MO HEALTHNET MANAGED CARE
QUALITY ASSESSMENT & IMPROVEMENT ADVISORY GROUP
June 23, 2016
Harry S. Truman Building
301 West High, Room 490
Jefferson City, MO 65101

MO HealthNet Division
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Jay Ludlam
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Paul Stuve
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John Dane
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Valerie Howard
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Crystal McNail
Renee Riley
Mike Popa
Beverly Smith
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Kathy Brown
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Barb Kliethermes
Mary Ellen McCleary
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Home State Health Plan
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Dana Houle
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Dan Wichner
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Joe Hills

Legal Services Eastern Missouri
Tiajuana Henderson

Agenda Items	Discussion	Actions
Welcome **Introduction** **Minutes**	Dr. Muzaffar opened the meeting at 10:02 am. All members introduced themselves in the room. Jacqueline Inglis was announced as the new QA&I Chair. Helen Jaco made a motion to approve the minutes. Home State approved the minutes and Dr. Paul Stuve seconded.	
Director and Budget Updates	Dr. Parks announced that the adult dental benefit has improved. MO HealthNet FFS will be picking up dental costs until the end of June. The health plans will be responsible for dental benefits starting July 1, 2016. He added OA signed the contract amendments and the health plans should be in receipt of them shortly. There are some providers, nursing home, and hospice rate increases in the budget. We are awaiting a decision from the governor if the rates increases will occur. He congratulated the health plans with getting all of the LCCCPs approved. He encouraged the health plans to continue to work with the providers to improve their work processes, give practice coaching, and partner with them to manage the populations enrolled in the LCCCPs. There is a change in funding that should take effect in July 2017 for Certified Community Behavioral Health Centers (CCBHC). The CCBHC will have a more standardized and comprehensive responsibility for a book of services including care coordination. The funding will be changed from a FFS payment structure to a prospective payment methodology. The state of Missouri is one of 24 states that received a planning grant. Eight demonstration slots will be awarded in October. More information regarding this change can be found in the Excellence in Mental Health Act and SAMSA website. MHD will provide more information in the future. Dr. Parks reminded the health plans that NPI data is required on all claims beginning July 17, 2016. This will allow us to know who the rendering providers are of services. It will allow for better analysis of the programs. Kimberly Tuck, Home State asked if the NPI was required for pharmacies and their rendering practitioners. Dr. Parks clarified	

	that NPIs are required for all providers. There were no additional questions.
Dental Program Updates	Dr. Dane provided a dental update to the group. He stated it took over four years to get adult dental benefits covered and Missouri is very excited for the new benefit to the MO HealthNet FFS and Managed Care population. He discussed low income adult needs and effects of poor oral health on adults. A provider bulletin regarding dental coverage was made available on the website on May 6, 2016. Services to be included in the adult benefit include diagnostic, preventive, periodontal, restorative, extractions, and sedation. Dr. Dane concluded his presentation by providing answers to several questions MHD has received including coverage date of the adult benefit for the managed care health plans, how providers get reimbursed for services, how to refund payments to patients that received services after January 1, 2016, and the codes that will not be covered within the new benefit. There were no questions in regards to dental program updates.
Behavioral Health Updates	Dr. Martin provided the group with behavioral health updates. He started by discussing the amendment changes that will be applied to the contract in regards to carve outs for behavioral health services for the Category of Aid 4 (COA4) population. He emphasized that the health plan is responsible for all inpatient stays for members with an admission related to a physical health and behavioral health condition. He provided clarification on the services that are carved out of managed care including behavioral health services for children within COA 4. He provided examples to clarify the services that the health plans are responsible for. Next, Dr. Martin provided an overview on Behavioral Health Parity. CMS published the new rule in April 2016 to state that treatment limitations and financial requirements for behavioral health benefits cannot be more restrictive than for medical or surgical benefits. The health plans and MHD is required to be in compliance with the rule by October 2, 2017. The rule holds the managed care health plans and MHD accountable for the same services that the commercial market provides to its members. Dr. Parks emphasized that the restrictive part of the rule is not new and has been in MHD's contract since 2009. The new piece of the Parity Rule is the health plans are required to perform a Parity Analysis in conjunction with MHD. He provided a specific example of how the health plans can't be restrictive with services. He looks forward to further dialogue about this conversation. Applied Behavioral Analysis (ABA) services are now covered for individuals under 21

