MO HEALTHNET MANAGED CARE
QUALITY ASSESSMENT & IMPROVEMENT ADVISORY GROUP
February 18, 2016
Harry S. Truman Building
301 West High, Room 490
Jefferson City, MO 65101

MO HealthNet Division
Rhonda Driver
Helen Jaco
Tim Kling
Paul Stuve
Eric Martin
John Dane
Rebecca Logan
Valerie Howard
Melody Webb
Crystal McNail
Renee Riley
Mike Popa
Beverly Smith
Lori Bushner
Kathy Brown
Stacie Gibson
Sidney Wilde
Mary Ellen McCleary

Home State Health Plan/ Cenpatico
Wendy Faust
Kristie Dempsey
Alissa Weber
Annie Brozio
Kristie Dempsey
Steve Jones
Susan Nay
Megan Barton
Daniel Dubois
Dana Houle

Missouri Care
Ron Lacey
Janet Hagan
Mark Kapp
Ron Lacey
Justin Cramer
Melody Dowling
Shari Riley
Jacqueline Inglis
Russell Oppenborn
Louis Gianquinto

Aetna
Cherie Brown
Laura Ferguson
Carol Stephens-Jay
Debbie Fitzgerald
Sheryl Salaris
Albert Satcher
Brian Dobbins

Primaris
Robin Corderman
Sandy Pogones

DentaQuest
David Thielmier
Aaron Washburn

Behavioral Health Concepts
Amy McCurry Schwartz

MO Coalition
Cindy Davis

Dept. of Mental Health
Natalie Fornelli
Stephanie Moore

DHSS
Wayne Schramm

Children's Mercy Pediatric Care Network
Candace Ramos
Shanna Widener

Great Circle
Pam Victor

Mid-MO Legal Services
Steve Kuntz

Legal Services Southern Missouri
Johnda Boyce

Legal Services Western Missouri
Emily O'Connor

Legal Services Eastern Missouri
Tiajuana Henderson
Lucan Caldwell-McMillan

Agenda Items	Discussion	Actions
Welcome **Introduction** **Minutes**	Wendy Faust, Home State Health Plan, MO HealthNet Managed Care Quality Assessment & Improvement Advisory (QA&I) Group Chair, opened the meeting at 9:00 am. Minutes from the October 2015 meeting were approved by Steve Kuntz. Helen Jaco introduced herself and provided a history of her job experience. Dr. Dane introduced himself as well and provided a history of his experience with Medicaid.	
Managed Care RFP Access/Secret Shopper Survey	Helen Jaco started by stating the state of Missouri will issue a Request for PFP this spring to begin the process of moving Missouri's Medicaid system to a statewide managed care system for low income custodial parents, pregnant women and children. It will be split into four regions. The expansion will provide health care to rural areas. The Eastern and Western regions will stay the same. The Central region expanded both to the north and south. The Southwest region was created for the purposes of adequately distributing the population amongst the health plans. The development of the Southwest region eased the changes in the system for MMIS. Ms. Jaco provided an update of the planned statewide managed care timeline. The anticipated date of managed care going statewide is May 1, 2017. The plan is to award three health plans with contracts and for them to be renewed annually for five years. Once the new contracts are awarded, the capitation payments will be delayed for the first two months. The current benefits being provided will continue in the same manner. For example, the services that are currently carved out will remain the same and dental benefits will be included in the same manner as the current MC contracts. She discussed several of the RFI concepts that the stakeholders submitted during the RFI process that will be included in the RFP. Ms. Jaco provided the group with an update on the results of the Health Plan Website Accuracy and New Patient Acceptance Rates Survey. The required 90% for these SFY 2016 Managed Care Contract Performance Withhold Program metrics was not met. The new patient acceptance rates for Primary Care Physicians ranged from 42% to 72% and from 26% to 63% for Psychiatrists. The website accuracy for PCP contact information ranged from 44% to 80% and Psychiatrists' information ranged from 43% to 63%. Wendy Faust asked if the health plans would be receiving a detailed report. Amy McCurry stated that MHD has the report. Ms. McCurry responded the report is detailed and broke out into individual health plans but not by regions.	-The report will go through internal review and will be provided to the health plan.

