to describe their community strategy, including potential creative solutions and programs that might be implemented to meet the unique needs of each community. CMOs should maintain a comprehensive data system.
3. Inappropriate ER utilization is associated with greater fragmentation and discontinuity of care with members' PCPs and other care providers. Recommend implementation of innovative programs and value-added services that are designed to educate members and promote better health management. Members can also be supported in accessing the appropriate level of care through education on the available alternatives to the ER, including the 24/7 Nurse Line.
4. Strategies to address inappropriate ED use include member and provider engagement and evaluation of access. Establish a tiered payment methodology in which non-emergent use of ERs would be paid below true emergency visits. This establishes a meaningful incentive for hospitals to assist in reducing unnecessary use of ERs.
5. Create a payment structure that supports reimbursement based on level of care provided.
6. Reducing inappropriate ER use starts with member education and strong primary care that is supplemented with innovative technology and a robust ER diversion program for members identified as frequent or at-risk ER users. Recommendations include:
    - Require ER care providers to deliver timely ER utilization data to CMOs on members' ER use;
    - Create ER diversion programs for high users and at-risk members;
    - Foster PCP engagement;
    - Employ predictive modeling;
    - Offer messages to case managers and providers when a member is accessing an emergency department;
    - Information Sharing with national, regional, and state exchanges; and
    - Incentivizing hospitals to direct members to the appropriate care settings.
7. Examples of strategies to reduce inappropriate ED utilization for nonemergency conditions include:
    - Supporting the PCP serving as a patient's medical home;
    - Offering intensive case management for patients with multiple ER visits.
    - Providing a telephone number for access to a member Engagement Unit and referral to the care coordination program;
    - Collecting and documenting correct demographic information from members and emphasizing the availability of the care coordinator to assist member with needs;
    - Collaborating with providers to identify members in need of social support;
    - Offering a toll free 24-hour nurse line to answer member concerns;

- Reminding members about the availability of weekend and evening clinics, urgent care centers and covering providers when the patient's doctor is not available; and
- Compiling a listing of urgent care centers available in each of our Medicaid markets and providing that listing to case managers when speaking to members and providers to ensure alternative care settings are known in non-emergency cases.

8. MHD should consider implementing policies such as: Prudent layperson review process to review claims and determine emergency situations; and Tiered emergency department reimbursement structures based on a contracted set of diagnosis codes that are adopted universally by each stakeholder to control costs associated with inappropriate ER utilization after it has occurred.

***Vendor*:** Care coordination services that are available 24 /7 have been shown to help reduce inappropriate emergency room usage.

***Providers*:**

1. Recommend the adoption of the Community Health Access Program (CHAPS) model by providers as well as inclusion by payers in the coding and billing of services.
2. Develop regional stand-alone outpatient psychiatric emergency services in a community-based setting creates processes that can quickly address and treat patients so they are able to return to normal activities and avoid the ED.
3. Interventions include:
    - Implement ER co-pay;
    - Inform members of urgent care centers;
    - Push for members to have a primary care provider;
    - Identify frequent users--have case managers contact them to discuss alternate care settings;
    - Increase patient responsibility for inappropriate ER utilization; and
    - Compensate at the end of calendar year when no inappropriate ER utilization is achieved.
4. MHD should work directly with providers to design new and innovative models that allow them to provide a minimum of care for non-emergent conditions in the ED, which are reimbursed and supported by MHD.
5. Offer 24 hour urgent care—deflect non-emergent ER cases after a pre-screening. Make urgent care clinics easier to access and work to inform the public regarding their services.

***Advocates*:**

1. Safety Net Health Plans, along with the providers and hospitals in their provider networks, are implementing initiatives to address avoidable ED use including:
    - Expanded after-hours primary and urgent care options;
    - Care coordination and data sharing through health homes;
    - Identification and targeting of high-utilization members;
    - Health navigator programs;
    - Supporting post-discharge care transitions into the community; and
    - Implementing a streamlined and integrated care model.
2. Recommend against patient co-pays or other patient financial/disincentive requirements.

***Associations*:**

1. Spread the St. Louis IHN model and Community Referral Coordinators.
2. MHD should implement strategies and regulations that lead to payment reform which 'tiers' hospital ED Medicaid fee schedules at reasonable and appropriate levels of non-emergent and emergent service; and that serve to encourage non-emergent patients to seek their primary care services in patient-centered medical home environments, and properly incentivize and remunerate PCPs and organizations for the services they provide to Medicaid patients covered through the traditional and MCO delivery systems.
3. CMO can provide education, financial incentives, or a combination of these and other factors. MHD can replicate the Emergency Room Enhancement Program at DMH. Also, vendor contracts which encourage outpatient behavioral health providers to maintain open appointment slots for urgent care patients could be considered.
4. Develop dental ER referral programs.
5. Rural Health Clinics could be able to partner with provider networks to offer after-hours care. MHD will have to consider how to structure reimbursement to make after-hours operations financially sustainable for RHCs given their cost-based structure.

Additional Recommendations

Association: CMOs should develop programs between hospitals and providers to organize ER referrals like the initiative implemented by Milwaukee that connected Medicaid and uninsured patients with non-emergency needs to primary care medical homes. There has been a 44 percent decrease in subsequent ER use for those patients who kept their appointments.

MCO: Delaware created a field-based care management program for high utilizer members who frequently used the EDs and showed a 17% decrease in ED utilization. Kentucky focused on quality management outreach efforts, pilot programs with hospitals, customer service provided by the nurse line, hiring of a case manager solely responsive for ED utilization, increased in-network PCPs by 75%, and expanded the case management program to decreased ED utilization rates.

Advocate: Colorado has reduced ER visits by using a primary care case management approach, while North Carolina achieved statistically significant reductions in ER use for asthma through its medical home approach.

Question 6c. How should a care management organization address the social and economic determinants of health that prevent participants from being accountable for responsible utilization of services such as homelessness/unstable housing, lack of education, lack of means of transportation, lack of social support network, etc.?

Responses to Question 6c: Total= 21 (MCO- 6, Provider- 7, Association- 5, Advocate- 2, Vendor- 1)

Overall Recommendations

1. Several responses pertained to the use of the following to address the social and economic determinants of health:
    - Integrated care model and Care Management/Coordination services;
    - Partner with community partnerships;
    - Utilize a bio-psychosocial model to provide assistance with access to services;
    - Utilize safety-net providers to provide the services; and
    - Provide educational programs.
2. MHD should consider adopting "health home" measures.
3. The RFP responses should include the consideration of a voluntary contribution specifically set aside to address gaps in funding for supportive housing in designated urban and rural regions of the state and funding for supportive employment.
4. The state should require CMOs to demonstrate their ability to comprehensively identify needs and their experience in addressing needs directly and through collaboration with community in the RFP.

Recommendations to Increase Efforts to Improve the System

***MCOs*:**

1. The integrated care management model provides the best opportunity to support individuals with complex illnesses and comorbid conditions who require care across multiple clinical and social domains, who are less likely to be responsive to standard care, and are more likely to benefit from an individualized approach to meeting their unique healthcare needs. At the individual member level, the MCO needs to identify its highest-risk and most vulnerable members. At the systemic level, the MCO must drive delivery system transformation by aligning value-based payment reform with initiatives to create integrated systems of care for State-identified high-priority populations. An integrated care system includes a spectrum of community-based physical and behavioral health (BH) care and psychosocial services and supports for individuals, their families and support circles that
    - Is organized into a coordinated network-within-a-network functioning as a "virtual team";
    - Drives collaboration across agencies and Community-Based Organizations;
    - Builds meaningful partnerships with individuals [and their families]; and
    - Effectively responds to the various social and economic determinants of health.
2. CMOs must continuously identify, assess, and reduce gaps in health care, including social and economic determinants, with programs targeting preventive services, health and wellness, access to qualified providers, and specific efforts focused on chronic conditions that disproportionately impact certain populations. CMOs and their providers must also work together to be culturally and linguistically responsive so that diverse populations get the health care services they need and to improve health equity across the health care system. MHD should require CMOs to propose programs and strategies for

how they will address these barriers to care. CMOs can address the social and economic health determinants that prevent participants from utilization of services by:

- Identifying barriers to care as early as possible through biopsychosocial assessment and holistic, person-centered care planning processes;
- Implementing programs for cross-cultural communication between a patient and his or her provider, such as partnering with physician groups to increase awareness of health care disparities and how to mitigate them;
- Providing cultural competency training for health plan staff that increases awareness of the impact cultural differences have on member satisfaction, access to care, receipt of health care services, and health outcomes;
- Establishing partnerships with public stakeholders, working collaboratively, and participating in local and statewide coalitions to increase access to care and improve the health of diverse communities; and
- Working collaboratively with state partners and stakeholders to help identify and address social and economic barriers to appropriate care.

3. CMOs should help member remove barriers to care. The Care Management team should engage with the community through participation at a variety of community sites. MHD should implement an intensive case management program. The CMs should utilize motivational interviewing. CMO's should develop a reference resource that provides local, State, and Federal resources for members.
4. Hiring staff from within the communities served. Initial and ongoing staff education and health literacy training through organizational, national, and local agencies will assist those who work directly with members to holistically approach the individual member. CMOs should offer all forms of communication, such as written communication by mail and through phone calls and messages as well as electronically through websites, member portals, and phone apps.
5. The network that provides the services (the Social Safety Net) remains tangential to the managed Medicaid delivery model. We recommend action that further integrates social service into the care planning for all managed care populations, with a long-term goal to increase transparency of the positive impact created by addressing social barriers to accessing health care.

***Vendor*:** Utilize a bio-psychosocial model to assist members by providing assistance to access social service, governmental, and other groups that can assist with solving their issues.

***Providers*:**

1. Provide oversight to the CMOs to ensure case management is being done correctly.
2. Include educational providers and other providers to be a part of the "treatment team" to assure that all persons serving a client is aware of unmet needs and when needs have been addressed.
3. Community integration is necessary for the improvement of social determinants.
4. Provide social programs to educate/offer opportunities to rise above.

***Associations*:**

1. Utilize local providers to assist with determining needs. MHD should offer more innovative services through Rural Health Clinics to address patients' social needs. MHD should remain mindful of the importance of reimbursing RHCs beyond their current per-visit rate for any additional services.
2. Safety-net providers are oriented towards understanding and better serving safety-net consumers. CMHC providers have strong relationships with a wide range of community agencies across multiple sectors and

can operate an ACO with a safety-net population focus. Maximizing these relationships can address social health determinants and reduce inappropriate health care utilization.

Recommendations to Innovate

***MCOs*:**

1. Require CMOs to demonstrate their ability to comprehensively identify needs and their experience in addressing needs directly and through collaboration with community-based organizations.

2. Evaluate CMOs' experience in developing innovative approaches to address issues such as housing and homelessness, addressing food shortages as well as access to healthy food choices, and experience in supporting training and employment initiatives.

3. MHD should establish realistic expectations for developing comprehensive solutions based on current Medicaid payment limitations. Should the State set expectations beyond reasonable identification and management of social determinants, supplemental payment should be established to support the actual cost and administration of the requirements, including the ability to capture expenditures through an encounter or additional reporting process.

***Providers*:**

1. We believe this is beyond the scope of MCOs. The use of local behavioral health (BH) providers, social workers, and community organizations is recommended. Those providers can utilize models of change to determine what interventions, if any, will resonate most with a local community, and can advise if MHD should invest its resources elsewhere if there is no propensity to change. We encourage MHD to build on programs already in development by CMS and other payers.
2. Provide affordable housing with supportive services for populations with chronic health care conditions. For example, a supported housing project in Washington State is nationally recognized for its documented success in improving health outcomes and reducing Medicaid costs by serving the chronically homeless with a high rate of alcoholism and high use of crisis services. Data published in the Journal of the American Medical Association revealed that 95 tenants had $8,175,922 in medical costs prior to enrollment in the supportive housing project. In the year after enrollment, medical costs for these same individuals decreased 53% to $4,094,291. In Chicago, a housing partnership, found that supportive housing saved Medicaid over $22,000 per person/per year; a Medicaid cost analysis in rural Maine found a 46% reduction in health care costs for those in supportive housing. While the state Health Home effort promotes linkages to housing and supported employment, there is a lack of structural supports that discourages providers to tackle true supportive housing that could yield the substantive savings described above. We propose that the evaluation of the responses to the RFP include the consideration of a voluntary contribution set aside to address gaps in funding for supported housing. Arkansas provides state-only funding through a general improvement fund program administered by the Division of Behavioral Health, earmarked on a regional basis to address gaps in funding for supportive employment. While not Medicaid matched, this funding source provides necessary reimbursement to address the funding limitations associated with supported employment.
3. Unless the State of Missouri elects to pursue a 1915(i) waiver for supported employment, the evaluation of responses to the RFP should include a voluntary contribution to a fund specifically set aside to address gaps in funding for supported employment or another identified pool of funds. Preference for funding programs could be determined through a RFP process that evaluates both proposed scope of service and the experience of a provider in supported employment.

***Advocate*:** CMOs can begin to address these issues through meaningful case management services. Access to medical-legal partnerships in particular is a proven way to address the social and economic determinants of

health by helping to remove legal barriers to housing, public benefits, appropriate educational services, and to combat domestic violence. MHD could also adapt measures employed in the "health home" program which includes a multi-faceted team-based approach (including community health nurses), and includes referral to needed community services as one of its core functions.

***Associations*:**

1. Require MCO's to credential and reimburse Provisionally Licensed LPCs.
2. There should be risk-adjustment to reflect different levels of resources needed to produce outcomes in populations whose socio-economic status allows fewer options or capacities. CMOs should be given the flexibility to address health concerns in ways not involving a medical intervention, such as air conditioning for asthmatic patients. CMOs should be engaged with local social welfare or government organizations to leverage available resources.

Additional Recommendations

***Provider*:** Endorse the recommendations of the NQF Report on Risk Adjustment for Sociodemographic Status or other Sociodemographic Factors. The state should consider risk adjustment as it improves its quality measures by controlling for differences in outcomes attributable to factors not under the control of the providers in order to illuminate those that are. Risk adjustments can also be made to reflect different levels of resources needed to produce outcomes in the lower socio-economic populations.

***Association*:** CMOs should incentivize primary care providers, such as FQHCs, to collect Social Determinants of Health (SDH) data and proactively use such data to address social behavior and environmental influences on one's health. Such efforts will require PCPs to build or integrate new forms into their EHR and workflow, and then take the time to collect and document the additional data elements. At minimum CMOs should pilot SDH initiatives with FQHCs and then study the impact of such efforts. Evidenced-based interventions and models that take social determinants into consideration and improve health outcomes and reduce health care costs should then be replicated and supported by CMOs in coordination with local partnerships.

***Advocate*:** It is not profitable for CMOs to address the mentioned barriers. MHD should be responsible for outreach and education on these systemic problems. Oklahoma, for example, in setting up its SoonerCare Choice Primary Care Case Management Program, hired 32 nurses and two social service coordinators to provide additional care coordination services to Medicaid recipients. We would suggest robust support resources available through a wide variety of entities and organizations, including but not limited to CMOs. The most efficient way to achieve better health literacy rates and create better health care consumers is to expand access to Medicaid to cover all people with incomes up to 138% of FPL. Care management organizations can perhaps incrementally increase health literacy through programming and strong provider networks, but cannot reach people who are not Medicaid eligible.

Question 6: Driving participant responsibility by creating incentives for healthy behavior

d. Describe any geographic areas or particular populations in MO for which program accountability might be easier or more difficult to implement, or may be more or less successful.

Responses to Question 6d: 14

Overall Recommendations

MHD should require that:

1. CMOs should be accountable for developing and implementing targeted strategies aimed at reaching all members to ensure they touch diverse populations.
2. CMOs have culturally competent initiatives in place to assure that all individuals receive equitable and effective care.
3. CMOs should be required to use new technologies such as telehealth, videoconferencing, mobile apps and in-home biometric monitoring with MHD providing compensation for these services.
4. CMOs demonstrate they have provider networks, local community partnerships, and specific programs in place that address the distinct geographical make-up of the population (and areas) served, as well as the unique cultures and ethnicity represented in Missouri communities, including but not limited to African American, Latino/Hispanic, and refugee populations.