	years of age under the state plan amendment. CMS recently approved the SPA and the services begun as of January 15, 2016. Participants receiving ABA through DD waivers will transition to FFS if under 21 with Autism Spectrum Disorder. All ABA services require precertification through Wipro Behavioral Health Help Desk. The Provider Bulletin is available on MHD's website. In closing, he discussed that a Senate Bill, 376.845 RSMo, was passed stating that the diagnosis and treatment of eating disorders is to be a new covered diagnosis for the health plans. This will become effective January 1, 2017.	
Data Update	Dr. Stuve discussed the member grievance and appeal log. He asked for feedback from the health plans regarding the HEDIS Template. Mark Kapp stated that the new template was a manual process and is concerned about potential errors. Missouri Care was the only health plan to submit the template. Aetna stated it was a manual process as well. Aetna worked on it but did not submit it. Dr. Stuve encouraged the health plans to see if the vendor could develop a report so it would no longer be a manual process. He showed a sample file, IDSS Data ID report, which might be a potential option for the HEDIS report. Aetna voiced concerns about submitting files in pipe delimited format. Dr. Stuve reminded the health plans of the reasons why a pipe delimited file is necessary for our reporting purposes. The case management log errors were then discussed. Dr. Stuve provided examples of the types of errors that are occurring in the logs. He added that he plans to perform a similar analysis on other reports that the health plan submits. Megan Barton, Home State, commented that the case management logs would be more useful if the report was outcome driven. In addition, she discussed her concern with MHD using the case management log for the withhold program since some information is not captured on the logs. She requested that MHD clarify the use of the log for withhold purposes. Kimberly Tuck, Home State, discussed the lack of demographic information available to the health plans. Dr. Stuve responded that there are changes underway to help resolve this issue. Helen Jaco clarified that there is progress towards helping with the lack of phone numbers in MMIS and is a top priority at the division. Dr. Stuve reminded the health plans that the deadline for the new report specifications are due September 30, 2016. The health plans did not voice any concerns regarding the	-The fields on the member grievance and appeal logs have been removed and the new specs will be on the website soon. -The health plans are to submit to Dr. Stuve the earliest possible date that might be reported on the care management log.

	specifications.
Health Home Managed Care Conversation	Dr. Muzaffar stated that CMS approved the Health Home State Plan Amendment. Asthma will be a standalone condition for children and obesity will be a standalone condition for children and adults. In addition, anxiety, depression, and substance use will be added as qualifying diagnoses for adults. There has been a lot of discussion around how to coordinate with the health homes and the health plans to ensure duplication of services is not occurring. Dr. Muzaffar discussed that MHD received a question if health home members could be carved out of Managed Care. She responded that health home members will not be carved out of managed care. Members would have the potential of losing resources that managed care provides if they were carved out such as transportation assistance and cell phones. There will be continued dialogue in regards to this topic. We plan to have clarification of the roles and will bring the group back together to discuss further. Kathy Brown discussed that MHD opened up the health home application to any providers interested in becoming a health home. After reviewing the applications, there will be a total of four new providers, two new pediatric practices and two primary care practices. There may be some others that will come on board at a later date. The program continues to grow. MHD is currently in the process of putting together a report of the outcomes to date. There are two parts to the report. The first part looks at utilization and the second part will look at qualitative data and clinical data.
Asthma and Obesity Update	Dr. Muzaffar started by stating that MHD is awaiting CMS approval of the state plan amendment for asthma education and asthma environmental assessments. She discussed qualifications for the providers and the algorithm that MHD has developed to identify eligible members for the program. Once approved, the program will be available to Fee-for-Service and Managed Care members. Dr. Ross-Davis stated that they have providers performing environmental assessments and inquired if they would need to obtain certification. Dr. Muzaffar stated that the providers would need to be certified, either state or nationally and when enrolling with MMAC they would need to provide proof of that certification. MHD is looking at medical nutritional therapy and intensive behavioral therapy for treatment of obesity. We are working with a group of clinical experts on how to develop