Performance Withhold Program Encounter Claims	Prior to today's meeting, each health plan was asked to submit questions they had in regards to the performance withhold program. Valerie Howard responded to each of the questions that were submitted. For Performance Metric 1-Encounter Data Completeness/Accuracy, the health plans did not have any questions. Ms. Howard stated that we do not plan to decrease the 98% threshold for encounter claims. She added that the health plans are currently meeting the required 98% in the majority of the regions; therefore, the threshold will remain the same for the SFY 2017 contract renewal period. Steve Jones, Home State, asked how the financial period was defined. Valerie Howard and Rhonda Driver stated that it is the public financial cycle that is submitted bi-monthly. The health plans will be notified of their performance for the second quarter in March and the payment will occur in April. Lou Gianquinto, MO Care, asked if there would be any financial penalties for quarter two performance. Ms. Howard and Ms. Driver responded that it is yet to be determined as MHD does not know the quarter two performance rates. For Performance Metric 2—Provider Panel, the Health Plan Website Accuracy and New Patient Acceptance Rates Survey Report will soon be provided for compliance with the first part of the performance metric 2, directory accuracy/completeness. The second part, wait times, has yet to begin. . Ms. Howard provided the health plans with the questions that will be asked when Behavioral Health Concepts (BHC) conducts the appointment wait time's portion of performance metric 2. Amy McCurry stated that they plan to start assessing the wait times in March and should be completed in six to eight weeks. Justin Cramer, MO Care, asked if BHC would pose as a health plan member. Ms. McCurry stated they plan to categorize providers and not call the same provider multiple times but will call the same provider for each health plan. They are planning to pose as case workers, calling on behalf of a client who is moving into the area and not members. Steve Jones, Home State, stated there shouldn't be different wait times for different health plans. He questioned what the plan was if there are differences in wait times for the health plans. Ms. McCurry stated that the physicians should meet the standard in the individual health plan's contract. Steve Jones, Home State, stated it would make sense to count the wait times across all three health plans for the providers that are shared. Rhonda Driver, MHD, stated that she disagrees with Mr. Jones' suggestions. MHD is interested in physician access for FFS and Managed Care. The providers respond differently to the health plans and this report will allow MHD to see that. Ms. Driver encouraged the health plans to share the results of the surveys with the providers to encourage change in their practice. Ms. McCurry assured the health plans that they are going to call a statistically significant number to help weed out the randomness in the results. Dr. Stuve, MHD, added that BHC should not make all the calls for one plan on the same day. Ms. McCurry stated that they will keep track of all of the responses from the providers so it can be reported after an internal conversation occurs. Jacqueline Inglis, MO Care, asked what the script would look like when the call is made. Ms. McCurry stated that they are going to pose as a case worker for a patient that is just moving to the area. This methodology will allow more flexibility in trying to schedule an appointment.	-The notes shared by Valerie Howard will be provided to the group after the meeting. -Valerie Howard is going to follow-up on the old EDSDT reports that Susan Eggen used to send to the health plans.

Valerie Howard discussed the performance metric 3, EPSDT-Withhold. She provided the CMS-416 Report instructions to help answer any questions on how EPSDT is being calculated. Ms. Inglis, MO Care, asked if there is ever a situation where a denied claim would not be included in the participation ration. Ms. Howard stated that the claim can be paid, unpaid, or denied and would be included in the ratio. MHD plans to change the frequency of this measure to an annual measure based on feedback from the health plans . Wendy Faust, Home State, discussed her concerns about how the health plan rates only include claims that they have and do not include rates on new members that may have had EPSDT screening. She inquired if the health plans would receive a report with the EPSDT rates, similar to the report the health plans used to receive from Susan Eggen. Valerie Howard stated she would look into it.

Another question received from the health plans regarding EDSDT withhold was if a well visit claim is submitted without the EP modifier, would it be counted towards the participant ratio. Ms. Howard responded that the code 99381 is a specific EPSDT code so a modifier is not necessary when using this or any of the other EPSDT specific codes. The codes are located on the website under the provider section.