Recommendations to Increase Efforts to Improve the System

MCOs:

1. MHD and CMOs should work together to enable and empower access to care when and where it is needed. This necessitates that CMOs build a diversified provider network including nurse practitioners, Physician Extenders, expand the availability of mid-level behavioral health providers, and hire bilingual staff.
2. CMOs should be required to create programs that address chronic care and disease management, and support healthy lifestyles, as well as to provide incentives to members and providers for achieving health care goals and improved outcomes.
3. MHD should allow for the payment of non-participating providers below the established Medicaid fee schedule in order to minimize unnecessary barriers to implementing solutions in Missouri geographies that would be new to managed care.

Advocate: MHD should closely monitor Health Plans and provider Networks in all regions or the state to ensure that member receive the healthcare services and case management needed to maintain and improve their health outcomes. MHD's monitoring should especially focus on homeless individuals, those with mental illness, chronic medical conditions and disabilities, children with special needs, and on underserved areas of the state,.

Recommendations to Innovate

MCOs:

1. Provide behavioral health outreach teams in rural areas during times of crisis and non-crisis.
2. Offer flexible payment structures whereby CMOs work with facility and community providers and advocates to identify gaps in provider capacity and to develop innovative models to meet the needs of members within the community.

***Provider*:** Use defined populations in smaller regions than those proposed to improve opportunities for innovative strategies that will have a greater impact if deployed across small, more discrete populations for whom results can be measured and tied to specific interventions.

***Advocate*:** Maintain a fee-for-service option in rural areas as a way to increase competition and improve accountability.

Additional Recommendations

***MCO*:** MHD require CMOs to provide specific strategies in their RFP responses they will use to support and inform new Managed Care beneficiaries so these new members can easily and readily access the care and services available.

Question 6e: Describe successful programs in other states which increased participants' level of health literacy or improved the participants' ability to be better health care consumers.
Responses to Question 6e: 12

Program Examples/Strategies

***MCOs*:**

1. "Stay Connected Cell Phone" for members in care management with high risk pregnancies.
2. 3-way calls with member and provider to set appointments to aid in appointment compliance.
3. Language line for language barriers and video relay for callers who are hearing impaired or deaf.
4. Interactive websites (access materials, video games, watch videos, etc.).
5. Health cost estimators to help consumers better understand the difference in costs of care if they choose care delivered in certain more efficient settings.
6. Targeted member outreach materials encouraging health lifestyles.
7. Education for hard to reach members through health fairs, church events, religious gatherings and partnering with FQHCs on health related programs.
8. Community health worker/promotora—use of culturally aligned community health workers to ensure that members receive health education and condition specific training.
9. Transportation to WIC appointments, breastfeeding classes, behavioral health inpatient, residential facility for parents to take part in family therapy, hospitals for parents visiting a child, methadone clinic, and pharmacies immediately after a medical appointment.
10. WellCare "Member Reengagement Program" to regain contact with transient members.
11. Provide education for hard to reach members through health fairs, church events, religious gatherings and partnering with FQHCs on health related programs.

Provider: Use plain language in verbal conversations with managed care participants and written materials provided to participants. The use of plain language has been proven to help those with serious mental illness to more easily follow treatment recommendations.

Advocate: Community Dental Health Coordinator Program (local oral health experts to educate community on oral health and link patients with dentists).

***Vendor*:** Adherence analytics related to critical health medications.

***Other*:** MCO health literacy training. Examples include: "Health Literacy MOC", clinic simulation training workshop, and health literacy focused quality improvement plans/cycles.

Overall Recommendations

MHD should require:

1. CMOs to develop specific programs for members with chronic health issues/disease management needs or mental health conditions. Such programs can have a strong focus on improving health literacy while promoting self-management, creating self-determination, and shared decision-making between the member and his or her health care provider.
2. CMOs provide social and case management programs that support the primary care physician, such as Missouri's own "Health Homes" and "Community Care of North Carolina".

Recommendations to Increase Efforts to Improve the System

MCOs:

1. To ensure the dissemination of engaging culturally competent and accurate health information, CMOs should leverage existing resources provided by other experts through enlisting a culturally diverse provider population throughout member communities to further encourage member participation; using brochures or web-based information offered by federal or nationally recognized entities; using online/medical libraries and creating grade-level, language and format appropriate member materials.
2. CMOs should utilize company-wide efforts designed to improve health literacy including staff and provider training.
3. CMOs should customize their approaches to address community priorities and health concerns. CMOs must work with state and local resources to communicate and engage members in a culturally and linguistically responsive way.
4. CMOs should empower members through technology thus allowing members to seek and receive information when they need it. Therefore, CMOs should take full advantage of mobile applications for cell phones offering members comprehensive mobile tools.
5. CMOs should use multi-faceted strategies that range from general education programs that seek to build health literacy and empower all members to take responsibility for their health status to high-touch, personalized outreach strategies tailored to the needs of individual members.

Provider: CMOs should use educational materials both printed and electronic, classes and face-to-face sessions and the biopsychosocial model to teach members health literacy.

Advocate: CMOs should provide more hands-on and intensive case management.

***Associations*:**

1. MHD and CMOs should enlist professional organizations (i.e. psychologists) to help design programs that encourage patients to change destructive behaviors.
2. MCOs should use licensed professionals when addressing problems with the behavioral aspects of physical health, instead of poorly trained paraprofessionals and if used, only under the direct supervision of a licensed behavioral health specialist.

Recommendations to Innovate

See Program Examples/Strategies above.

Additional Recommendations

***MCO*:** MHD should require CMOs to thoroughly describe innovative health literacy programs and their results in other states as part of a scored component of the RFP selection process.

Association: MHD should require care management entities/contractors to establish systems whereby knowledgeable oral health coordinators provide the connection to dental health care access and health care education.

Others:

1. MHD should include a question focusing on health literacy to the RFP's "*Provider Responsibility for Quality"* section. The question should ask if MCOs have implemented any training programs targeting providers and health care systems to be health literate organizations, with adequate health literacy support for patients.
2. MHD should include a question in Section 6.e of the RFP asking MCOs to identify any health literacy empowerment sessions/materials targeting participants by providing new skills, enhancing confidence, and increasing knowledge to manage their health and chronic conditions.

Question 7: Improving access to local health care provider appointments at needed times

a. Describe the obstacles Care Management Organizations (CMO) encounter with health care providers when attempting to encourage those providers to offer appointment times "after hours" and on weekends.

Responses to Question 7a: 20

Overall Obstacles Identified

The obstacles observed by the responders were similar and included the following:

1. Financial and utilization obstacles,
2. Resource management and staffing issues,
3. Lack of provider interest,
4. Lack of member interest, and
5. Policy and system obstacles.

Obstacles Identified by Entity Type

MCOs:

1. MCOs identified the following financial and utilization obstacles:
    - Several responders stated that providers want a financial incentive to extend hours but the health plan is not able to support the financial incentive.
    - There is a perceived lack of return on an investment in extended hours.
2. MCOs identified the following resource management and staffing issues:
    - There are increased expenses and overhead costs (staff and facility) for extended hours.
    - Providers would have difficulty balancing supply and demand on a daily basis.
    - Providers are concerned there would be varying and unpredictable peak times.
    - Providers are concerned there would be safety issues with extended hours.
    - Providers are often understaffed and overburdened.
    - There is a lack of qualified providers willing to provide services after-hours.
    - There is a lack of knowledge by providers on sustainable models for providing extended care.
3. MCOs identified there is a lack of interest in extended hours by providers.
    - Providers are unwilling to extend hours because it would interfere with their personal quality of life.
    - Some providers already have busy and thriving businesses and do not want to extend hours.
    - Solo practices in rural areas are already overextended and exhausted.
4. MCOs identified a lack of interest among members for extended hours:
    - Members are not interested in after-hour services.
    - It is more difficult for members to get to services after-hours due to transportation obstacles.
    - Emergency rooms are more convenient to members.
5. MCOs identified the following policy and system obstacles: Claims for after-hours services may need to be differentiated.

***Vendor*:** Vendors stated that providers will need capital incentives.

Providers:

1. Providers stated they are concerned about no show rates for extended hours.

2. Providers identified the following resource management and staffing issues:
    - There are increased expenses and overhead costs (staff and facility) for extended hours.
    - Providers would have difficulty balancing supply and demand on a daily basis.
    - Providers are concerned there would be varying and unpredictable peak times.
    - There are only one or two providers in rural areas so they would be burdened with additional responsibility.
    - There is a lack of qualified providers willing to provide services after-hours.
    - There is resistance among providers to use mid-level practitioners for after-hours services.
    - Providers identified a lack of interest in extended hours by providers and stated that providers are unwilling to extend hours because that would interfere with their personal quality of life.
3. Providers identified the following policy and system obstacles: Currently, there are policy restrictions regarding place of service for behavioral health services for children. Access would be greater if services could be provided in schools.

***Advocates*:**

1. Advocates identified Member obstacles and stated that individuals with mobility impairment have special access issues. Extension of hours may not assist these individuals.
2. Advocates identified policy and system obstacles as follows:
    - There is inaccurate information in provider directories. This will not be remedied by extended hours.
    - The Missouri regulation, CSR 400-7.095 is not appropriate to address access and network adequacy.

***Associations*:**

1. Associations identified the following financial and utilization obstacles:
    - Current MO HealthNet reimbursement is not sufficient to revamp operations and add staff.
    - Low utilization of after-hours care would not support the effort.
2. Associations identified the following resource management and staffing obstacles:
    - The current supply of primary care physicians is insufficient to meet an increased demand.
    - There is a lack of qualified Providers willing to provide services after-hours.
    - Efforts to add capacity would be consumed by Medicare and commercial participants in addition to MHD.
    - There is a lack of a sufficient number of behavioral health providers to meet increased capacity.
3. Associations identified Member obstacles and stated that individuals with mobility impairment have special access issues. Extension of hours may not assist these individuals.
4. Associations identified the following policy and system obstacles:
    - Current policy requires two visits for members needing behavioral health services; one for an assessment and another visit for testing. This creates a barrier to services since members have to drive twice to get these services.
    - The current policy for prior authorization for psychological testing is burdensome.

Recommendations to Innovate: N/A

Additional Recommendations: None

Question 7b: Improving access to local health care provider appointments at needed times

What strategies should Care Management Organizations (CMO) utilize to encourage and support health care providers to offer appointment times "after hours" and on weekends? Specifically address strategies that can be utilized in rural and urban areas.

Responses to Question 7b: 18

Overall Recommendations

Recommendations made by the responders were largely similar with variations on the themes of:

1. Enhanced reimbursement for providers;
2. Member incentives to utilize after-care hours;
3. Program models;
4. Enhanced use of technology to provide services;
5. Provider education and support strategies;
6. Member education strategies;
7. Compliance procedures;
8. Innovative network adequacy strategies;
9. Development of new revenue streams to fund services;
10. Use care extenders; and,
11. Additional Managed Care contract requirements.

Recommendations to Increase Efforts to Improve the System

***MCOs*:**

MCOs recommended increasing current efforts in the several areas.

1. Enhance the use of technology by using telemedicine, satellite offices and mobile clinics.
2. Incorporate provider education and support strategies such as:
    - Provide training on after-hours access and open access scheduling.
    - Support providers in their efforts to expand access through extended hours.
    - Provide emergency room visit rates to providers to show them benefits of using extended hours versus emergency room care.
    - Conduct office visits to address concerns one-on-one.
    - Share best practices with providers to improve appointment availability and after-hours availability.
    - CMO could target contact with specialists to address concerns.
3. Use compliance procedures such as:
    - Document hours of operation in provider application.
    - Conduct on-going monitoring of appointment and after-hours visits.
    - Conduct Secret Shopper Surveys to confirm compliance with appointment standards.
4. Use members education strategies such as:
    - Ensure members have access to information about extended hours through provider directory.

- Reform emergency room policies to encourage appropriate use of emergency room.

5. Use program models such as:
    - Advanced care management to prepare consumers for visits so the visit is more productive.
    - CMOs could provide effective tools so providers can access care plans and assessments.
    - CMOs could co-locate care managers in high volume practices.
    - CMOs could provide better data analytic tools to providers for understanding their population.
    - CMOs could provide tools to providers to assess care gaps.

***Vendor*:** Enhance the use of technology by using telemedicine, satellite offices and mobile clinics.

***Providers*:**

1. Provide member incentives for utilizing after-hours clinics versus emergency room.
2. Enhance the use of technology by:
    - Using telemedicine, satellite offices and mobile clinics.
    - Using virtual therapy and e-therapy for after-hours behavioral health.
    - Including E-therapy in emergency rooms to reduce cost.

***Associations*:**

1. Enhance the use of technology by using telemedicine, satellite offices and mobile clinics.
2. Support providers in their efforts to expand access through extended hours.
3. Increase current efforts in network strategies by:
    - Including in-network providers that can provide all services required in the benefit package in one location.
    - Using flexible scheduling to encompass before and after hours.
    - Encourage CMOs to contract with local providers so members do not have to travel.

Recommendations to Innovate

***MCOs*:**

1. Enhance reimbursement for providers by:
    - Supporting enhanced rates by raising rates to health plans.
    - Aligning extended hour rates with urgent care center rates.
    - Providing incentive and engagement programs to providers.
    - Including incentives in provider contracts for outreach and education to members on extended hours.
2. Contractually require in-network providers to arrange for back-up during planned absences.
3. Implement innovative network strategies such as:
    - Including in-network Person Centered Medical Homes and Health Homes with extended hours in network.
    - Preferentially recruiting practices with extended hours.
    - Health plans work with providers to evaluate and leverage potential resources for sharing patient care.
    - Providing direct phone numbers and email addresses of in-network providers to members with active cases for after-hours contact.
    - Developing a sustainable model of after-hours care.

***Vendors*:**

1. Enhance reimbursement for providers by supporting enhanced rates by raising rates to health plans.

2. Implement innovative network strategies such as providing mobile health clinics in rural settings.

***Providers*:**

1. Develop new revenue streams to fund services by expanding Medicaid. Medicaid expansion is the key to creating the additional revenue, through federal funding, which is required to create incentives for providers without creating an additional budget burden for the state.
2. Enhance reimbursement for providers by:
    - Supporting enhanced rates by raising rates to health plans.
    - Align extended hour rates with urgent care center rates.
    - Align extended hour rates with commercial rates to provide sufficient incentive to provider.
3. Implement innovative network strategies such as:
    - Align with or integrate urgent care centers into primary care network.
    - Create partnerships between health systems and pharmacies that have in-store clinics.

***Advocates*:**

1. Support enhanced rates by raising rates to health plans.
2. Contractually require new network adequacy standards that are specific and appropriate in obtaining MCO network adequacy for:
    - Provider/facility-to-patient ratios,
    - Travel distance,
    - Patient travel time to healthcare,
    - Patient wait times to make appointments, and
    - Patient wait times in office. These are similar to the Medicare Advantage adequacy standards.

***Associations*:**

1. Enhance reimbursement for providers by:
    - Supporting enhanced rates by raising rates to health plans.
    - Provide enhanced rates based on lower emergency room visit rates.
    - Incentives should be targeted to FQHCs and RHCs since their cost-based reimbursement provides a funding mechanism.
    - Provide incentives to Providers for services delivered in urgent care settings vs. ERs.
2. Managed Care contract changes:
    - Contractually require new network adequacy standards that are specific and appropriate in obtaining MCO network adequacy for provider/facility-to-patient ratios, travel distance, patient travel time to healthcare, patient wait times to make appointments and patient wait times in office. These are similar to the Medicare Advantage adequacy standards.
    - Change MHD policy to allow behavioral health assessments and testing at same visit.
    - Change MHD policy so more prior authorizations for behavioral health services are not required than are required for physical health.

3. Implement innovative network strategies such as:
    - Allow open enrollment and full participation of all providers in any MCO referral system.
    - Align with or integrate urgent care centers into primary care network.
    - Create partnerships between health systems and pharmacies that have in-store clinics.
    - Use combined primary care/urgent care strategy to create broader reach to patients.
    - In rural areas, MCOs could work with providers to assess community needs and to model cost/revenue associated with after-hours services.