	the program. The program will be available to adults and children. The program is based on the USPSTF recommendations. The training is currently being developed for the providers to provide obesity services. Dr. Martin added that the providers that are eligible would include psychologists, professional counselors, and licensed social workers. The providers would need to be certified in order to use the Health and Behavioral Assessment Intervention codes. Dr. Muzaffar discussed the national certification for registered dieticians. MHD anticipates the program starting in early 2017. Megan Barton, Home State, asked if the COA4 children would be carved out for the intensive behavioral therapy portion of treatment for obesity. Dr. Muzaffar stated we would provide clarification on this in the future. Kimberly Tuck, Home State, asked if NCQA Accreditation was an acceptable certification to provide the obesity service. Dr. Muzaffar responded that the providers would need to receive a state or national certification specific to obesity treatment.
Legal Services Quarterly Report	Johnda Boyce, Legal Aide of Western Missouri, presented the Legal Services Quarterly Report. She discussed that they are available for any members and help assist with various problems. They do outreach in the community. She provided an example of a case that she has been assisting with. The cases currently being managed are eligibility issues. She encouraged the group to send Legal Services referrals for any issues the members are encountering. There were no questions regarding the presentation.
Best Practices	Megan Barton, Home State, presented on their Member Experience Team as their best practice. This team is a new team in the customer service department that performs outbound calls to all new members. They are responsible for completing a Health Risk Screening, a Pregnancy Screening, providing education on primary care providers, emergency room, and urgent care, informing members of the member incentives, assisting members in scheduling appointments, assisting with transportation as needed, and making referrals to medical and behavioral health care management based on members' responses to screening questions. The health plan has been able to complete health risk screens on 21% of the members, and with research was able to reach 24.74% of the members since implementation of the new program in May. Dr. Muzaffar asked what challenges the health plan has faced with the program. Ms. Barton responded that getting staff trained and tracking outcomes was the biggest challenges. She added the health plan is still in the planning phase. Melody Dowling, MO Care, presented the Intensive Family Interventions Services as

	their best practice. The health plan has partnered with Great Circle to help the member and family understand and recognize their mental health symptoms, assist member and family manage their mental illness, and improve the parent's capacity to care for and manage their child's mental illness. The goal is to reduce ER visits among this population. The program can be used as a stepdown after an inpatient stay. The program was implemented a year ago. The program initially started in the Eastern Region but is now available to all managed care counties. Dr. Muzaffar asked the biggest challenge in implementing the program. Ms. Dowling responded that billing, coding, and identifying members for the program were the biggest challenges. Carol Stephens-Jay, Aetna, presented the Member Incentive Submissions as their Best Practice. The process for members to submit member incentive materials used to be by mail or fax only. Now members have the ability to email their information to the health plan. This process is used for two incentive programs currently. Dr. Muzaffar asked if the health plan would be measuring growth. Aetna stated they were and participation continues to increase monthly.
Health Plan PIP's	Mark Kapp, MO Care, presented on the Follow-Up After Hospitalization for Mental Illness PIP. He discussed that there have been significant improvements since the health plan has implemented the Behavioral Health Provider Incentive Pilot Program. Two of the three CMHCs in the pilot improved from the 25th percentile to the 75th and 90th percentiles when comparing data from July 2015 through September 2015 to the same time period the prior year. The health plan plans to expand the exclusion criteria for providers beyond the three current CMHCs to all community mental health centers with a Missouri Care panel of 50 or more based on utilization and claims data. Dale Pfaff, Aetna, presented on the Childhood Immunizations PIP. He stated that the PIP focuses on the Combo 3 immunizations which include DTaP, IPV, MMR, HiB, Hep B, VZV, and PCV. He discussed benefits of the PIP and barriers that are associated with the PIP. Dr. Muzaffar asked how Aetna is addressing the issue of not having appropriate data for immunizations. Mr. Pfaff stated that staff is being trained to find the immunization information in the EMR, since many providers now document this information in the EMR. Carol Stephens-Jay added receiving the immunization files throughout the year helps. Dana Houle, Home State, stated that they try to interact with all the health departments and work with contracted entities to get immunization