The Performance Metric 4- Case Management Withhold questions and responses were discussed. Ms. Howard emphasized that the metric measures if initial case management needs assessments occur within 15 days of health plans notification of member pregnancy. The measure doesn't assess how many attempts it took to reach the member. Cheri Brown, Aetna, asked how members with no demographics are measured. Ms. Howard encouraged the health plans to use the case management logs when they have attempted outreach and have been unable to reach the member. The health plans must make three different types of attempts in order to document it as unable to reach the member. These members will not be counted against the health plans. Cheri Brown stated that if the demographics are not available upon enrollment, the member was auto-assigned a PCP, and the address is incorrect, the health plan is unsure how it is possible to attempt three different types of contact to reach the member. Dr. Stuve encouraged the plans to follow contract requirements. He added that he is unsure how to use three different types of attempts on members with incorrect demographics. If MHD audits the health plan records the documented notes should indicate that three different types of contacts were attempted for members identified on the case management log as unable to contact. Wendy Faust, Home State, asked if the three attempts needed to occur within the 15 days after notification of pregnancy. Ms. Howard confirmed that was correct. Jacqueline Inglis, MO Care, stated that 42% of the members they receive do not have active phone numbers or invalid numbers so she is concerned they will never meet the 80% threshold. She added that the first seven days members are eligible members but are not actively enrolled with the health plan. If the health plan outreaches the members in those seven days, the member questions why the health plan is calling. She stated that they had a vendor that took up to 22 days to locate members. She requested MHD reconsider the 80% threshold. Deb Fitzgerald, Aetna, added that if they perform outreach in those seven days that oftentimes the member has

	selected a new health plan. Members appear on the 834 file but choose a different health plan and were never effective with the health plan that initially performed outreach. Crystal McNail, MHD, asked what the time lag was and how long it takes for a member to be active in the health plan. Cheri Brown, Aetna, stated that it takes 5-10 days for members to become active with the health plan leaving them only a few days to attempt three contacts. The health plan requested clarification if the pregnancy notification started when the health plan received notification via the 834 report or if they can use the active enrollment into the health plan date. Dr. Stuve discussed the logs for members enrolled in case management when the reason is pregnancy. He stated that all members screened for case management but don't qualify should be represented on the quarterly log. Megan Barton, Home State, stated they are putting a reason for case management on the logs for every member even if the member wasn't enrolled. Valerie Howard impacts the bi-annual measurement timeframe. Whereas the health plans should have been notified in January regarding their performance for Metric 4, they will be notified sometime this spring after the March case management log submissions. Finally, Ms. Howard discussed the Performance Withhold Metric 5, Medicaid Reform. MHD counts the health plans' members that opt into the member incentive program. There needs to be an affirmative approval from the member that they will be enrolled in the member incentive in order to be counted towards active members. There are no passive enrollments for this metric. Health plans will be subject to a possible audit to confirm self-reported member participation Mark Kapp, MO Care, asked what specialty types MHD will accept for the Provider Incentive Program. Valerie stated that it is up to the health plans to determine which physician specialties they include in their programs. Dr. Stuve added that the health plans are allowed to categorize the providers. Ms. Inglis asked if the health plan has a pending program for the LCCCP should it be approved prior to implementation. Ms. Howard responded that all incentive programs must be approved.	
Data Updates Template Revisions	Dr. Stuve stated that the health plans received data templates and asked if the health plans brought any data representatives. He started his presentation by discussing the claims adjudication log. Each acceptable value needs to be used. Paul Stuve stated MHD will start rejecting data that does not follow the drop down lists. He requested the health plans not change the drop down choices in anyway. Russell Oppenborn, MO Care, asked how MHD defines a denied claim. Paid claims can have a zero amount in the FFS world if there is a third party and the service was approved. There can be denied lines on paid claims. Denied claims are for providers that are out of network. EQRO has a definition of denied claims. Dr. Stuve stated that the health plans will be provided with the definition of denied claims. Dr. Stuve showed an example to the health plans of what a pipe delimited report looks like. Steve Jones, Home State, inquired if claims that are received and processed in that quarter be reported.	-Definition of denied claims will be provided to the health plans. -Email would be added as an option for the complaint, grievance, and appeal log. -Dr. Stuve will review the options in the Member Complaint, Grievance, and Appeal log and make necessary changes to make the options consistent with the provider log. -A completed option will be added to the Member Complaint, Grievance, and Appeal log. -A non applicable (NA) option for the

Dr. Stuve stated we are interested in the claims that are processed in that quarter and should be documented on the log.

Dr. Stuve discussed the Fraud, Waste, and Abuse report and stated that originally there were five reports and now there will be two. The fields are largely the same. The health plans had no questions on the changes.