Additional Recommendations

***MCOs*:**

1. Add a question in the evaluation section of the RFP that requires the bidder to provide information on their experience and success in increasing after-hours and weekend hours.
2. We have effective strategies they could share with providers who are concerned with financial and resource issues as well as impact of extended hours on personal quality of life. However, our strategies are considered proprietary since they contain information about their reimbursement structure. We suggest a personal follow-up discussion with MHD to detail their strategies.

Question 8a: Describe how a care coordination and care management program should be successfully integrated within the care management organization. Describe how success should be qualitatively and quantitatively measured.

Responses to Question 8a: Total = 16 (MCO-7, Provider-2, Association-4, Advocate-1, Vendor-2)

Overall Recommendations:

1. Care Management Organizations (CMOs) must demonstrate the ability to build and maintain strong relationships with Primary Care Providers, offer customized approaches that meet providers where they are, and enhance provider capabilities by offering resources and support.
2. CMOs should have experience with Health Homes, PCMHs, and other tested models that facilitate strong care coordination and improved care access at a system level.
3. CMOs should have capabilities, experience, and demonstrated outcomes in the following areas:
    - Identification of members with potential or actual care coordination needs through early screening, comprehensive assessments, and periodic reassessments;
    - Placement of members into care coordination programs based on needs assessment;
    - Development of an integrated care plan that addresses physical and behavioral health, and quality of life support needs for members;
    - Reciprocal referrals and information sharing;
    - Multidisciplinary teams to coordinate care for members needing more intensive services; and
    - Ongoing evaluation of the care coordination program.
4. MHD should use measures from CAHPS® and HEDIS® as well as utilization management data to evaluate CMO performance. Measures should be standardized at the state level and should be similar for both Physical and Behavioral Health.
5. CMO Integrated care coordination should take place on a single platform with standard screening and assessment tools and a single care plan. Historically, CMOs have helped perpetuate challenges by developing separate internal structures. Integrated physical and BH care management teams should work side-by-side. A unified quality monitoring (QM) plan and a single utilization management (UM) plan should address both medical and behavioral health, including: an identification and assessment process to determine members' holistic health needs; a system-of-care approach, including assessing and offering services for social health determinates; an integrated claims payment process for medical and behavioral claims within the same IT platform; a comprehensive member services function within the call center that addresses both medical and BH needs; and an integrated clinical management platform where staff who specialize in both medical and BH work together and view all service authorizations including pharmacy information.

Recommendations to Increase Efforts to Improve the System

MCOs:

1. Enforce NCQA requirements that the care management organization must assess five areas for collaboration between medical and behavioral health (BH) care:
    - Information exchange between BH care and Primary Care Practitioners, medical/surgical specialists, organizational providers or other relevant medical delivery systems;

- Appropriate diagnosis, treatment and referral of behavioral disorders commonly seen in primary care settings;
- Appropriate use of psychopharmacological medications and consistent guidelines for prescribing by behavioral and medical practitioners;
- Screening and managing patients with coexisting medical and behavioral conditions; and
- Collaborative development and adoption of primary or secondary prevention programs for BH care.

2. MHD should reflect the integrated model offering a single strategy and a single set of metrics across physical and behavioral healthcare. A collaborative statewide approach incorporating feedback from members, providers, health plans and stakeholders can help build a successful quality strategy that establishes the priority goals specific to the needs of Missouri. Standard metrics like HEDIS, utilization data and cost measures should be followed by CMO Plans to achieve the goals. Measures around quality of lifestyle should have solid statistical backing and a standardized collection and analytic approach regardless of how a member enters the system. It is also important that cost measures should be considered in total, rather than separately for behavioral or medical costs, as we often see increases in behavioral spend that lead to decreases in overall spend over time when an integrated approach is implemented.
3. We use a series of measures in our integrated Pay-For-Performance model for providers that may help serve as a guide to MHD's efforts to identify critical metrics for identifying success. Our P4P program includes both Primary Care Providers (PCPs) and CMHCs, as we know that PCP's treat a large portion of our behavioral health members. The following HEDIS measures are included in the program. ***PCP HEDIS Measures:*** Follow-up care for children prescribed ADHD medications-Initiation Phase; follow-up care for children prescribed ADHD Medications-Continuation and Maintenance (C&M) Phase; Antidepressant medication management-Effective Acute Phase Treatment; Antidepressant medication management - Effective Continuation Phase Treatment; CMHC HEDIS measures-follow-up after hospitalization for mental illness (7-Days).

Advocates:

1. MHD needs to ensure that MCOs actually provide case management to all members, including those with mental health needs and special needs children, monitoring through random audits and other measures whether case management services are provided, and impose financial penalties for violations of the requirements.

Recommendations to Innovate

MCOs:

1. Fully integrating, or "carving-in," specialized BH services offers the most effective and highest levels of collaboration and communication among health professionals. Information is shared among interdisciplinary team members. The interdisciplinary team includes a diverse group of healthcare professions, including physicians, specialists, behavioral health therapists, psychiatrists, pharmacists, advocates, peer support specialists, and others depending on the needs of the member. This model offers an opportunity to develop a comprehensive, individualized service plan addressing the biological, psychological, and social needs of the member.
2. Care Management Organizations should have Multifaceted, bi-directional, technology-based tools to support team integration and an integrated member information system platform that enables communication, care efficiency, and outcomes tracking.
3. Measures of Successful Integration:

- *Qualitative Measures:* Qualitative measures are surveyed from the member's perspective using the Consumer Assessment of Health care providers and Subsystems (CAHPS) surveys and the Integrated Practice Assessment Tool (IPAT).
- *Quantitative Measures:* obtained from member health records/utilization data are HEDIS BH and utilization Measures. In addition to re-admission rates, HEDIS data monitors medication adherence and care gap closures. These measurements are correlative in nature. Possible additions or alternatives could include a post CC/CM participation survey.

Vendors:

1. Our continuous follow-up after discharge from an inpatient setting helps to assist the patient stabilize throughout the duration of the pregnancy. We utilize county and state mental health resources to link our patients with all programs suited for their mental health needs.
2. Success could be measured qualitatively by the number of "transitions of care" and referral documents that are exchanged between BH providers and the patient's PCPs. Other measures could include the reduction of duplicative or conflicting medications and lab services.

Providers:

1. Care coordination/care management related to BH can be successfully integrated within the CMO with a stratification based on severity of the BH diagnosis and social supports.

Additional Recommendations

Providers*:*

1. An example of care coordination lapses involve patients with serious mental illness and one or more co-occurring major medical conditions, who are not authorized for further inpatient care but cannot be safely discharged because no alternative care settings are available or willing to accept them. MCOs should be required to assist in securing follow-up outpatient, home-based, or post-acute.

Associations*:*

1. Telehealth and online learning communities, like the ECHO program, offer excellent opportunities for providers across specialties and geographic areas to communicate and collaborate. Telehealth can also be used to connect patients in low-access areas to behavioral health services.
2. Paraprofessionals in behavioral health should be under the direct supervision of a psychiatrist or psychologist to better guarantee safe and effective care.
3. Use a psychologist to diagnosis and make non-medication treatment recommendations. Then use a prescribing professional to address the medication issues, which if a BH issue, would be based on a psychologist's diagnosis. Do not expect family physicians, let along nurse practitioners and PAs, to have the necessary background or time to address BH issues by themselves.
4. A primary problem in integrated care is the archaic and inefficient insistence that non-prescribing behavioral health specialists bill use-timed codes. BH providers should, like physicians, nurse practitioners, PAs, and dentists, and have access to E&M-type codes, based on the same qualities of service, e.g. complexity and risk as E&M codes, rather than time. Integrating paraprofessionals into a practice would be easier if a psychologist was not tied to "face-to-face" time.
5. Psychologists need access to all of the Health and Behavior codes without additional education and training requirements to allow psychologists to treat the psychological aspects of physical illness and disability. They have been part of psychologists' scope of practice in Missouri since psychology's licensure act was passed. Medicare, the VA, and other states who have authorized these codes do not

require additional education, as does Missouri. The codes should be available to psychologists and their patients at any locations in which they are providing services.

6. Psychologists should receive the same bonuses that physicians receive. The fact remains that mental health access is poor in Missouri because of our lack of support for it and because we maintain a false dichotomy between physician and other doctoral level professionals in healthcare.
7. Too large an emphasis in mental health on outcomes without a system to triage patients who are very ill from those who are less ill will fail. Chronically mental ill individuals need ongoing care, as would a patient with heart disease, COPD, MS, or diabetes. A system of "averages" (i.e. a BH provider who assumes that patients should never receive more than "average" care in terms of number of sessions) penalizes those who are chronically ill, causing them to become more ill and more costly over time. NAMI has correctly and repeatedly made this point.

***MCOs**:*

1. An element, often overlooked by the CMOs, is the need to include "non-benefitted" services offered through the social safety net. It is critical that an integrated care plan include these services.

Question 8b: Should the care management organization allow behavioral health organizations to bill for general medical care if they have an appropriately credentialed rendering provider? What are the advantages and disadvantages?

Responses to Question 8.b.: Total = 15 (MCO-6, Provider-4, Association-3, Advocate-1, Vendor-1)

Overall Recommendations: All 15 indicated "Yes"

Advantages:

1. Members receive their general medical and the behavioral health care in one location ("a one stop shop"), do not have to schedule separate appointments with different providers, and experience less fragmentation of care.
2. Mental illness and addiction are healthcare issues and must be integrated into a comprehensive physical and behavioral health care system that includes primary care settings.
3. Many people suffer from both mental illness and addiction. As care is provided, both illnesses must be understood, identified, and treated as primary conditions.
4. The system of care will be accessible and comprehensive, and will fully integrate an array of prevention and treatment services for all age groups that will be informed by evidence, responsive to changing needs, and built on a foundation of continuous quality improvement.
5. By allowing a behavioral health provider to fully integrate through inclusion of a physical health clinician on the team, any gaps in care can be identified and addressed.
6. Enhanced communication between critical helping professionals, integrated health records, readily available access to information about a person's health conditions and needs.
7. If there is primary care physician on site, there is a higher level of comfort in that primary care doctor prescribing some common behavioral health medications which reduce strain on psychiatric capacity and decrease the stigma often associated with mental health treatment.
8. There is a better chance the patient will receive all the care needed if it is provided in one place.
9. A major advantage is improved access to care for members particularly in situations in which the member has previously had only behavioral health services. The member would have access to additional medical services that they may have not been exposed to for early intervention of health issues like obesity and diabetes. Early intervention could have a significant impact on future health care costs and decreases the risk of adverse outcomes like hospital admissions.
10. This could be a cost saving measure if all services could be achieved at one location. Allowing both medical and behavioral needs to be addressed in one setting would reduce the need for non-emergency medical transportation to separate sites. Caretakers would not have to travel to multiple locations to have behavioral and medical needs met.
11. Members with serious mental illnesses are often reluctant to utilize PCPs because they have trouble getting to appointments, crowded waiting rooms make them nervous, feel uncomfortable disrobing in front of doctors, and believe doctors do not always listen to them, among other factors. Allowing health providers with the appropriate credentials in a setting the consumer is comfortable helps ensure that they receive primary care and reduce ER utilization.

Challenges:

1. Resistance from providers to share information or co-locate services in order to provide general medical care in a behavioral health setting.
2. Will require more than a credentialed medical provider. Some BH facilities are not set up to deliver the full scope of primary care practice: for example, availability of exam rooms with sinks.
3. Requires the MCOs to develop an electronic claims adjudication system (if one does not already exist) to accurately process and pay claims for services through diverse funding streams.

4. Lack of provider experience with the administrative requirements. A significant number of behavioral health providers (particularly small or single-practitioner offices, or those located in very rural areas of the state operating on a cash basis) may not have experience with the requirements of managed care or accurate claims submission.
5. Provider credentialing: Certain providers serving members through non-Medicaid funding sources may not meet the standard requirements for credentialing. This will require flexibility on the part of the MCO so that continuity of care is not disrupted.
6. Because so many members with BH conditions do not receive consistent general medical care, a psychiatrist may be the only physician contact the member receives, unless they visit the ER. This presents a significant disadvantage as psychiatrists may feel pressure to prescribe other types of medication for health issues such as asthma or blood pressure issues.
7. Behavioral health facilities often lack robust medical management tools for the care and treatment of complex patients.

Recommendations to Increase Efforts to Improve the System

***MCOs**:*

1. It is important that relevant clinical information be accessible to both the primary and behavioral health providers consistent with federal and State laws and other applicable standards of medical record confidentiality and the protection of patient privacy.
2. Our affiliate health plans have experience implementing this concept of reverse integration in Behavioral Health Homes. For example, in Virginia, our affiliate health plan is implementing the Enhanced Care Coordination Program as a component of the Commonwealth Coordinated Care Medicare-Medicaid Plan Demonstration.
3. With the right program integrity controls in place, there should not be a barrier to providers being properly reimbursed for their services. We encourage MHD to partner with CMOs to develop the right program integrity model and to ensure there are no regulatory challenges preventing such billing particularly when these services are provided on the same day.

Providers:

1. There must be effective data sharing to improve care and reduce duplication, and referral paths developed to ensure patients are connected to care for medical needs beyond the scope of the behavioral health care provider.
2. Financing and billing must be addressed to sustain integration efforts.

Recommendations to Innovate

1. MCO has supported this model in other states by assisting the provider in getting any needed credentialing and licensing in place as well as lifting claims edits that disallow billing for two different services on the same day from the same provider. We have also embedded our nurse care managers into large community mental health centers to engage our members in that location. Members were able to visit their care manager while at the center for an appointment to address both their physical and behavioral health conditions and needs. The care manager provided care coordination, completed health risk assessments, helped the member develop their individualized plan of care as well as identified and resolved gaps in care and connected them to their PCP when needed. The model has been hugely successful and is being expanded to new practices and states.
2. MCO provides a medical screener tool as a resource to educate the behavioral health providers to address medical issues and encourage follow up with the PCP.
3. There are alternative payment structures and value-based contracting models where providers are reimbursed based on outcomes, apart from individual services.

Question 8c: Should the care management organization allow general medical organizations to bill for behavioral health care if they have an appropriately credentialed rendering provider? What are the advantages and disadvantages?

Responses to Question 8c: Total = 15 (MCO-6, Provider-5, Association-3, Advocate-2)

Overall Recommendations: All 15 indicated "Yes"

1. Yes, the managed care organization should allow general medical organizations to bill for behavioral health (BH) care if they have appropriately credentialed rendering providers.

Advantages:

1. Expands access to behavioral health treatment;
2. Integrated care: if a PCP is treating a member for depression or substance use, the PCP can manage his/her other health issues with a better understanding of the total healthcare needs;
3. Members are more likely to engage in BH treatment in familiar and comfortable clinical settings;
4. There is significant evidence that many people seek BH care at their primary care office. Either they either don't know their symptoms are indicative of a BH condition, or don't want to visit a BH provider due to the stigma of getting BH treatment, especially in small rural towns.
5. Treating both medical and behavioral needs in a seamless setting reduces the need for non-emergency medical transportation to separate sites and enhances continuity of care. Caretakers would not have to travel to multiple locations to have behavioral and medical needs met.

Disadvantages:

1. Disadvantages include unfamiliarity or lack of training on modern evidenced-based BH clinical practices. General medical providers may not be up to date on the latest clinical modalities that are most effective members with behavioral health conditions. This extends to the nuances of psychopharmacology as general medical providers may not be familiar with newer BH medications and the side effects that are connected to the drug.

Recommendations to Increase Efforts to Improve the System

***MCO*:** CMOs must support medical organizations providing BH care by providing training and oversight, and care coordination protocols that support outcomes, integration, and member participation.

***Provider*:** Data must be effectively shared to improve care/reduce duplication, and referral paths developed to ensure patients obtain proper medical care for needs beyond the BH provider's scope.

***Advocate*:** We are supportive of colocation of physical and behavioral health care providers, and other methods of integrating physical and mental health care.

Recommendations to Innovate

***MCO*:** We have supported this model in other states by assisting the provider in getting any needed credentialing and licensing as well as lifting claims edits that disallow billing for two different services on the same day from the same provider. We developed a Primary Care Behavioral Health Education and Supports Program to assist primary care providers doing BH screenings and brief treatment. We assign dedicated staff to visit primary care offices to provide the information, resources and referral pathways for the providers for BH treatment.