	data. Dana Houle, Home State, presented the ED Super Utilization Outreach Program. This program focuses on members who were frequent utilizers of the emergency room. Ms. Houle stated that Home State has seen a significant reduction in ED Utilization baseline period of July through December 2012 through the first six months of 2014. She added the largest numbers of ED events are from pregnant members. Home State's QIC committee suggested looking at the data more closely to determine admission reasons. She stated another reason for ED utilization is dental pain. Home State is incentivizing members with a toothbrush PIP and offering resources in the area so the member can see a dentist. The data will be run and analyzed for the next QIC meeting in September. Dr. Muzaffar requested to see the results of the data analysis.	
Waivers	Angie Brenner, Director of Federal Programs, Division of Developmental Disabilities, started the conversation by introducing herself, Melissa Knipp, waiver services, and Clay Sterns, intake eligibility. The Division of Developmental Disabilities is covered under the 1915 C Waiver, while Managed Care is covered under the 1915 B Waiver. The Department of Mental Health is divided into two divisions, Division of Developmental Disabilities and Division of Mental Health. There are six main regional offices in the state with five satellite offices. We serve over 33,000 people within the division with 15,000 members in a waiver. Members can be eligible for DD services but not eligible for waiver services. In order to be eligible for a waiver, the member must be Medicaid eligible, have three areas of impairment, and meet level of care. Every individual who is determined eligible for DD services is entitled to receive support coordinator/case manager. In order to receive waiver services, all state plan amendment services and natural supports must be exhausted first. The support coordinators assist with determining if all services have been exhausted before using waiver services. Megan Barton asked for clarification on what exhausting services means. Angie Brenner responded that all state plan services must be exhausted before waiver services. For example, state plan personal care services must be used before accessing personal care waiver services. Cherie Brown, Home State, added that this isn't true for all members and for members in an Autism waiver it is the responsibility for DMH to provide services. Angie Brenner inquired who was responsible for the state plan services. Dr. Eric Martin clarified that	- Contact points will be assigned for issues with the regional offices or waivers. - MHD is discussing developing a list to provide to the health plans identifying members in particular waivers.

the health plans are responsible for care management but services that are carved out is a responsibility of FFS. Ms. Brown requested that the regional centers receive education on who is responsible for covering services. In addition, she provided an example of a child that was denied services from the regional center. Ms. Brenner encouraged the health plans to notify them of issues and confirmed that the regional center staff will be receiving additional education.

Ms. Brenner and Dr. Martin discussed that MHD and DMH are currently in the process of identifying children that are receiving ABA services by providers that are not enrolled with MMAC. MHD is encouraging providers to enroll so children can remain with their current providers. Dr. Ross-Davis, Aetna, inquired if there could be a separate line of resource for questions regarding ABA and PCA. Until contact points are assigned, Ms. Jaco encouraged the health plans to send issues through Managed Care. Ms. Barton asked for clarification on the role of the support coordinator. Ms. Brenner stated that there is a little overlap with the roles of the care managers at the health plans and the support coordinators. A big difference is the support coordinators can't help coordinate state plan services. Their role is to assist the member with coordinating waiver services only. Ms. Barton stated that it is difficult to determine who is in a waiver.