The Prevention, Detection, and Coordination Logs have been condensed into one report. There is a new field allowing the health plan to select the type of report. Dr. Stuve requested that the health plans provide a short description of the activity the health plan performed in the free text box. Lou Gianquinto, MO Care, asked if there will be a field number restriction. Dr. Stuve responded that it will be limited to 255 characters.

The Complaint, Grievance, and Appeal log has some minor changes. The report will now be two (2) separate reports versus four. The health plans should only report closed cases. The report should be in pipe delimited format. Melody Dowling, Missouri Care stated the provider type does not match on page three (3) and page six (6). She added that page six (6) has the correct choices. Dr. Stuve stated he would review the choices on the member logs since the options for both logs are different. Dana Houle, Home State stated she had the same comment about the log. Melody Dowling asked how the option of letter and written are different. Dr. Stuve stated that he would eliminate written as an option and add email as an option. Melody added that the issue resolution options in the member report do not always match a member grievance. Melody Dowling provided an example of when the options would not be applicable. Dr. Stuve stated he would add a completed option to the log. Dana Houle, Home State, stated on the member grievances log a NA option should be added in the expedited review question since not all member grievances require an expedited review. Dr. Stuve agreed to add the field. Melody Dowling requested to add an issue ID for instances for multiple grievances from the same member on the same day. Paul stated the health plan could use their own internal log number.

Dana Houle asked for clarification on the appeal codes for the Provider, Grievance, and Appeals log. She asked if we are doing a provider appeal that is not applicable to a member do we use the 300 series of appeal codes. Dr. Stuve stated we would investigate the intent of the 300 series codes.

The call center log should be submitted in an Excel format. The report is going to be compiled into one report. The group had no questions on this log.

The disease management log must be submitted in a pipe-delimited log. Jacque Inglis, MO Care, asked when the logs would be need to be submitted in the new format. Dr. Stuve stated the April through June log due in September should be the first report submitted in the new format. The expedited review question will be added to the Member Complaint, Grievance, and Appeal log.
- Dr. Stuve will investigate the intent of the 300 series codes for the Provider Complaint, Grievance, and Appeals Log.
-The health plans should send a list of acceptable values for case management by March 1, 2016.

	new disease management report is more detailed. If you are only sending mailings do not put them on the new log. Members actively enrolled in disease management should be reported on the new log. If members are in multiple disease management programs, we request that they be submitted multiple times. The annual report due June 30, 2016 was discussed. There were no questions from the health plans regarding the template. Laura Ferguson, Aetna, asked if the health plans are using the Novolin catalog for the Quality Measures Report. MO Care and Home State stated that they are using this catalog. Dr. Stuve asked the health plans about having a proposed HEDIS reporting template. He would like to change the format so it can be easily pulled into a database and be used by DHSS. MHD wants it to be in a pipe delimited format. Some of the rows on the annual June 30th report would not need to be reported if this report was created. NCQA requires this data already so the health plans should be reporting it currently per the NCQA HEDIS Tech Spec Manual. Mark Kapp stated he thinks this will be helpful and allow for consistency among the three health plans. Laura Ferguson stated that there is a file that can generate a report with this information. Dr. Stuve requested the health plans send an example so he can get an idea of the structure. All three health plans work off the same software for these measures. This will take up to a year to get DHSS on board. Bob Patterson is open to the idea but will need to see the report. Mark Kapp stated he would send an example. Jacque Ingles asked that if the case management log is for members that are outreached and not in case management. Dr. Stuve stated that all members that are outreached should be in the case management log. Dr. Stuve asked the health plans how many women they discover are pregnant before they receive notification. Debbie Fitzgerald responded that many members refuse case management for pregnancy. A third of the members do not have accurate ME codes to identify they are pregnant. The health plans do not want to add a field and requested to use the reason for CM-1 for the reason for screening. Dr. Stuve stated the log is missing an option for members that are screened but don't qualify for case management. If it is added to the log it would be the July report due in December. Megan Barton states that she doesn't want to change the log; It would require education to the staff. Dr. Stuve discussed the implementation schedule. He requested the health plans send a list of acceptable values lists for the levels of case management by March 1st. If the logs are not correct the health plans will be required to change the logs and resubmit. He provided an example of a sample report of submission errors. The updated templates will be out on the website within the week.
Management of Obesity in Children and Adults	Dr. Timothy Kling and Dr. Eric Martin presented on the new obesity program MHD plans to implement. About two years ago the Missouri Children's Service Commission set up a