***Association*:** We believe in a traditional fee-for-service contracting arrangement that general medical organizations should be able to bill for behavioral health care if they have an appropriately credentialed rendering provider. Providers in a PCMH or Integrated Health Home (IHH) environment may benefit from other contracting arrangements that make this a less critical issue.

***Provider*:** Integration of behavioral health consultants (BHC) in the primary care practice is a key to improving population health. MHD should work with providers to determine how to reimburse for services delivered by a BHC in the primary care setting. The physician or nurse practitioner can then spend their time on the medical decision making aspects of care and coordinate with a trusted BHC to provide education on lifestyle choices that impact health and provide access to community resources to help the patient determine how to take better care of their physical and mental well-being. BHCs, located in the clinical area also provide assistance to the PCPs for chronic pain management, patients in crisis, assists care managers in referrals for ongoing BH services and group sessions.

Additional Recommendations

Association: It is in the state's best interest for quality and cost control due to the DMH provider allocation system to handle more intensive services. CMHCs have significant experience and training in providing treatment for those in need of the most intensive services.

Advocate: We are supportive of continuing to include BH care with the same Plans that provide physical health care, rather than carving those services out, provided the State does a better job of holding Plans accountable. If the State splits off BH from physical health, such fragmentation could have an adverse impact. Pediatricians play an important role in addressing BH needs, from screening for such problems as attention deficit disorder to providing counseling. If a child were placed in a separate BH CMO system, how would the state ensure that that the treating physician is kept in the loop, and that the child's physical needs are still being met? If the patient's physical health care is still being managed by the existing Medicaid MCOs, but BH is managed somewhere else, how will the two systems communicate with each other? MHD would have to address these and other questions if BH and physical health care are fragmented. MHD may want to investigate the Healthy Indiana Plan's new model for integrating BH care into primary care settings. The program seeks to foster collaboration between psychiatrists and primary care physicians, including sharing of electronic health records, and provides financial incentives for participating psychiatrists.

Question 8d: How will the care management organization implement integration strategies and what strategies will they choose to effectuate integrated care (like co-location)? What incentives and assistance should the care management organization offer physical health care providers and behavioral health care providers to co-locate and integrate care?

Responses to Question 8d: Total = 12 (MCO-6, Provider-5, Association-1, Advocate-1, Vendor-1)

Overall Recommendations:

1. Provide methods to share data about all of the patient's care to all the patient's providers.
2. Incentivize integration and provide payments to practices to cover integration costs.
3. Co-location offers the best opportunities to integrate but is never sufficient by itself.
4. Reimburse and incentivize the use of Behavioral Health Consultant's (BHCs).
5. Provide data, analysis, training, and technical assistance to practices to integrate care.

Recommendations to Increase Efforts to Improve the System:

MCOs:

1. We recommend a strategy that promotes integration of BH care with physical health care by aligning financial incentives, with a clear step-wise progression toward full integration. As organizations evolve toward full integration of primary and BH care services, having a vision of what integrated care will look like will help them get there. The Substance Abuse and Mental Health Services Administration (SAMHSA) provides a detailed vision and operational description depicting six levels of collaboration/integration:

    - **Level 1 — Minimal Collaboration:** BH and primary care providers work at separate facilities and have separate systems. Providers communicate rarely about cases. When communication occurs, it is usually based on a particular provider's need for specific information about a mutual patient.
    - **Level 2 — Basic Collaboration at a Distance:** BH and primary care providers maintain separate facilities and systems. Providers view each other as resources and communicate periodically about shared patients, typically driven by specific issues. For example, a primary care physician may request a copy of a psychiatric evaluation to know if there is a confirmed psychiatric diagnosis. Behavioral health is most often viewed as specialty care.
    - **Level 3 — Co-Located Care- Basic Collaboration Onsite:** BH and primary care providers are co-located in the same facility, but may or may not share the same practice space. Providers still use separate systems, but communicate more regular due to close proximity, especially by phone or email, with an occasional meetings to discuss shared patients. Movement of patients between practices is most often through a referral process that has a higher likelihood of success because the practices are in the same location. Providers may feel like they are part of a larger team, but the team and how it operates are not clearly defined, leaving most decisions about patient care to be done independently by individual providers.
    - **Level 4 — Close Collaboration with Some System Integration:** closer collaboration among primary care and BH providers due to co-location in the same practice space, and the beginning of integration in care through some shared systems. A typical model may involve a primary care setting embedding a BH provider. In an embedded practice, the primary care front desk schedules all appointments and the BH provider has access and enters notes in the medical record. Often, complex patients with multiple healthcare issues drive the need for consultation, which is done through personal communication. As professionals have more opportunity to share patients, they have a better basic understanding of each other's roles.

- **Level 5 — Integrated Care:** close collaboration approaching an integrated practice. There are high levels of collaboration and integration between BH and primary care providers, who begin to function as a true team, with frequent personal communication. The team actively seeks system solutions as they recognize barriers to care integration for a broader range of patients. However, some issues, like the availability of an integrated medical record, may not yet be resolved. Providers understand the different roles team members must play and have started to change their practice and the structure of care to better achieve patient goals.
- **Level 6 — Full Collaboration in a Transformed/Merged Practice:** The highest level of integration and greatest amount of practice change. Fuller collaboration between providers allows antecedent system cultures to blur into a single merged practice. Providers and patients view the operation as a single health system treating the whole person. The principle of treating the whole person is applied to all patients, not just targeted groups.

Provider organizations can determine how far they've progressed toward full integration using the Integrated Practice Assessment Tool (IPAT) located at: http://ipat.valueoptions.com/IPAT/. The IPAT is a self-assessment tool that uses a decision tree model with a series of yes/no questions that cascade to a level determination. Once completed, the tool can help providers determine activities that will enable them to move to the next level of integration.

2. MCO cautions against singular reliance on co-location as a solution to integration. Our affiliate health plans have experienced co-location initiatives that resulted in continued silos of care, with communication a leading barrier to true integration. Instead, a robust and provider-accessible information technology system serves as an important tool in facilitating integrated care and the necessary communication structure. We suggest MHD seek Care Management Organizations with the following resources:

3 Multifaceted, bi-directional, technology-based tools to support team integration;

4. An integrated member information system platform that enables communication, care efficiency, and tracking of outcomes;

5. Data system components that link care coordination to the organization's utilization management team; and

6. Provider assistance that targets achieving outcomes through education and training as well as information and data capabilities.

7. All providers have access to our shared Provider Portal to coordinate the care of our members. Providers will be able to coordinate the care of a member by having the ability to view member information from the behavioral and physical health side.

8. When the CMO is already offering an integrated platform, it is easier to effect change among providers to break down barriers to integration.

9. We use the following strategies to help providers realize returns on their investment for integrating which includes: Value-based contracting options with pay for performance incentives based on reaching key HEDIS measures; Data-sharing facilitation, such as assistance in finding funding for new EHRs or interconnectivity tools or simply offering visibility through sharing of claims data.

10. We believe there are some key advantages of a traditional Medicaid managed care structure in partnership with new models such as ACOs are as follows: CMOs can push integration across provider types and not be limited only to the largest provider groups; CMOs hold data across providers so even independent practices have opportunities to take advantage of co-location strategies with the right support from CMOs; While a single provider-led organization may have pieces of that member's picture, the CMO is responsible for the "whole person" and can see the entire picture. This helps integrated

practices see even beyond their walls, which is critical in an environment where members are rightfully able to choose their providers.

11. Co-location requires substantial coordination to be successful. It offers the best opportunity for effective communication and collaboration among physical and BH providers with the ultimate goal being that all providers are looking at one care plan and all treatment options together.

***Association*:** Integration is about identifying all of a consumer's health care needs regardless of why or through what door he or she entered the primary or BH system. Co-location does not mean that providers are collaborating or truly integrated. Just because providers are in close proximity does not mean that they are interacting clinically or sharing consumers. Integration is a systemic change that needs to be resourced, and if done correctly, will demonstrate improved health outcomes and savings.

Recommendations to Innovate

***MCOs*:**

1. The CMOs approach should assist in developing community supports and services, such as supportive housing, transportation, employment, and other community-based services.
2. Behavioral Health Consultants (BHCs) work side-by-side with all members of the clinical care team (including PCPs and nursing staff) to enhance preventive and clinical care for BH problems traditionally treated solely by physicians. The BHC role is to facilitate systemic change within primary care that leads to a multidisciplinary approach, both from a treatment and reimbursement standpoint. BHCs collaborate with physicians to develop treatment plans, monitor patient progress, and flexibly provide care to meet patients' changing needs.
3. The CMO should also focus on integration within the provider network to facilitate co-location and full integration by assisting with getting the system set up and ensuring they can be paid for both types of services provided to the member. The CMO should embed staff at provider sites to engage the members and providers into the Integrated Care Team process to ensure the individualized plan of care addresses all issues and can be used by all involved so that the member does not have multiple plans of care to follow. The care management organization can implement integration strategies at the provider level (e.g., co-location) by acting as a facilitator to FQHC's and other high-volume primary care settings in bringing behavioral health services into their scope and practices.
4. Various payment structures, from increased bundled payments for FQHC's to enhanced fee-for-service rates for the BH coding have been effective in making this an attractive service delivery option. We have seen much success in FQHC's and other high-volume primary care settings in adopting the BH consultation model. Primary Care Behavioral Health Consultation (PCBHC) is an approach to population-based BH clinical care that is simultaneously co-located, collaborative, and integrated within the primary care clinic. The goal of PCBHC is to improve and promote overall health within the general population. PCBHC is considered a fully integrated model. BH is a routine part of the medical care and the BH clinician is part of the primary care team. A patient may be just as likely to see a BH clinician as a nurse during a routine office visit. The patient's PCP (or nurse practitioner) is the principal provider in the model, who initiates referral and immediate, "warm" or "hallway hand-offs" to the BH clinician. Unlike in specialty BH care, the BH clinician does not take over responsibility for treating the patient, but rather temporarily co-manages the patient with the PCP. Roles of the Behavioral Health Consultants (BHCs) can vary, but often include the following:

    - Assessment of behavioral health issues, confirming or refining psychiatric diagnoses;
    - Clarifying and further exploring salient points of mental health or substance abuse history (e.g., history of suicide attempt; history of success using medication to stop smoking years before);
    - Addressing specific problems impacting overall health and wellness;

- Identifying critical behavioral health elements to add to a patient's overall care plan;
- In multiple chronic conditions, addressing issues of self-management and adherence to medical treatment.

To keep the BHC committed to immediate availability, assessment, and brief intervention, many primary care practices attempt to adhere to certain guidelines or prescriptive limits. For cases of mild symptoms or specific problems, the patient is typically offered 3-4 brief visits (15-30 minutes each) with the BHC. For cases of moderate symptoms, the patient may be seen "in house" with the BHC for 4-6 sessions and/or referral for traditional psychotherapy is considered. For cases of severe psychopathology more suited to traditional mental health intervention, specialty referral is usually recommended. However, for all patients, the BHC remains involved for periodic assessments, "booster" sessions, and coordination with the specialty practice. Some primary care providers are more comfortable with a less integrated arrangement such as simple co-location, and these options should be supported as well. The Co-located Care Model is where behavioral health providers and PCPs practice within the same office or building but maintain separate care delivery systems, including records and treatment plans. However, BH providers and PCPs may consult one another for enhanced treatment outcomes.

5. One of the most powerful tools that CMOs have to effectuate change in provider practice patterns is the effective use of data. For instance, Missouri Care will analyze data to determine the right synergies among potential partners. In this method, we will identify where there are large crossovers of patients such as a PCP that sees 200 patients that are also seen by the local Community Mental Health Center. Once synergies are identified, we will bring parties to the table to discuss options for collaboration, integration or even co-location as appropriate for them and their patients. We will identify barriers to those issues and work to help providers find solutions to overcome those barriers which are often unique to individual practices.

***Vendor*:** MCO's could be incentivized through enhanced payment and requiring their provider networks to join the SDE to integrate care.

***Provider*:** Incentives based on a shared savings infrastructure and support staff will encourage co-location. Incentives should be offered to organizations that have integrated behavioral health and primary care medical services. There should be a timeframe setup to define this integration, for example if behavioral health services are utilized the same day as medical services a payment multiplier could be used for the integrated visit. This multiplier could then decrease as time extends from the date of the medical visit and expire by 7 days.

***Advocate*:** MHD may want to investigate the Healthy Indiana Plan's new model for integrating mental health care into primary care settings. The program seeks to foster collaboration between psychiatrists and primary care physicians, including sharing of electronic health records, and provides financial incentives for participating psychiatrists.

Additional Recommendations

Advocate: We are generally supportive of continuing to include behavioral health care with the same plans that provide physical health care, rather than carving those services out, provided the State does a better job of holding health plans accountable.

Question 8e: What incentives and assistance should the care management organization offer physical health care providers and behavioral health care providers in separate organizations located at separate sites to coordinate care?

Responses to Question 8e: Total Responses = 12 (MCO-6, Provider-4, Association-1, Advocate-1, Vendor-2)

Overall Recommendations

1. MHD should require CMOs to have internal processes for physical health providers and behavioral health (BH) providers in separate organizations located at separate sites to coordinate care.
2. Physical health and BH providers with sufficient ability should be paid additional fees to coordinate.

Recommendations to Increase Efforts to Improve the System

***MCOs*:**

1. Primary care providers should be held accountable for relationships developed with their patients. Through this relationship, BH issues may be identified early on. When primary care providers are recognized as a patient-centered medical home, those separate locations are accounted for within the processes developed as part of a PCMH. The PCP must be accountable to know where the patient goes and hold the referral partners accountable as well for keeping the PCP apprised of patient progress in the BH sphere. Care coordination fees to recognize the extra work and administrative burden that is placed on practices should be utilized.
2. Require mutual screening, referral and communication. Some basic contractual requirements for BH providers can include maintaining updated primary care provider information on each member, establishing authorizations for disclosure, and requiring PCP updates upon admission, discharge, or significant changes in level of care or treatment plan.
3. The health home model typically provides the added payments and incentives to cover the care coordination component provided by the physical health care provider. Similarly, consideration could also be given to supporting the establishment of BH homes, where the physical care component is brought into the BH clinic setting.
4. Providers that demonstrate a robust service delivery system supported by empirical are incentivized by value-based contracting. Our providers are required to track their performance and outcomes in respect to specific benchmarks. This can include measures of integrated care, HEDIS or other predetermined performance outcomes.
5. Our clinical training team provides onsite and call-in trainings to promote care coordination. Providers can access an online internal portal for trainings with a variety of topics at their convenience including Mental Health First Aid, SBIRT training, screening tools trainings and trainings on forms of integration and care management tools.
6. CMOs should offer the following to help physical and BH providers coordinate care:
    - Flexibility in the use of forms, screenings and assessment tools. This is important because forcing providers to use additional tools not built into their EHRs can actually de-incent collaboration by adding unnecessary paperwork;
    - Developing data sharing strategies either through portals, interconnectivity options or various reporting tools;
    - Supporting and facilitating Grand Rounding on shared cases with complexity;

- Developing care plans for more complex members and identify care teams that include both training and toolkits for both PCPs and BH specialists to help them identify members where care coordination is needed and help them build strategies into their practice, such as internal rounds and consultation, to coordinate;
- Relationship-building with case managers, the primary care and the BH care providers; and
- Connectivity to social safety net services, family caregiver support and other formal and informal supports.

7. Alternative payment structures for providers who have the infrastructure and a desire to take on more pieces of care coordination. In these structures, providers may be paid a PMPM to "own" management of their patients. We believe CMO's should only intervene when a case becomes too complex for the collaborating providers to manage.
8. Have tools that ensure the delivery of comprehensive person-centered care. MHD should partner with CMOs that have robust capabilities to allow access to assessments and care planning tools for all involved providers to allow them to see assessments and care plans as well as directly provide feedback to the care management team. In addition, CMOs should be able to demonstrate that their care management processes coordinate between providers to ensure effective member treatment. This is particularly important in terms of integrating physical and BH, but also applies to the integration of multiple specialists and non-traditional services. Location of services becomes less relevant if a CMO has appropriate tools to minimize fragmentation in the delivery of services.