Legal Services inquired about the availability of the waivers. Ms. Brenner stated that there are a designated number of slots available for each waiver. The in-home waiver wait lists are not as long because the list is more of a processing list. The other waivers do have a wait list. Ms. Brenner discussed how a priority of need is assigned. She stated that individuals with a higher level of care will be assigned a higher priority of need allowing them to get in a waiver more quickly. She discussed the waivers that are available to children and discussed the services available within those particular waivers. The five waivers that are available include the Comprehensive Waiver, "Lopez" Waiver, Community Support Waiver, Waiver for Children with Autism Spectrum Disorders, and Partnership for Hope Waivers.

Valerie Howard asked about the process of putting children on the waivers since oftentimes once children are on the waivers they do not come off. Ms. Brenner responded that the funding that DMH receives helps add slots to the waivers. The autism waiver is a waiver that children age out of. Dr. Ross-Davis asked what the

	average amount of time it takes for a member to receive notification that they qualify for a waiver. Mr. Sterns responded that it depends on the amount of time it takes for the parents to get the information back to the state. Once the division receives all of the medical and school records, a decision is made within 30 days. DD eligibility is the first step. Waiver eligibility is determined after DD eligibility has been made. This requires an additional assessment. Tasha Smith, Aetna, provided an example of a child waiting over a year to get on a waiver. Mr. Sterns verified that it's possibly related to financial constraints or low priority of need (PON) scores. He encouraged the health plans to contact intake unit at the regional centers to help with answering eligibility questions and help determine why children are not on waivers. Home State, Cheri Brown provided an example of a child that is currently inpatient because it is unsafe for him to return home due to his older brother being violent. The older brother is awaiting determination of eligibility for waiver services. Ms. Brenner stated that they would need to see the specifics for the child. Home State requested a specific contact person to reach out with problems. Mr. Sterns stated that in instances like these, the health plan should go to the support coordinators first. If the health plan is unable to get answers, the regional director at the local regional office should be contacted. Mr. Sterns added that he would provide the health plans with his contact information. In addition, the map on Slide 29 has the contact phone numbers for all of the Regional Offices in the state. Melissa Knipp ended with discussing the five assurances required by CMS which include the level of care, service plans, health and welfare, financial accountability, and administrative authority. The Quality Enhancement Unit collects data and ensures compliance with the five assurances. A level of care must be reassessed yearly.
First Steps Program	Pam Thomas, Part C Coordinator for the First Steps Program, started the discussion by describing the differences of educationally based and medically based services. Medically based services occur in a clinic or hospital most frequently and are one-on-one with the child, whereas educationally based services occur in groups primarily. She provided handouts titled Division for Special Education Services and Support Characteristics of Educationally Relevant Therapy and Medical/Clinical Therapy and Missouri First Steps Eligibility Criteria. She provided an example of a child receiving medical services and educational services and the differences within those two service types. She discussed that when a physician orders therapies it isn't always included in

the IEP or IFSP plan and will need to be approved by the health plan or FFS in order for the child to receive the service.

Ms. Thomas discussed the differences in IEPs and IFSPs. IFSPs are for children birth to age three. IEPs are for children age three to 21 years of age. The location of services varies for IEPs and IFSPs. IFSPs are delivered in the home 96% of the time and the parents are the direct recipient of the services, while IEPs occur in the least restrictive environment including the classroom, small group setting, or in the home. Both services address educational and developmental needs. If it is determined there isn't an educational need, the child will need to seek medical services and an IEP or IFSP plan of care would not be created. The involvement of the parents is different in both programs. In order to qualify for First Steps Program the child must have a qualifying condition, while qualifications for IEP services are a two-step process. The child must meet a disability category and must test positive for an educational need. Not all children in First Steps will receive an IEP.