	subcommittee to look into childhood obesity. The subcommittee came up with several items to give back to the commission for the legislature on childhood obesity. MHD's program will include children and adults. The program was structured off of US Preventative Services Task Force recommendations. Adults with a BMI greater than 30 and children with a growth chart percentile greater than 95 will be eligible for the program. The interventions are primarily behavioral health interventions. The primary care provider refers the member for the service and obtains a prior authorization for the service. If the member meets the criteria a referral is sent to a registered dietician and a behavioral health provider. Dr. Martin added that training is being developed for providers that will deliver the obesity intervention. The cost model indicates there is a cost saving for both children and adults in the first year. The planned implementation date is early 2017.	
Health Home Updates/ Application Updates	Kathy Brown gave a brief update on the Health Home initiative to the primary care side. MHD is planning to submit to an amendment to the state plan amendment to add obesity and asthma for adults and children to be stand-alone conditions. It is going through our internal approval process at MHD. We will submit to CMS after the review process has been completed. We are adding anxiety, depression, and substance use disorders as well. Last April we had a meeting with the health homes providers and the health plans. We are planning to schedule a conference call in April to follow up on the previous meeting and re-assess how communications are going. On the primary care side, we have been given approval to expand the number of health home providers for the primary care health home initiative. We are awaiting internal approval for the applications to become available. MHD is anticipating approval of the applications by tomorrow. A bulletin will be posted as soon as MHD is ready to start processing applications. A deadline will be set for written inquiries and then an information webinar will be held to address any questions we receive during the written inquiry period. Applications are due April 8, 2016 and decisions should be made on who will be approved to be a health home provider by May 6, 2016 with an anticipated start date of July 1, 2016 for the awarded contracts. We did this process in 2014 and added eight (8) new providers' organizations at that time. All three health plans requested that the meetings occur face-to-face. Kathy Brown stated the first meeting is on the schedule and will be a conference call. We plan to have a much focused agenda so that will help for this first meeting. Possibly after the conference call we can move into regional meetings. Steve Kuntz asked if there were studies on the effectiveness and benefits of the health homes. Kathy Brown stated they have been up and running for four years and reports are run periodically. Those reports are available. We are working on a report for submission that goes into the outcomes of the initiative. Kathy Brown added that health homes are showing cost savings and	-Primary Care Health Home applications will be due to MHD by April 8, 2016. -All applications will be approved by May 6, 2016. -Implementation date for new health homes July 1, 2016.

	better clinical indicators.
2014 MCO- Specific Patient Abstract System Report	Wayne Schramm presented the 2014 MCO- Specific Patient Abstract System Indicators. This report focuses on nine (9) indicators by specific plans and regions and state totals for 2014 comparison for rates for years 2010, 2011, 2012 and 2013. Patient abstract data has been linked to Medicaid eligibility and lock in file to determine if they are on MO HealthNet or in a specific plan at the time of hospital admission or ER visits. Rates are presented for Fee For Service (FFS) areas, the non-MO HealthNet population and total state-wide population for comparison. Mr. Schramm included rates for three of the four asthma indicators for those under age 18. These rates increased in 2014 for all MO Health Managed care populations, with ER visit under age four (4) being the exception. These same rates have decreased in 2013 so no long term trend indicated. All four (4) asthma indicators show higher rates for plans in the eastern region in comparison to other regions. The difference in changes in eastern region and other regions have decreased over time. In 2010 eastern region inpatient asthma rates were nearly double the western region. In 2014, the differential was less than 20%. Asthma rates in Managed care regions overall where higher than in the FFS areas especially for ER visits. Total emergency room visits for under 18 were higher in the eastern region. These rates did not substantially change in 2014 but the rates in central region did go up. Total ER visit for 18 to 64 age group were highest in western region. ER visits in both age groups higher in Managed care regions than FFS regions. Preventable hospitalizations under 18 visits were highest in the eastern region of the three managed care regions. These preventable hospital rates increased in the eastern and western with a decrease in central regions. These rates were 40 percent higher in FFS areas than managed care areas. Mr. Schramm presented health plan specifics and stated that MO Care had the lowest rates for asthma indicators. Home State had higher rates for total ER visits and preventable hospitalizations. Also, Home State had the highest rates for asthma inpatient admissions. Lastly, Aetna had the highest rates for asthma ER visits.
Executive Director of Central Missouri Community Action Agency	Darin Preis, Executive Director of Central Missouri Community Action Agency, shared that the organization covers eight (8) counties. He discussed that the Community Service Block Grant is the Federal funding source that designates Central Missouri Community Action as a local community action agency. The funding, passed through the Missouri Family Support Division, is designed to ensure that projects and initiates are developed to address the causes and conditions of poverty at the local level. Initiatives include family, community and agency focused efforts. An intentional community initiative designed to engage all aspects of the community to address local causes and conditions of poverty. Community organizers work with community entities to ensure that all families' are able to meet their basic needs as well as opportunities for lifelong learning, develop relationships with local industries, small businesses, and organizations, and provide learning opportunities to local Chambers of Commerce, economies development entities and other centered around the realities of poverty at the local level, needs of those living in