Recommendations to Innovate

***MCOs*:**

1. Hold providers accountable for their performance as a PCMH through annual evaluation processes in the absence of PCMH recognition through either an accrediting body or through the health plan due diligence of the practice.
2. Many times the BH provider visit is the first stop for some patients, who have not yet visited their PCP, and aside from metrics designed to incent PCPs to have at least annual visits with their patients, there is inherent difficulty in incenting the BH partner. The ideal scenario is for PH and BH providers to come together to create a structure where both entities are at risk for treating the population. Metrics would be aligned between both to encourage coordination.
3. An incentive and assistance model that encourages collaboration with physical and BH providers to exchange information and coordinate care. Such a model promotes delivery of high quality, integrated physical and BH care services for members while driving provider accountability and efficiency. Care Management Organizations should actively engage providers and offer the tools and infrastructure needed to share information, including person-centered care planning.
4. Active collaboration with some of the largest Community Mental Health providers, Truman Medical Center Behavioral Health, Burrell Behavioral Health and Pathways Community Health reflects our drive to cross-organization collaboration. With this initiative we have identified their members' PCPs, shared their medical spend in aggregate and by level of care and are working to identify where there are large volumes of shared membership to build more synergistic collaboration.

Vendor: Enhanced payment to ambulatory care providers to be a part of the SDE could help ambulatory and allied health providers participate. SDE participation will afford these providers with the ability to exchange clinical information in a secure HIPAA compliant manner in real-time.

Provider: MO HealthNet Division could consider grant funding for care navigators specifically designated for these services. Both MCOs and providers could apply for these grants, with requirements for demonstrated improvements in access to care and outcomes for continued funding.

Additional Recommendations

Provider: Effective care coordination is dependent upon effective communication and data sharing. Access, consults, education and referral paths for both physical and BH care providers are needed at the highest levels to improve both physical and behavioral health care conditions. Fully integrated and accessible administrative data must be available real-time for care management purposes.

MCOs:

1. Ideally, physical and BH providers are co-located. In the absence of co-location, coordination must take place between Physical and BH providers treating the same patient. This can prove difficult with many BH providers lacking connectivity and the ability to seamlessly communicate with Physical Health providers.
2. We do this through notifying providers of the involvement, we alert PCPs when one of their patients is admitted to a BH inpatient admission, we facilitate the sending of the discharge summary with aftercare and medication information to primary care, and we engage all the providers to be involved in the member's interdisciplinary care team (ICT) with the appropriate consent required.
3. CMOs should provide several means of communication to coordinate member care. For example, when a member sees his PCP and is determined to need a BH referral, it is common for the care coordinator to assist the member with the referral. Care coordination staff can host a conference call with both providers to integrate patient care and allow provider networking opportunities.

Question 8f: What procedure codes for behavioral health care services to address behavioral health care issues related to general medical conditions (Screening Brief Intervention, Referral, and Treatment or Health Behavior, Assessment and Intervention, etc.) should the care management organization reimburse?

Responses to Question 8.f.: Total = 14 (MCO-6, Provider-4, Association-3, Advocate-1)

Overall Recommendations

1. The MCOs should reimburse the medically necessary services related to screening, consultation, treatment and referral of individuals with behavioral health (BH) conditions being treated in a primary care setting. Early identification and intervention in primary care settings improves the overall health of the population and supports the integrated system of care model.

2. There were multiple recommendations to cover Health Behavior Assessment and Intervention (HBIA) codes and Screening Brief Intervention (SBIRT), and Referral codes. These are services that are currently covered in FFS.

3. A total of 48 specific services/codes used in integration were recommended (see table attached).
    a. Thirty-seven of those services are already covered or about to be covered in FFS.
    b. Nine of the codes not currently covered in FFS are for services that can be paid for using a different code than the one recommended in RFI responses.
    c. Eleven of the recommended services are not covered currently in FFS

Code	Code Description
96155	Health and behavior intervention Family Tx without patient ,15 minutes, face-to-face;
90863	PHARMACOLOGIC MGMT W/Psychptherapy by non-physician
90833	Psychotherapy W/Medication Check 30 MIN
90836	Psychotherapy W/Medication Check 45 MIN
90837	Psychotherapy 60 MINUTES
90838	Psychotherapy W/Medication Check 60 MIN
H0012	Substance Abuse Residential SUB-ACUTE DETOX Outpatient
G0444	Annual depression screening, 15 minutes
H0023	Behavioral health outreach service (planned approach to reach a targeted population)

Recommendations to Increase Efforts to Improve the System

MCO recommendations: Providers already use the E&M 99-series codes regardless if it is behavioral or physical health, so it would not be appropriate for additional provider codes during that same visit. They should use the appropriate E&M code to match the type of visit for that day. There is no single answer, but an issue that must be solved with CMOs working in collaboration with MHD to make sure certain codes are allowed on the same day to encourage co-location strategies.

Provider: We believe there is value in both the SBIRT and the HBAI codes, and both should be strongly considered for reimbursement in any new model for delivering care to Missouri's Medicaid recipients.

Association: Both the Screening Brief Intervention, Referral, and Treatment service and the Health Behavior, Assessment and Intervention service are covered by Medicare, a possible baseline standard that would promote consistency between types of payers.

Recommendations to Innovate

MCO: multiple individual codes recommended-see table attached

Vendor: multiple individual codes recommended-see table attached

Provider: multiple individual codes recommended-see table attached

Provider: This decision should be driven by outcomes. If paying for particular BH codes results in better care at lower costs, CMOs should have the flexibility to do so. Demonstration projects could be developed to allow testing of the effect of the added codes.

Provider: a more systemic, preventative screening for mental illness and substance use disorders should also be put into place which allows for primary and specialty providers to bill for screening on a regular interval (at least every six months) as an add-on for a routine visit, as well as at any point in time in which a medication with abuse potential is prescribed. Early identification allows for swifter referral to treatment and decreased social costs associated with untreated substance use disorder.

Additional Recommendations: none

Question 8g: How can a care management organization improve and assure prompt access to behavioral health care professionals for both participants and providers who seek access for consultations? Please address specifically the ability of participants to have prompt access to providers such as psychiatrists and child psychiatrists, particularly with regard to the various geographic regions of the state.

Responses to Question 8g: Total = 15 (MCO-6, Provider-4, Association-3, Advocate-1, Vendor-1)

Overall Recommendations

1. Multiple recommendations to expand and support telemedicine for behavioral health (BH).
2. Increase available BH prescribers by training primary care to do BH prescribing, expanding use of psychologists, and using advanced practice nurses.
3. Raise rates for BH providers.

Recommendations to Increase Efforts to Improve the System

***MCOs*:**

1. The MCO model includes credentialing and contracting a comprehensive network of providers to deliver covered services. We readily contract with physician extender providers such as physician assistants and nurse practitioners, as appropriate. Our case managers help members identify services and the most appropriate providers to fit each member's needs. Providers receive incentives to increase access to care or to demonstrate positive outcomes. MCOs should offer value-based payments including incentives to ensure that members complete regular screenings, follow-ups to hospitalization, regular testing for chronic disorders, and recommended vaccinations. MCOs provide enhanced reimbursements only for the services that are necessary, which we identify through regular reporting such as gaps-in-care reports. This aligns incentives between providers and the MCO and reduces unnecessary care simply for the purposes of obtaining more reimbursement.
2. The goal of the CMO should be to contract with all existing Medicaid providers for continuity of care. In the event an existing provider chooses not to contract, the CMO can enter into a single case agreement for any members already in care to prevent disruption. In a similar spirit, CMOs should be reluctant to close a network. Rather the goal is to increase the skill level and quality of all network providers and encourage expansion in areas of need. Expansion occurs through recruitment of non-Medicaid providers and working with existing providers to expand capacity.
3. With a nationwide shortage of adult and child psychiatrists, we propose telemedicine to expand access for psychiatric services and better use other providers, like nurse practitioners, who are able to prescribe medications for members. We also propose to train primary care providers on appropriate prescribing patterns for low acuity BH conditions to expand access for these services.
4. Members can access appropriate BH services by CMOs:
    - Developing and maintaining a comprehensive, accessible behavioral health network;
    - Providing Telemedicine services to those members in rural or underserved communities;
    - Keeping the provider network list up-to-date and available on the member web site;
    - Creating and distributing easy-to-understand member materials regarding services access;
    - Promoting collaborative relationships between members and their primary care providers so that they can also assist members with seeking appropriate BH services;

- Maintaining a well-trained member services staff who can recognize when members may need BH services and connect them with Care Management staff or help them find providers for self-referral;
- Hiring, training, and maintaining adequate Case Managers trained in BH; and
- Working with members 1:1 to schedule and keep scheduled provider appointments.

***Providers*:**

1. Partnering with Missouri's Community Mental Health Centers (CMHCs) is an efficient and effective approach because there is an existing infrastructure of access to BH professionals including psychiatrists and child psychiatrists. Reimbursement structures needs to support growing the existing CMHC infrastructure to meet the current demand and to ensure access is prompt. Growing the number of Advanced Practice Registered Nurses as physician extenders and expanding telemedicine capabilities statewide will provide addition coverage for various regions of the state.
2. There is a shortage of and a highly competitive market for psychiatrists in Missouri. It takes 6 months to a year and $20-40k to recruit a psychiatrist. A competitive hourly wage for psychiatrists would be a good start to solving our physician shortage. Fee-for-Service Medicaid has not raised BH reimbursement for at least 25 years. This makes it difficult for Missouri to compete when it comes to recruitment of many types of specialized personnel.

***Associations*:**

1. MHD should compel MCOs to allow provisionally licensed BH clinicians to be credentialed if they otherwise meet the standards. The Medicaid fee-for-service program recognizes provisionally licensed practitioners. Failure of MCOs to do so will significantly limit access to care.
2. Use a psychologist to diagnosis and make non-medication treatment recommendations. Then use a prescribing professional to address the medication issues, which if a BH issue, would be based on a psychologist's diagnosis. Do not expect family physicians, let alone nurse practitioners and PAs, to have the necessary background or time to address behavioral health issues by themselves.
3. Psychologists need access to all of the Health and BH codes without additional education and training requirements. These codes allow psychologists to treat the psychological aspects of physical illness and disability. They have been part of psychologists' scope of practice in Missouri since psychology's licensure act was passed. Medicare, the VA, and other states authorizing these codes do not require additional education for psychologists to use them, as does Missouri. The codes should be available to psychologists and their patients at any locations in which they practice.

Recommendations to Innovate

***MCOs*:**

1. Our subcontractor is in the process of implementing telemedicine services to support access to both physical and BH services for all of our members beginning in Q4, 2015 with full operation by Q1, 2016. The telemedicine platform will support telephonic and web-based or mobile video interactions over a secure connection. Our approach is to offer our members direct access to a provider "on-demand" where our care managers will also have the ability to access the platform and assist members with setting up a virtual appointment. Likewise, the sub-contractor is also examining how we can leverage the telemedicine solution to support provider-to-provider consultation or where a specialist, such as a BH provider, can be virtually connected in real-time to a PCP's office for a three-way consultation with the PCP and member. We are also looking at alternatives to use the platform for "check-ins" focused on prevention and wellness appointments where it may be easier or members with transportation or the challenges to travel to their PCP offices. We support the state examining how telemedicine services can be expanded and reimbursed.

2. Web-based and other mobile tools will open innovative and useful pathways to integrate physical and BH services, especially for members living in rural areas or underserved urban communities, which often present a challenge to both members and providers in receiving healthcare services. Innovative options include:

    - Primary care providers who are treating members with BH issues can receive consultation regarding medication or for members with a more complex psychiatric need than was originally diagnosed. PCPs frequently have difficulty accessing BH consultation due to lack of psychiatric and BH resources near the communities they serve.
    - MCOs can serve as partners by expediting the process through timely release of information and linking the member to the telemedicine platform.
    - In underserved areas with limited psychiatric services, when members are prescribed medication for a BH issue that requires monitoring by a qualified psychiatrist or psychiatric nurse, the use of telemedicine technology can help provide access to a qualified clinician to perform the necessary review and monitoring.
    - Members who cannot easily travel to access qualified BH therapy for conditions that require intervention outside of their primary care providers' offices, can use this technology.
    - Two-way video connections at the members' homes or through other community sites, such as the PCP's office, allow practitioners to virtually view the member and assess their condition to determine current status, whether a referral should be made to another provider or whether crisis intervention is warranted.
3. The definition of access to care needs to be expanded from physical access and appointment standards (and related communication, collaboration and literacy issues) to convenient care clinics and technology that can supplement and sometimes supplant physical appointments.
4. Behavioral health provider organizations that are licensed or certified by the State or accredited by a national accrediting body are credentialed as organizations in accordance with NCQA standards for BH CMO CR-11 and PH CMO CR-08 rather than individually credentialing each licensed clinician working within the organization. Under this standard, qualified Organizations are required to credential their own staff. The role of the CMO is to review the accredited and /or licensed entity's policies and employee records during site visits to confirm they are properly credentialing staff. This approach reduces administrative burden on providers while maintaining the integrity of NCQA credentialing requirements. It also allows members open access to any licensed clinician working under the auspices of the organization without the delay involved in plan credentialing of each individual clinician.
5. Support providers in establishing outpatient care services in schools. This helps to alleviate some issues with transportation.
6. CMOs should support this effort by:

    - Training PCPs to bolster their role in prescribing and medical management;
    - Supporting prescribing PCPs with counseling for members and supporting co-location of licensed mental health professionals when possible;
    - Supporting the use of extender providers when appropriate and when supported by the CMOs data infrastructure to ensure quality outcomes;
    - Supporting and enhancing telehealth opportunities particularly to provide consultation to PCPs; and
    - Identifying community leaders to bring together community stakeholders to seek solutions unique to those communities.

***Providers*:**

1. We have successfully used telemedicine to obtain psychiatric and BH specialists when the service is not available locally. We always combine this service with having a counselor/ other specialist on site to assist, answer questions, and create a more comfortable experience for our members.
2. In our Region (SW Missouri) access to these services is a significant challenge, regardless of the payer involved. If MHD were to try to address this, they would first need to address the overall shortage of providers in this area, and then become the payer of choice for new providers in the market. Loan forgiveness and other attractors might be a way to incentivize newly trained mental health providers to consider Missouri.
3. There are many business operations changes that can be made/improved upon at the local provider level to increase prompt access to providers. Offering same day access improves operational efficiencies, avoids revenue loss, and allows clinicians to spend more time engaging consumers in treatment. Just-In-Time Scheduling (JIT) is a tool that is being utilized throughout the country to help prescriber teams see new consumers within 3 days of their diagnostic assessment. This model is designed to increase access and decrease no-show rates in a clinic's psychiatric services.
4. School-based mental health services are an evolving strategy to address these concerns by removing barriers to accessing and improving coordination of BH services. School-based mental health services offer the potential for prevention efforts as well as intervention strategies. Telehealth can also give providers more mobility in terms of new freedom to deliver health care while on-the-go and in different venues—expanding the walls of a clinic's service offerings. Telehealth can result in more effective care delivery. Tele-behavioral health can support the health system's move toward collaborative and integrated approaches by strengthening relationships within a team and across agencies. In practice, agencies can gain expanded access to experts, like BH specialists not located in the community. Telehealth can ease the task of convening consultation sessions between PCPs and BH specialists to screen and manage referrals. Technology can also provide clinicians with ready access to health indicator data for use in addressing clinical and non-clinical issues.

***Association*:** Missouri has a severe shortage of psychiatrists and other behavioral health clinicians, impeding access to care. Vendor contracts should promote the use of appropriately billable and compensated telemedicine services in behavioral health.

Additional Recommendations

Provider: One way to increase access is in the use of telemedicine services. We have seen great response to our telemedicine initiatives for basic care needs and occupational medicine services. BH as one possible area in which we might expand these services. If MHD provided reimbursement for such services, we believe there would be an increase in access for Missouri Medicaid members.