Ms. Thomas discussed the differences in the service names and how differently the services are delivered. She emphasized that it is impossible for providers to be billing for the same service. The billing modifiers are different. Megan Barton, Home State, stated that they are receiving several questions and asked for clarification as to the process. Crystal McNail emphasized that duplication of services does not occur with IFSP/IEP and medically based services. The goals in an IEP/IFSP are very different. Cheri Brown stated that in order to coordinate services they must see the IEP and IFSP. She added if a provider orders speech therapy and speech therapy is included in the IEP it is not the responsibility of the health plan to cover those services since the IEP is addressing the child's developmental issue. Ms. Thomas responded by asking Home State how they know if children are receiving educationally based services. Cherie Brown responded that most children with developmental issues receiving Medicaid services qualify for IEP or IFSP services. She added that the health plan requires copies of IEP and IFSPs to educate the parents on the services and get them acclimated to the services available in First Steps or the school through an IEP. Ms. Thomas asked for clarification regarding the contract requirements and coordination of services. It was discussed that the contract does require the health plans to coordinate services. Ms. Thomas added that dually enrolled providers of IEP/IFSP and medically based services

can't share the IEP or IFSP without the parent's consent due to FERPA laws prohibiting it. The providers would not know if the child was receiving an IFSP or IEP unless the parent discloses this information. It is the parent's choice to disclose this information and is not a requirement in order to receive additional service. Oftentimes, they are not easily accessed. Ms. Brown added that since new providers have been added to their panels, more issues have been occurring related to the inability to easily access a copy of the IEP or IFSP, which had not been a problem before. Ms. Thomas discussed that the therapy manual states that it is the provider of IEP or IFSP's obligation to coordinate those services if the child requires medically based services. Dr. Ross-Davis stated that they request a copy of the IEP and IFSP from the parents sometimes to compare services to determine authorization. There is a barrier with getting a copy of the IEP from the schools. She added that medical systems and school systems are not collaborating and, therefore, the possibility of duplication of services may occur.

Ms. Thomas emphasized that duplication of services is not occurring. Dr. Ross-Davis stated that the claims data will show duplication since the codes being billed are the same. Ms. Thomas stated that IEP services are coded as a TM modifier with a code of 96. IFSP services are coded as a Missouri First Steps with a TL modifier with a code 56. The CPT codes may be the same. Dr. Ross-Davis added that CPT codes are flagging in the system as duplicative services since the CPT codes being billed are the same and the same diagnoses codes are on the claims. Megan Barton added that in order to determine the medical necessity for a service other services the child is receiving need to be reviewed. She added that some parts may be duplicative and provided the example of speech therapy being duplicative. Ms. Thomas discussed her concerns with the health plans stating that the services are duplicative. In the Interagency Agreement with MHD it states that receiving services through an IEP or IFSP will not prevent the child from receiving other benefits. Ms. Barton stated that the health plan utilizes resources in the best way per the contract. Dana Houle added that it might be helpful to have specific services listed under the therapy umbrella. Dr. Ross-Davis agreed and stated that we have the opportunity to encourage collaboration amongst the two providers.

Helen Jaco clarified that under the contract there should not be a delay in services while the IFSP and IEP is being developed. She encouraged the health plans to continue to not

	delay services. Ms. Jaco inquired how often the services are rendered duplicative. Ms. Brown stated that it occurs more often than not. She provided an example of speech therapy and how the goals are the same but the interventions to achieve the goals may be different. Since the end goals are the same for both providers, the service is deemed duplicative and denied. Ms. Thomas asked Ms. Brown what criteria the health plan is using to base their decision. Ms. Brown stated that they use Interqual criteria. Dana Houle added that the modalities delivered in the school system are separate and distinct from the modalities delivered in the home setting. She requested clarification of the differences in the modalities because there is not a clear distinction currently. This would help clarify the information and help with determining that the services are not duplicative. Ms. Thomas ended the conversation with discussing that there are ten First Step providers in the state. There are 536 school districts that provide IEP services. The structure, people, and plans are very different for both IEPs and IFSPs.	
Adjourned	Helen Jaco closed the meeting at 2:52.	Next meeting is planned for October 20, 2016 in the Truman Office Building, Room 490