	poverty and the cost of poverty to individual communities. Through these educational presentations, community members are invited to participate with existing Community Action Teams to develop, enhance and identify local solutions to the overall causes of poverty within a community.
Legal Services Quarterly Report	Tiajuana Henderson, from Advocates for Family Health Legal Services of Eastern Missouri, discussed their role in providing legal services to the Medicaid population. Ms. Henderson shared there are four (4) legal aid offices in Missouri. She shared they work with advocating for members having problems obtaining services through the MO HealthNet programs. We provide education and advocate for families with questions on benefits, rights and managed care participants responsibilities. She provided a brief overview of the history of Advocate for Family Health, their scope of work, the type of clients they serve, their serving counties, and types of cases they handle. She shared the significant recent events in the project, and shared that eligibility is still the most frequent problem they encounter. She did share some concerns for the Eastern Region and closed with sharing her contact information. In closing, Mr. Stuve asked if there are issues that are different in last three to six months. Ms. Henderson shared that nursing care for children and home nursing have become issues. Children are being denied services so we are working to get them reassessed. This causes increased anxiety for families.
MO Care's Field Case Management Pilot	Jackie Ingles, MO Care, presented on their Field Case Management pilot. The program was launched in July. The first step of the program was to educate participants and providers about case management. Then the focus was to get members engaged in case management by performing visits. This provided a different platform for the members and staff. The pilot team worked to get participants connected to services in their community. Managing urban versus rural members has its challenges. Rural cases can be very labor intense. The biggest barriers are being able to locate and contact members. The staff will visit the member at hospital but once they are dismissed the health plan is unable to locate them. Ms. Ingles stated that the health plan would like to expand the pilot and add more staff. Real time referrals from agencies and providers are of greatest value to the health plan and case managers. Ms. Ingles shared that 52% of members do not want to participate in the case management program. Stuve Kuntz stated it is concerning that 33% of your members are unable to reach. Steve added that the health plans should have an address at least. The health plans stated they do have addresses for the members, but oftentimes the addresses are incorrect. The members list a home address but do not live there all of the time making it impossible to locate the member. Ms. Ingles stated that the health plans have a 40% to 45% return mail rate. On the 834 report that the health plans receive, 42% of the members have no phone number listed and 20% of members

	have an invalid phone number. Wendy Faust stated the health plans invest a lot of resources to help locate members. Home State has instituted on their mailings the National Change of Address and still receives returned mail. Steve Kuntz added that it is very difficult for members to communicate with Family Support Division regarding necessary changes. There was a lot of conversation amongst the members in regards to the success of face-to-face case management. In addition, the inability to contact members was discussed in length. Members of the group suggested utilizing social service agencies to locate members. The health plans stated that they attempt to reach members by going to the hospital, contacting the daycare provider, and reaching out to social service agencies.	
Health Plan shared documents	The following documents were shared with the group including Health Plan Best Practices, Health Plan Quarterly Reports, EQRO Task Force 2014 recommendations, Case Management Success and Unsuccessful Case Examples, and Performance Improvement Projects.	
Adjourned	Adjourned at 3:15	Next meeting scheduled for June 23, 2016 in Room 490 Truman Office Building