***Associations*:**

1. Paraprofessionals in behavioral health should be under the direct supervision of a psychiatrist or psychologist. This will better guarantee safe and effective care.
2. A main problem in integrated care is the insistence that non-prescribing behavioral health specialists bill use-timed codes. This is archaic and inefficient. BH providers, like physicians, nurse practitioners, PAs, and dentists, should have access to E&M type codes, based on the same qualities of service, e.g. complexity and risk as E&M codes, rather than time. Integrating paraprofessionals into a practice would also be easier if a psychologist was not tied to "face-to-face" time.
3. Psychologists should receive the same bonuses that physicians receive. BH access is poor in Missouri because of our lack of support for it and because we maintain a false dichotomy between physician and other doctoral level professionals in healthcare.

Question 8h: Describe how federal mental health parity requirements under The Wellstone – Domenici Mental Health Parity and Addiction Equality Act of 2008 and 45 CFR Parts 146 and 147 should be measured for compliance. What operational, financial, or clinical considerations should MHD make when developing an enforcement protocol for care management organizations?

Responses to Question 8h: Total = 10 (MCO-6, Provider-1, Association-2, Vendor-1)

Overall Recommendations:

1. All recommended that CMOs must be required to fully comply with the Mental Health Parity and Addiction Equity Act (MHPAEA).
2. The state and/or MCO must document that the Quantitative Limitations (QTLs) and Non-quantitative Limitations (NQTLs) processes and strategies (such as benefit structure and limitations, utilization management, network management, etc.) are comparable across medical/surgical (physical health) and mental health/substance use disorder (behavioral health) benefits, including the following:
    - MCOs use of nationally recognized Utilization Management (UM) Medical necessity criteria sets that are transparent to the providers requesting services that require authorization.
    - Ensuring that levels of comparable physical health (PH) and behavioral health (BH) care have the same authorization parameters, e.g. physical/occupational/speech PH therapies are comparable to intensive outpatient and partial hospitalization BH services. If PCP visits do not require prior authorization then neither should psychiatric or behavioral therapy outpatient visits.
    - Those MCOs employ the same authorization patterns either per state contract requirements or equitably across comparable PH and BH services. The penalty for failure to obtain preauthorization must be no more punitive for BH benefits than it is for comparable PH benefits.
    - If utilization review is conducted by different entities/individuals for PH and BH benefits managed by an MCO, processes must be in place to ensure comparability in the standards used for UR and comparability in the independence and qualifications of the individuals performing UR.
    - If step-therapy or “fail-first” requirements are employed within a state contract or by MCOs they are applied equitably across comparable PH and BH services.
    - Formulary design and/or limitations are based on the same factors and applied equitably across PH and BH drugs Care/Case Management.
    - The state and/or MCOs cannot limit case/care Management services more stringently for BH illnesses than it does for PH illnesses. The factors utilized to identify members who are offered support to improve management of their health conditions must be applied equitably across PH and BH disorders network management.
    - The credentialing process is the same for comparable PH and BH providers, i.e., PCPs, psychiatrists, neurologists, other MDs have the same credentialing requirements.
    - Equitable levels of providers (PH & BH MDs; NPs and Licensed BH professionals; etc.) receive the same levels of Medicaid reimbursement − Also consideration must be given as to how this impacts value-based service contracts and provider incentives.
    - Equitable standards for comparable PH & BH provider admission to participate in a network.
    - Training needs for state Medicaid compliance regulators to enforce BH Parity.
    - The need for budget increases to cover any expansion of BH services to match comparable PH services within the benefit structure.

3. Several respondents recommended Audits to assure compliance

Recommendations to Increase Efforts to Improve the System

***MCOs*:**

1. MHD should require CMOs to demonstrate parity compliance as a component of the RFP response and to attest to their willingness to work with the State as a partner in compliance, including participating in external reviews of readiness for parity compliance. We also recommend that MHD work with CMOs to evaluate the State's guidelines and assure that state policy does not conflict with parity requirements. MHD should require uniform parity reporting from all contracted plans and conduct regular auditing to confirm parity.
2. MHD is encouraged to verify that the CMO is properly managed, adequately trained, and appropriately staffed to meet the obligations of the MHPAEA. We encourage MHD to consider an enforcement protocol for CMOs to ensure that financial requirements and treatment limitations are compared only to services that are within the same classification of medical or behavioral health service. We also encourage MHD to consider a protocol that verifies that CMOs are within compliance of quantitative and non-quantitative treatment limitations. Regarding clinical considerations, MHD is encouraged to consider an enforcement protocol that makes certain CMOs disclose their specific processes, strategies, and best practice standards utilized to determine how benefits are allotted. Specifically, it would be helpful to verify that NQTLS such as prior authorizations are granted evenly for both BH and PH-related events.
3. The CMO should make the criteria for medical necessity decisions for BH benefits available to any current or potential member, or contracting provider, upon request. The specific reason for all medical necessity and benefit denials should be delineated in the written denial notices to members and providers. When required, explanations of benefits (EOBs) also include payment denial reasons.
4. The State should develop reporting and enforcement protocols that are consistent with the federal regulations. Any requirements, however, in terms of the provision of services or administrative requirements must be matched equally with reimbursement to the health Plan. In many instances the expansion of services that is required to meet the new parity regulations will substantially increase the cost of providing BH as compared to historic experience and trends. Appropriate adjustment should be made and ongoing evaluation conducted to determine if assumptions and trends for the rate is consistent with actual experience.
5. There will be considerable operational, financial and clinical considerations for both MHD and MCOs. For this reason, we recommend beginning the SPA process with CMS as soon as possible, along with determining the increase in costs of parity compliance related to the above-stated items, as well as training needs for state Medicaid compliance regulators and budget increases to cover any expansion of BH services to match comparable PH services within the benefit structure.

Recommendations to Innovate

***Providers*:**

1. Under the current Managed Care system there is not parity between mental health and substance abuse; although, many times these issues go hand-in-hand. The state needs all access for addiction treatment. A board or non-connected oversight committee should be developed to provide accountability for CMOs.
2. MHD should consider establishing a standard of "psychosocial necessity" instead of "medical necessity" for the supportive services needed by members with Serious Emotional Disorders (child SED) and Serious Mental Illness (SMI).

Additional Recommendations

Provider: Fee-for-Service Medicaid has not raised behavioral health reimbursement for at least 25 years. This makes it difficult for Missouri to compete on a level playing field when it comes to recruitment of many types of specialized personnel.

Association: Psychologists should receive the same bonuses that physicians receive. The fact remains that mental health access is poor in Missouri because of our lack of support for it and because we maintain a false dichotomy between physician and other doctoral level professionals in healthcare.

Question 9: Empowering providers to implement desired changes in their individual practice's health care delivery

c: Describe successful programs to train and support health care providers to become better at care coordination.

Responses to Question 9c: 21 (6 Provider; 7 MCO; 3 Vendor; 4 Association; 1 Advocate)

Overall Recommendations

1. MCOs should train and support providers in a collaborative manner with tools and resources to address care coordination and minimize care gaps (possibly including provider incentives).
2. Transform local practices through PCMH certification or health home expansion and support access to and use of clinical data.
3. Require training by CMOs, offered free or at low cost, with incentives like CEU credits.
4. Implement ACO models or use similar approaches.
5. MHD should support ECHO and dissemination of provider-driven standards of care.

Recommendations to Increase Efforts to Improve the System

MCOs:

1. CMOs should have experience in developing comprehensive provider training plans to support all provider types, including training in key clinical areas like care coordination, care management, disease management, and population health management. Different providers require different training modalities. CMOs must offer multiple resources and touch-points to accommodate their needs. CMOs must work collaboratively with providers, prior to program implementation and ongoing, to assure they have the information, training, tools, and resources needed.
2. We offer care coordination tools, webinars, and personalized assistance to give providers the information and resources they need to deliver quality services. We support PCPs and offer training to inform about screening members for behavioral health (BH) needs and connecting members to appropriate supports. Training and supports for providers should include: integrating physical and behavioral health, using the latest nationally-recognized best practices as well CMOs new or updated clinical practice guidelines, recognizing co-occurring disorders (screening, assessment, and integrated treatment), and improving health literacy and informed health care decision-making.
3. To engage the provider community, training programs should address each provider type and include a variety of training methods such as in-person training, conference calls, written materials, online tutorials, live webinars, and ongoing personalized assistance. CMOs must demonstrate an understanding of the current Missouri health care delivery system and the issues that providers are experiencing to effectively develop training approaches. MHD should require CMOs to demonstrate their experience in training and supporting providers, including development and implementation of comprehensive training plans. CMOs must have training programs in place to address key clinical and service delivery areas such as care coordination, medical homes, disease management, and population health management. To augment these training programs, CMOs should be able to provide actionable information and technical assistance and support to its provider network.
4. CMOs must work collaboratively with network providers, aligning incentives and sharing information to improve member health outcomes. We utilize an active network account Executive (AE) team of clinical educators, a robust portfolio of value-based contracting models, and embedded staff in provider offices to facilitate information sharing. AEs work with providers and their office staff to communicate quality goals, ensure provider access to performance data, gather feedback on provider barriers and leverage additional Health Plan resources. AEs provide training on accessing member and panel-level information

so the provider knows which members are missing recommended services or have conditions requiring monitoring. The AEs also keep providers' offices informed of planned quality activities and priorities for the Health Plan, such as provider incentives for wellness visits. AEs assist providers to meet quality outcome goals. Providers can access a Web-based dashboard to track progress on each metric and produce self-service reports and drill-down data mining. The dashboard allows identification of frequent ER utilizers, readmissions, HEDIS results, care gaps, clinical risk and other member-centric data to foster outreach.

5. One of the means we use to support, inform and empower health care providers is through Clinical Practice Guidelines (CPGs) and Practice Improvement Resource Center (PIRC). Through these efforts we outreach and provide education and resources to participating providers, promoting engagement, better care coordination/management, disease management, and population health management. We use guidelines that outline best practices to better manage member care and foster improved care coordination, care management, disease management, and population health management. At least biennially, and as appropriate, we review and update guidelines, and disseminate newly approved or revised guidelines to all providers through provider orientations, reoccurring one-on-one provider visits by our provider relations team, the provider manual, provider newsletters, our secure Provider Portal, and targeted mailings.
6. We offer an online Provider Portal that makes patient care management easier for our providers. Eligibility verification, patient roster management, and submission of prior authorizations, claims, and referrals can all be accomplished through the Provider Portal. Adherence to the Missouri periodicity schedule is at the heart of a successful care management program. The Provider Portal identifies patients who are due for their periodic exams and other preventive services to enable providers to target their outreach and recall efforts. The online availability of key functions supports providers who have extended office hours and those who are open on the weekends. We also offer extended Provider Hotline hours to ensure network access to needed resources for members.
7. Many practices are interested in assuming direct responsibility for services such as care management, but may have barriers to do so. Transformation support is fundamental to a Practice's ability to assume additional responsibility, including access to data and in-practice support on how to interpret and use the data, and how to develop effective plans of care and engage consumers on an ongoing basis. Successful programs include a wide spectrum of supports that are customized based on individual Practices and their capabilities. In certain instances, practices require augmented resources until they are comfortable with assuming the responsibility on their own. CMOs should be able to demonstrate their experience in supporting system transformation as well as provide examples where they have enabled providers to assume additional responsibility.

Vendor: We have done in-house training by bringing in experts to conduct intensive staff training. Our staff then offers support for providers and educational materials on-line. We have also offered large training meetings for groups of providers, using free gifts and lunches as incentives.

***Providers*:**

1. There are a multitude of Care Management workshops and seminars available to providers. Require providers to maintain CEUs in their identified area of need or expertise.
2. Allow for opportunities in the RFP to build upon our success with super-utilizers and health homes. We are willing to discuss how we might share and replicate our care management expertise.

Advocate: A comprehensive care management team, including nurses and social workers can support PCPs to improve health care management. Missouri's "health home" model provides an example of how other professionals support PCPs to better manage and coordinate care.

Associations:

1. Local providers have the expertise to allow programs to address patients' needs. Providers are the best judges of the continued education or training needed to successfully implement these programs. CMOs that closely partner with providers will be better equipped to evaluate their needs and implement

supports. Telehealth is a promising means of connecting providers to experts many miles away. This is especially important in rural areas.

2. We have robust training to expand evidence-based practices to ensure quality BH care. Clinicians must use research, theory, practical experience, and a consideration of client perspectives. Publicly-funded BH systems are committed to using all available resources to provide the best possible services to consumers and families to promote their recovery and full community participation.
3. Providing free education on integrating topics would certainly help.

Recommendations to Innovate

***MCO*:** The MCO can embed an experienced case manager in a Practice to teach skills and mentor the providers on how best to utilize a CM. The MCO can train Practice or community based case managers using internal training programs and tools. Community and practice-based case managers can attend case rounds conducted by the MCO to discuss specific complex member issues. Joint Operating Councils, (meetings between provider and Plan staff), have been successful in teaching providers how to conduct data analysis for population health management.

***Providers*:**

1. ACOs are being very aggressive in educating their providers on care management and population health techniques. This education is essential to their success, and thus these programs likely are currently the most aggressive platforms doing this kind of provider education at present.
2. MHD should mandate education to drive each of these agendas. Providers would appreciate it if this was mandated but provided at no cost or a nominal cost. It is hard to hold people to standards unless they have received the proper training and understand expectations.
3. The requirements of the Patient Centered Medical Home certification program have had a significant impact on better coordination of care across the continuum. It's worth noting that the decision to pursue this certification and changes were all internal; no external education sources were required. Local providers are better suited to innovate and change the care delivery model in meaningful ways than outside organizations, such as MCOs.

***Association*:** The ECHO program, implemented at University Healthcare appears to be successful and based on provider-driven standards of care and best practices. It provides a mechanism for disseminating the information to practitioners statewide. Academic medical centers and public health departments and schools often offer continuing education regarding population health management. NCQA-accredited patient-centered medical homes also have demonstrated their effectiveness in modifying patient behavior and achieving desired health outcomes more efficiently. As their role expands to build on those successes, further investments in care management infrastructure will be needed to replicate those successes for patients with a broader range of costly medical conditions.

Additional Recommendations

Association: Work with the provider groups (e.g. MOPA, NASW---MO chapter, MMHCA) to help encourage their membership to become more sensitive to these issues. Make the relationship between these groups and MHD less adversarial and more collaborative. MHD and MCOs need to reach out to provider groups beyond just physicians. Provide financial rewards for compliance and expansion of services. Provide psychologists with the same bonuses that Medicaid offers physicians to increase interest in providing care to Medicaid patients. Medicaid patients generate more provider costs than do commercial patients, generally have a higher no show rate and generate more crises that a provider must manage, often without additional reimbursement. MHD and MCOs reimburse at a lower rate than do the commercial companies, resulting in less income for providers to mitigate the increased administrative costs under managed care. And there is the threat of audits under Medicaid that are stressful, time consuming and expensive, and not as common under commercial contracts. Allow psychologists to use patient extenders. Free psychologists from time-based codes.

Question 9: Empowering providers to implement desired changes in their individual practice's health care delivery

d: What should care management organizations do to incentivize and support health care providers to offer appointment times "after hours" and on weekends?

Responses to Question 9d: **16** (4 Provider; 7 MCO; 1 Vendor; 3 Association; 1 Advocate)

Overall Recommendations

1. Financial incentives such as higher reimbursement rates or per-member-per-month payments for providers for "after hours" and weekend appointments to address "return on investment" issues.
2. Non-financial incentives for providers.
3. Incentives for members to access appointments "after hours" and on weekends.
4. Incentives should be individualized to particular practices and locations in order to be most effective, for example shared savings, aligned incentives, and additional payments.
5. Lack of appointment availability "after hours" may drive ED utilization; practice level data may help determine when this is applicable and may help providers see the value in alternative hours availability (although without some financial incentive, this may not be effective).
6. MCO's strategies and record of success should be evaluated in the RFP.
7. MCO should provide education and outreach to providers to support "after hours" and weekend access.
8. Rural Health Clinics (RHCs) could partner with provider networks to offer after-hours care if MHD structures reimbursement to make it financially sustainable given the RHC cost-based structure.
9. Flexible hours could be used to accommodate evening or weekend appointments without increasing staffs' overall work week.

Recommendations to Increase Efforts to Improve the System

MCOs:

1. To incentivize and support "after hours" and weekend appointments, a Health Plan can:
    - Preferentially recruit practices that offer extended hours when setting up and expanding the provider network, including PCMHs and health homes with after-hours appointment availability;
    - Document hours of operation in the provider application process;
    - Host provider training sessions on extended hours and open access scheduling, and post this information to the provider portal;
    - Provide information to practices on the rate of ER utilization among their patients so that they can easily see the potential benefits of extended hours.
    - Conduct provider office visits to address access concerns one-on-one;
    - Conduct ongoing monitoring of appointment and after-hours availability;
    - Follow up with providers who do not follow appointment wait time and after-hour standards per our provider agreement; and
    - Use a provider Value-Based Care program to incentivize providers to offer extended appointment availability.

2. A Health Plan to share best practices with providers to improve appointment and after-hours availability. For example, one of our health plans worked with a family medicine practice whose members had a pattern of high ER utilization. The plan determined that this was partially attributed to lack of appointment availability at the practice. The plan recommended the implementation of an open-access appointment system. As a result, the provider realized a 10% reduction in ER visits among their patient panel and an improved no-show rate from more than 30% to 15%.
3. Timely access to health care, including "after hours" and on weekends, is important to achieving optimal member health and well-being. One obstacle we encounter with providers is their perceived lack of return on investment for extended appointment times. Providers who have established appointment times and office hours that do not include evenings and weekends are hesitant to expand due to infringement on their own quality of life and increased expenses. Moreover, providers may already have thriving and busy practices without extending their hours. Since specific provider incentive and engagement programs generally contain proprietary information, we would welcome follow-up discussions with MHD to further discuss potential obstacles and our solutions. We recommend that MHD include a question to evaluate a CMO's experience and success in increasing after hours and weekend hours in the RFP.
4. CMOs should incent providers, both through financial and non-financial means, to encourage non-traditional t after hours and weekend availability. We provide both financial incentives and non-financial performance awards to our top providers who offer greater access to care. We support innovative contracting arrangements that align financial incentives to improved member access to PCPs. To support continuous network improvement, we conduct continuous outreach regarding access and availability. This effort analyzes compliance with appointment availability, after-hours access standards, and network compliance with time, distance and cultural competency standards. Network expansion activities are taken when deficiencies arise, and provider engagement allows us to better understand access challenges. We publicly recognize providers for their outstanding performance and consistent support of our QI programs in key areas such as follow up after ER visits and routine preventive and well care services for both adults and children. Online availability of our provider portal supports providers who have extended office and weekend hours. We also offer extended provider Hotline hours to ensure provider access to resources.

Recommendations to Innovate

MCOs:

1. The first step in working with providers is to assess the community need and the provider's willingness to invest the resources required to provide after hour and weekend services (staffing, overtime, and other overhead costs). Each community may require a different model, including utilizing more mid-level providers (nurse practitioners, physician assistants), developing after-hour clinics in the local FQHC, telehealth or other options. All incentives should support the delivery of appropriate care and scheduling and not create any adverse incentives.
2. MHD can support CMOs in allowing for an enhanced fee schedule for after-hours care. CMOs can promote information on after hours and weekend care and can share "best practice" strategies that have worked in similar markets/environments. CMOs can also work with MHD and local providers to evaluate other available resources and how to work together to enhance the number of providers and bring more services into these counties through telemedicine, satellite offices or mobile clinics.

***Vendor*:** Perhaps the best incentive is to cover the operating costs associated with longer hours.

***Providers*:**

1. From a provider prospective, afterhours and weekend operations provide little return on investment unless reimbursed at commercial insurance rates or better. If MCOs intend to create any incentives for

providers to keep these hours, they will have to provide reimbursement rates that are significantly higher than those currently offered for seeing Medicaid patients. They will also have to provide incentives to members to visit a provider on a Saturday or late evening. This goes against the standard MCO model and will not allow them to deliver shareholder operating margins.

2. MO HealthNet Division will have challenges in providing the required incremental funding unless and until Medicaid eligibility is expanded in Missouri. We feel confident this will be one of the keys to creating the additional revenue, through federal funding mechanisms, required to create incentives for providers without creating an additional budget burden for the state.
3. When there is enough volume for providers to have their financial needs met during the daytime and weekday, there is no incentive to work on evenings or on weekends. Providers would need to be incentivized to deliver services during non-traditional hours. For example, in the hospital we provide a 2nd shift incentive for working the 3-11pm shift, and an additional incentive to work overnight. A similar structure would be needed to incentivize after hours/ weekend appointments.
4. Increased rates are needed for providers seeing patients after hours and on weekends. Identify the geographic or demographic needs of the providers and respond appropriately.

***Advocate*:** CMOs can contract with urgent care clinics and safety net providers to expand the scope of their hours during the week and on weekends. MHD can also provide additional per-member-per month payments to organizations that provide such after-hours care.

***Associations*:**

1. After-hour clinics have been tried with some success as a means of reducing inappropriate emergency room visits. The provider reimbursement, however, is insufficient to justify their existence in many instances. Rural Health Clinics could partner with provider networks to offer after-hours care. MHD will have to consider how to structure reimbursement to make after-hours operations financially sustainable for RHCs given their cost-based structure.
2. As an incentive, CMOs should provide an enhanced reimbursement rate to physicians or other mental health providers for routine, after-hours appointments. Another example would be providing an incentive payment to providers who demonstrate a reduction in inappropriate utilization of ER visits over time among their consumers.
3. Flexible scheduling of office hours to encompass times before and after normal working hours could provide some opportunities. Incentives to offer more access during off-hours could be targeted to FQHCs and Rural Health Clinics, whose cost-based reimbursement systems would provide a funding mechanism if sufficient staff capacity were available. MHD vendor contracts could provide incentives for services delivered in urgent care centers to curtail unnecessary emergency department use. MHA members indicate that the use of non-physician practitioners to expand access to services already has been implemented to capacity with the confines of current law.

Question 10: Managing the one-time costs of converting a FFS population to managed-care

Currently, capitation payments are made to MCOs at the end of each month that a person is enrolled. Health care providers can bill MHD for fee-for-service enrollees up to two years after the date of service. Therefore, when people currently enrolled in fee-for-service are moved to coverage by MCOs there will be a substantial period of time during which MHD is paying both the current capitation rate and the claims for services provided during the previous months when the person was still in fee-for-service. This is referred to as "claims run out". MHD estimates the cost of the claims run out that will occur when moving the remainder of the low income custodial parents, pregnant women, and children covered in fee-for-service to coverage by MCOs to be $114 million. What can be done to mitigate this one time claims run out cost?

Responses to Question 10: 15 (MCO-7, Provider-3, Association-3, Advocate-2, Vendor-0)

Overall Recommendations

Both MCOs and Associations proposed that, in order to mitigate cash flow, MHD delay capitation payments for 1-2 months to Managed Care Organizations; Missouri approached the cash flow issue in this way during the introduction of Managed Care in 1995.

Recommendations to Increase Efforts to Improve the System:

***MCOs*:**

1. In the first year of the program, withhold the first two months of capitation payments to the CMOs and pay the withheld amount over the last ten months of the contract year spread evenly—1/10th of the withheld amount per month.
2. Change the timely filing requirements for initial claim submission and adjustments, and decrease the final adjudication limit from two years to one year, consistent with federal regulations on timely claims submission (42 CFR 447.45(d)(1)).
3. Slow down claims processing time for FFS run-out claims to extend the period these claims would be paid, and spread out the impact of "double paying". This option places the cash flow issues on the providers of service.
4. Implement out-of-network default rates to promote good faith contracting between CMOs and provider systems within MO HealthNet.
5. Contract with CMOs to administer the claims run-out independently of the managed care contract.

***Provider*:** Since initiative will save the state over 100 million dollars per year. For the first two years the savings could be applied to these claims.

***Advocate*:** Alleged savings are negated by substantial transition costs. Plans should not insist on immediate payment while the State is still paying fee-for-service claims.

***Associations*:**

1. Automatically enroll all providers into the new managed care programs. Providers would have the right to opt out, but the presumption is that providers would continue to provide care.
2. There has to be heavy legal consequences for companies who after their contracts have ended fail to pay providers for services that happened before the managed care contract ended.

Recommendations to Innovate

***Provider*:** MHD should follow the bundled payment model(s) already in place with CMS, and not convert to a capitated payment model; cash flow would be more similar to the current fee for service model, with reconciliation of any over- or under-payments on a periodic basis.

Additional Recommendations

Association: Contracts should include a simple and clear provision that all legislative and rule requirements of Missouri Medicaid apply to their operations and services, and that there is no implied license to contractually legislate or regulate a different standard of care or professional services than the legislature intended for Missouri's citizens.

MCO: MHD should implement certain cost savings measures such as capping or limiting excessive hospital reimbursement for non-emergent ER visits.

Question 11: What can be done to minimize state and provider disruption, expense, and administrative burden when managed care plans change ownership?

Responses to Question 11: 13 (MCO-7, Provider-3, Association-2, Advocate-1, Vendor-0)

Overall Recommendations

1. Managed Care Plan ownership changes periodically occur in any market as a normal course of business and the changing environment of health care makes this a continuing issue. Transitions in MCO ownership affect members, in addition to providers and MHD.
2. The RFP should obligate continuity of health and business operations and policies by the acquiring entity (new owner) for a specified period of time.
3. The RFP should require that the acquiring entity provide a transition plan from both seller and buyer, subject to state approval, which addresses:
    a. **Health Operations**: mandate consistent operations (referrals, pre-certifications, credentialing, etc.) including:
        - Aligning networks—require acquiring entity to maintain the acquired provider network with existing contract terms for a period of time to ease the transition for providers and participants;
        - Assuring Continuity of Care–require a period in which the acquiring entity must maintain provider relationships and care plans to minimize disruption:
        - Assuring that credentialing risks and administration burdens not be transferred to the providers; and
        - Honor the former entity's prior authorization protocols for a period of time.
    b. **Business operations:** (claims, call center, documentation of open issues, etc.)
        - Obligate transfer of relevant data from the previous owner;
        - Maintain external facing telephone numbers for both members and providers; and
        - Transfer provider contract and terms to the acquiring entity.
    c. Reporting:
        - Obligate transfer of relevant data from the previous owner; and
        - Hold both parties liable for missing data when it affects stakeholders.
4. The RFP should require the acquiring entity to provide a communication plan from both seller and buyer, subject to state approval, which addresses:
    a. **Provider communications**
        - Claims submission changes,
        - Designated phone line and contacts for questions regarding the transition, and
        - Other material changes to processes.
    b. **Member communications:**
        - Include information regarding opportunities to switch plans, and
        - Primary care provider changes.
5. A "readiness review" should be conducted prior to approving the transition.

Recommendations to Increase Efforts to Improve the System

MCOs:

1. Book lost savings to the State against the acquiring entity.
2. The acquiring plan can be expected to bear the direct costs of preparing and publishing associated provider and member notices, legal costs incurred by the State, cost of software modifications, and all other costs to be borne by the buyer or seller as a condition of State approval.
3. Disruption and added expense can be mitigated by ensuring the CMO spends adequate time planning for the change, and any process changes that need to take place. Comprehensive transition and communication plans should be developed by the acquiring CMO with input and approval from MHD. MHD could require all involved parties to produce a detailed transition plan that addresses contracts, credentialing, data collection and a timeline for confirming the transition steps.
4. Consider adding provisions to the CMO contract that, in the event of a change in ownership, the purchaser is obligated to maintain continuity of care and operations in a manner that is consistent with the terms of the contract.
5. Require a continuity-of-care period in which the acquiring entity must maintain provider relationships and care plans to minimize disruption. These continuity-of-care periods, however, must be complemented with capitation rates that are consistent with the original entity and do not apply any new savings that the State believes would be applicable to the acquiring entity.
6. Recommend that MHD update the contract language in the CMO agreement to clearly communicate expectations, requirements and roles and responsibilities for all stakeholders in the event of a transition.
7. Network alignment expectations can be set to ensure network adequacy and access to care, requiring the acquiring Plan to mirror the historical plan network for a period of time.
8. Recommend MHD require all relevant data be collected from the previous owner.
9. Require a 90-180 calendar day written notice to the State of any proposed change in ownership.
10. Streamlined administrative processes and HIE data sharing would mitigate the transition issues.

Providers:

1. Mandate consistent operations (referrals, pre-certifications, credentialing, etc.) for managed Medicaid members and providers, regardless of the payer. This will likely reduce costs associated with ownership changes. Unfortunately, it will likely serve to reduce innovation and reform as well.
2. The transition period needs to be clear and well thought out for providers and Recipients to make sure members are not the losers during the transition.
3. Make sure accountability for CMOs is done on the front end and not after it is identified as a problem a few months into implementation.

Advocates:

1. Focus first and foremost on what will minimize disruption and maintain health access for beneficiaries, rather than providers or the State.
2. Allow Medicaid beneficiaries to disenroll from any plan and/or opt out of managed care altogether whenever there is a change in ownership.
3. Ensure that participants are allowed to continue with their current providers, either by requiring the plans to continue to contract with the same providers under the new ownership and/or requiring them to reimburse those providers out-of-network.

4. Mandate that all managed care providers also accept Medicaid on a fee-for-service basis.

***Associations*:**

1. Standardized utilization review protocols, data submission standards and other operational processes and metrics applicable to all MCO vendors would help mitigate the disruption caused by change of ownership.
2. Could require MHD approval of a detailed plan for the administrative transition prior to change of ownership.
3. MCOs should be completely transparent about changes and provide constant communication with providers about all changes. Additionally, MCOs should be responsive to any concerns made by providers or members. The burden should be on the Plan for administrative changes, and there should be plenty of lead time.

Recommendations to Innovate

***Provider*:** The state needs to proceed with caution to make sure all CMOs have an extensive and comprehensive provider network. During the last rollout this was not the case in many of the rural counties. Due to these poorly supported networks recipients had to travel hours to get to their desired appointment or area of specialization.

Additional Recommendations

MCO: For companies that are publicly traded, MHD should specifically exclude beneficial ownership changes that occur through the normal sale of stock on the market for investment purposes only, or fluctuations in total shares of stock that impact ownership percentages, but do not impact or influence the management of the organization.

Question 12: What can the MHD do, through its contracting practices and the duration of the contract, to minimize disruption for participants and maximize efficiencies for care management organizations in the future, particularly with regard to future MO HealthNet eligibility expansion and other opportunities for care management expansion?

Responses to Question 12: 12 (MCO-7, Provider-2, Association-2, Advocate-1, Vendor-0)

Overall Recommendations

1. Four MCOs recommend extending the contract period to 3- 5 years with optional renewals. The benefits of an extended contract term include:
    - Minimize disruption to members, providers, and MHD.
    - Maximize benefits to state and stakeholders:
        a. **Improved access**: Permits full development of relationships with members, providers, stakeholders, MHD, and other partners necessary to create system changes and enhancements.
        b. **Improved cost effectiveness**:
            i. MHD's and the CMO's ability to achieve program goals and desired fiscal predictability and stability.
            ii. Many of the innovations and reimbursement policies, including incentives and risk sharing, take time to establish and time to develop results.
        c. **Improved quality**: More robust data gathering to rigorously evaluate performance, make adjustments as indicated, and gauge the impact of quality improvement projects and other tests of innovation.
        d. **Improved workflow/relationships**: A longer contract period allows for the development of robust programs and investments in the health care community.
2. A mix of MCOs and Associations advocated for avoiding another reprocurement in the event of eligibility or benefit expansion. The benefit of rolling such changes into the existing RFP is a functioning infrastructure from the existing Health Plans that will lead to increased savings for the State and improved health outcomes for the new members.

Recommendations to Increase Efforts to Improve the System

***MCOs*:**

1. MHD should consider a minimum contract length of three to five years, subject to two optional 12-month extension periods, supports:
    - Full development of relationships with members, providers, stakeholders, MHD, and other partners necessary to create system changes and enhancements,
    - Both MHD's and the CMO's ability to achieve program goals and desired fiscal predictability and stability, and
    - More robust data gathering to rigorously evaluate performance, make adjustments as indicated, and gauge the impact of quality improvement projects and other tests of innovation.
2. MHD should extend the length of the contracts to five years. Many of the innovations and reimbursement policies, including incentives and risk sharing, take time to establish and time to develop results. In addition, CMOs are most successful when they are imbedded in the community as full

partners, which also takes time. A longer contract period allows for the development of robust programs and investments in the health care community.

3. It is critically important for both MHD and the Care Management Organizations that termination rights under the agreement are clearly articulated.
4. During the term of the care management contracts, if additional populations, or newly eligible members in existing populations are included in managed care, MHD should not issue a new RFP. Instead, it should simply add new members to the existing contracted CMOs through an open enrollment period.
5. MHD should provide notice in the upcoming RFP that there is potential for additional populations and new eligible membership to be included in the contract via a contract amendment so that all potential bidders have clear notice that this is an option moving forward. Most ACA expansion populations were rolled into existing state managed care programs and plans over the last two years with no separate procurements.
6. MHD should focus on coordinated communication efforts with providers, MCOs, and Advocacy Groups to minimize disruption for members and maximize efficiencies for CMOs through transitions and expansions of Missouri's health programs. This approach ensures that all parties are aware of expansion efforts and can coordinate with MHD to address any potential obstacles or barriers prior to the transition.
7. MCO contracts should require a plan to operate statewide in order to avoid disruption when members move or providers cross arbitrary bounders established by a regional design.
8. Federal law requires states to provide CMOs with actuarially sound prepaid capitation payments, meaning the payments must be adequate to ensure health plans can cover medical costs, administration, taxes and fees. This actuarial-soundness requirement is important because it ensures CMOs are paid in a way that protects the stability and sustainability of the Medicaid program by adequately reimbursing plans based on the cost of health care expenditures and populations served. Actuarial soundness is an important tool for retaining the viability of Medicaid managed care as an alternative to fee-for-service delivery systems.

***Provider*:** There should be a transition period in which all providers can bill the new MCO and receive the Medicaid rate until the provider can be established in the new network. With this plan in place there will be no lapse in service for Member and no lapse or denial of reimbursement for the provider.

***Associations*:**

1. The contract must factor in the possibility that Missouri may be selected as a demonstration state and have certified community behavioral health clinics (CCBHCs). This will require the establishment of a Prospective Payment System (PPS) and that payment methodology could be paid to providers in a variety of ways, including sub-capitation.
2. The RFP could be structured to permit expedited review of bids to add enrollees to the Medicaid system pursuant to eligibility changes authorized by the General Assembly. This expedited process could focus on variances of premiums and actuarial risk based on the enrollees' higher levels of income.
3. The RFP could permit retrospective risk-adjustments to premium payments based on the claims experience of those added populations. This would shorten the delay in implementing these changes because of contracting and bidding requirements.

Recommendations to Innovate

***MCOs*:**

1. Through clear notification in the upcoming RFP as to the potential for new services to be included during the life of the contracts, and then subsequent contract amendments to add in new services, these

programmatic expansions can be accomplished without disrupting the continuity of care and services to existing members. MHD will gain efficiencies by adding services in an integrated program approach as opposed to carving out services.

2. MHD can substantially minimize disruption to members and ensure efficiencies for CMOs by reducing population-specific requirements to a minimum as new populations are transitioned to Managed Care. While certain population-specific requirements are necessary, these should be kept to a minimum to allow for consistency between populations and to allow for market acceptance across populations.

***Provider*:** On benefit packages, implement participant cost sharing (e.g., co-payments).

***Advocates*:**

1. Individualized counseling for individuals to understand the implications of change and are assisted in making the choice of plans that works the best for them.
2. MHD must also be aware that it needs to provide educational materials that all individuals can understand and provide those materials in alternate formats where needed.

Additional Recommendations

Association: Missouri should very carefully consider how to define eligibility and implement initiatives for the vulnerable population. It is necessary to have clarity and consistency to ensure that medically complex individuals, including those with serious mental health and substance use disorders, can access benefits that provide the services necessary to meet their health needs.

MCO: Re-procurements favor incumbents if the plan is performing on all these critical areas and are aligned to state priorities such as payment reform. Long term partnerships allow for the hard work of year-over-year quality improvement, often in program-wide quality initiatives, minimize the significant cost and distraction (for the state and the Plans alike) of more frequent procurements and engages all stakeholders to work collaboratively within this program design.

Advocate: The State must design an enrollment process that addresses the needs, desires and concerns of every Medicaid enrollee changing from their existing health plan to a care management organization.

***Vendor*:** An automated real time data system with all of participant's data can help with a transition.

Question 13: What cost saving improvements could MHD make to its inpatient and outpatient rate setting methodologies, physician and outpatient fee schedules, or benefits packages?

Responses to Question 13: 11 (MCO – 4, MCO Dental – 1, Advocates –2, Providers –2, Association –1)

Overall Recommendations

1. ***Inpatient Reimbursement***:
    - Develop DRG reimbursement for inpatient admissions to make payments based on diagnosis factors and hospital base rates, and modernize the payment methodology using national data. Eliminate per diem reimbursement to better manage unit cost trends. It will decrease providers' ability to eke out higher reimbursement through Charge Master or length of stay manipulation. This would also help MHD better manage unit costs for outlier cases.
    - MHD and CMOs should place limits on the CMO contracting surcharge that some larger hospitals have imposed. CMO payments to these hospital systems can be well above the FFS Medicaid rate. Other states have already implemented limits on the hospital contracting surcharges, such as Florida (120% limit).
    - In addition to a fixed schedule for hospital services, create a hospital franchise fee or hospital pass-through that can provide additional compensation to those providers that serve a disproportionate share of Medicaid participants.
2. ***Outpatient Reimbursement***:
    - Change the outpatient payment methodology to something other than percent of billed charges. Consider a fixed fee prospective outpatient payment system like the Ambulatory Payment Classifications (APCs). Information regarding APCs can be found at this link: http://www.acep.org/Clinical---Practice-Management/APC-(Ambulatory-Payment-Classifications)-FAQ/ .
    - Adjust rates paid for certain services when provided in hospital outpatient departments (HOPDs) so they more closely align with the rates paid in freestanding physician offices. Under current policy, Medicaid usually pays more for services in outpatient departments even when those services may be performed safely in physician offices. For example, Medicaid pays more than twice as much for a level II echocardiogram in an outpatient facility ($453) as it does in a freestanding physician office ($189). This payment difference creates a financial incentive for hospitals to purchase freestanding physicians' offices and convert them to HOPDs without changing their location or patient mix.
    - Continue exploration into revising the hospital outpatient reimbursement methodology to closely mimic Medicare's outpatient methodology. This would reduce administrative complexity and expense associated with hospitals' need to manage two complex and inconsistent payment systems for outpatient services.
3. ***Emergency Department (ED) Reimbursement***:
    - Allow CMOs to use Prudent Layperson (PLP) rules and develop a triage rate for EDs. This change would reduce unnecessarily high ED payments for conditions or services that are not emergencies, and which could have been more appropriately treated at a lower triage reimbursement in an alternative setting. This would allow MHD to be consistent with the Low Acuity Non-Emergency (LANE) adjustment incorporated in the capitation rate development. This would also encourage hospitals to collaborate with CMOs and MHD to find solutions for unnecessary ED overuse, lower costs and encourage members to establish primary care homes to increase quality.

Recommendations to Increase Efforts to Improve the System

MCOs:

1. Cost savings improvements in provider rate setting could include value-based programs, pay-for-performance incentives, ACO-type global fees, PCMH, chronic care management, and payment mechanisms based on conversion factors relative to the Fee Schedules applicable to Missouri.
2. If a provider will not contract with a CMO, reimburse that provider at 90% of the MHD FFS Fee schedule. This would help ensure reasonable contracting, especially in monopoly regions where renewal unit cost increases can become unacceptable from a Medicaid pricing perspective.
3. For states that direct their CMOs not to negotiate provider reimbursement above the FFS fee schedule, two benefits are achieved: 1) costs are contained initially and over time by avoiding rate pressures driven by provider negotiations; and 2) providers who want additional payments are more motivated to enter into value-based contracts to access incentives, thereby supporting system transformation.

***MCO Dental*:** The State should implement an adult dental benefit designed to reduce the need for costly ED care. This could be a minimal preventive services benefit including two exams, two cleanings, one set of x-rays per year, and a capped dollar amount for restorative care.

***Advocates*:**

1. MHD should require all providers that accept Medicaid through one or more MCOs to accept Fee-for-Service payment as well. Without this revision, participants may be unable to easily establish themselves with a provider who can continue to serve them as they transition from one form of payment to another.
2. MHD could also streamline the enrollment of individuals into MCOs after they are approved for managed care. MCOs currently have 7 days to enroll pregnant women from notification of enrollment or 15 days for all other participants (RFP B3Z15077 2.12.15(b)). To promote the continuity of care for participants and consistency it would be advisable to reduce the enrollment time to 7 days for all individuals.

***Association*:** Serving individuals with behavioral health conditions and other chronic illnesses in community settings may improve compliance and satisfaction with treatment. The payment should reward appropriate level of services.

Recommendations to Innovate: N/A

Additional Recommendations

Providers:

1. Low physician reimbursement by MHD is a problem in Missouri and a Kaiser Foundation report shows that *all* of MHDs services are 13% below the national average. Lowering provider fees is not a viable means to contain costs, especially given provider access problems.
2. MHD's FFS reimbursement for behavioral health services is one of the lowest in the nation. The previous managed care rollout allowed CMOs to undercut the FFS rate which drove away many professionals. Incentives should be in place to reward efforts to reduce inappropriate utilization.

MCOs:

1. MHD should ensure that all codes are routinely updated in the fee schedule, especially non-specified codes. Currently non-specified (dump) codes are manually priced at a percent of charges since they are not included in the fee schedule.
2. Fee schedules should be updated once per year and announced 90 days in advance of the effective date. This will ensure that CMOs have ample time to update their system, claims are paid accurately, capitation rates are accurate, and provider complaints are minimized.
3. CMO Kick Payments: There should be two low birth weight kick payment rates: Low Birth Weight (1,501 – 2,500g) and Very Low Birth Weight (<1,500 g).

Question 14: What other options for care management should MHD consider in order to reach the goals listed in the introduction in addition to, or as an alternative to, contracting through capitation payments for the full medical risk to traditional managed-care insurance companies, as is done in the MO HealthNet Managed Care Program today?

Respondents to Question 14: 14 Respondents

Overall Recommendations

1. MCOs advocated for continuation and expansion of full-risk, capitated care management.
2. Providers, Associations and advocates recommend that MHD explore new provider-driven models (Health Homes, PCCM, ASOs, etc.), and requested more timely and accurate data-sharing by MCOs to providers and MHD.

Recommendations to Increase Efforts

***MCO*:** Full-risk managed care is the most effective approach to achieving the State's goals, ensuring program sustainability and systemically driving transformation while insuring budget predictability. It also leverages innovations that would be unattainable without the infrastructure of managed care, and engages providers through value-based reimbursement models. MHD should:

- Expand MCO care management to Medicaid populations not now covered, (Aged Blind and Disabled) and expand services (pharmacy and long-term care) for better coordination;
- Collaborate with MCOs to meet clinical and cost saving goals in areas such as shared quality improvement, combatting member and provider fraud, and providing joint training/education in topics like disease management, helping primary care providers identify/ treat depression, etc.;
- Support new MCO entrants into MHD programs by limiting the number of CMOs in each region to maintain a sustainable membership threshold of 50,000-60,000 members, and allow new entrants time to establish operations, gather data and make targeted performance improvements;
- Require that all CMO entities (ACO, CMO, HMO, etc.) be licensed by the Missouri Department of Insurance to bear full financial risk;
- Maintain the same Member, Provider and taxpayer safeguards currently in place, including full-financial risk management, maintenance of adequate reserves, and meeting access and availability standards for any entity providing care management;
- Implementing pay-for-performance premium withholds to ensure contract compliance; accreditation from a national organization; implementation of a Quality Assessment and Performance Improvement Program that includes a comprehensive QI Committee Structure; routine reporting to MHD on service process and health outcome metrics; MHD secret shopper and External Quality Review audits; monitor Member Satisfaction through CAHPS surveys and track grievance and appeals; implement multidisciplinary Care Teams; monitor fraud, waste and abuse; and hold each delivery model to the same standards of operation.

Providers, Associations and Advocates:

1. Require MCOs to provide timely cost and claims data to providers to improve care delivery and health outcomes;
2. Demand a program that holds MCOs and CMOs accountable through financial rewards and risk-sharing strategies; and
3. Require full transparency in reporting performance data and costs; and
4. Expect that an extremely high percentage of payments to CMOs are spent for patient care, not administration, marketing and profits.

Recommendations to Innovate

Association: MHD should consider contracting with other care management entities such as ACOs or independent practice groups to incentivize providers to develop practical and lasting improvements that reward Providers for delivering quality care and managing BH and other chronic conditions more effectively. Providers should take the lead in defining how care should change and the payment changes needed to support it since Providers are in the best position to define changes in care that will reduce costs and improve quality.

Dental MCO: MHD should consider implementing a dental benefit program management (DBPM) model, estimating that it could save between 5% and 10% of current costs. It indicated that keeping dental separate from medical care is crucial for program accountability and that allowing medical MCO Plans to manage the dental benefits under an "integrated plan" dilutes the State's efforts to increase its financial commitment to dental services and results in duplicative administrative costs since most MCOs subcontract with a dental plan to manage the benefit.

***Provider*:** MHD should consider partnering directly with Providers. The state should expand Medicaid under ACA to finance these new collaboration models. Otherwise, the State should temporarily invest new monies to support initiatives that help MHD and Providers innovate to make long-term improvements that cut costs without irreparably harming the State's Providers.

***Advocates*:**

1. Medical Homes, ACOs and PCM programs all involve care coordination, one of the most effective ways to achieve higher quality care and cost control. MHD should consider models that ensure robust networks, sufficient payment for care coordination services, and retains the use of fee-for-service payments for people with disabilities. These key elements could be found in a PCCM and ACO models.
2. MHD should not pay MCOs or providers a capitated rate for Medicaid services to people with disabilities. The current FFS model does not discourage providers from providing the appropriate level of care, and it protects people with disabilities better than risk-based models. However, a missing component of the traditional FFS model is payment to primary care providers for care coordination that often must happen outside of the actual medical visit. It may benefit a patient with multiple chronic conditions to have his PCP contact specialists serving the patient to make sure that everyone knows what medicines are prescribed or what procedures have been ordered. MHD should consider a payment system that pays providers for this coordination.
3. Since House Bill 11 authorizes statewide expansion, but not a particular type of care management model, MHD should examine whether other management models might work better in some areas of the State. Recent state studies found lower overall cost (1.7%) with managed care, but significantly higher care management and administrative costs (149%). MHD data indicates that MCOs achieved fewer hospital admissions and shorter lengths of stay, but more readmissions after discharge and more ER visits, as well as fewer outpatient visits, and did worse on 10 of 18 clinical quality measures. Further, MHD consultants found no significant difference in access to, or quality of care, between managed care and fee-for-service for the non-disabled population, indicating that "in all cases, the differences were very slight with no clear advantage for either of the delivery systems". It further indicated that a higher percentage of children receiving well-child exams were referred on for treatment in fee-for-service settings than in managed care. Some states have found non-capitated programs to be more cost-effective than capitated programs while providing comparable or better access than that available under capitated programs. Connecticut has achieved improvements and savings switching from a capitated MCO model to a medical home model for its Medicaid population. New data from North Carolina shows substantial cost-savings ($78 per quarter per beneficiary) and significantly improved health outcomes through using that state's PCCM program with greatest savings in the use of inpatient services. Missouri's existing Health Home model also indicates that there are successful non-capitated models for serving higher-cost populations.

Other Recommendations

***Provider*:** MHD can drive down costs and reduce member transportation costs and missed appointments by incenting in-home appointments for medical and behavioral health.

***Research Vendor*:** "Provider Numbers" should be collected on MCO claims, and MHD should collect actual cost data to enable researchers and evaluators to better understand and compare the true costs and savings. When MHD contracts with a third party to manage healthcare for a segment of the Medicaid population, it loses important data currently available through its FFS paid claims data base. MCO-submitted data is not as robust as FFS claims data.