Primaris
Healthcare Business Solutions

2018 External Quality Review

Care Management

home state health

Measurement Period: Calendar Year 2017

Validation Period: June-August 2018

Publish Date: Dec 07, 2018

MoHealth Net

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1.0 Purpose and Overview

The Department of Social Services, MO HealthNet Division (MHD) operates a Health Maintenance Organization (HMO) style Managed Care Program called MO HealthNet Managed Care. MHD contracts with Managed Care Organizations (MCOs) to provide health care services to enrollees.

Effective May 1, 2017, Managed Care is operated statewide in Missouri. Previously, Managed Care was only available in certain regions (Central, Eastern, and Western). MHD extended the health care delivery program in the Central Region and added the Southwestern Region of the State in order to incorporate the Managed Care statewide extension for all the eligibility groups currently enrolled in MO HealthNet Managed Care. The goal was to improve access to needed services and the quality of health care services in the MO HealthNet Managed Care and state aid eligible populations, while controlling the program's cost.

The Managed Care Program enables Missouri to use the Managed Care System to provide Medicaid services to Section 1931 children and related poverty level populations; Section 1931 adults and related poverty populations, including pregnant women; Children's Health Insurance Program (CHIP) children; and foster care children. As of SFY2018 ending, total number of Managed Care enrollees in MO HealthNet were 712,335 (1915(b) and CHIP combined).

Home State Health, one of the three MCOs operating in Missouri (MO), shall provide services to individuals determined eligible by the state agency for the MO HealthNet Managed Care Program on a statewide basis in all Missouri counties in the following four (4) designated regions of the State of Missouri: Central, Eastern, Western, and Southwestern.

Services are monitored for quality, enrollee satisfaction, and contract compliance. Quality is monitored through various on-going methods including, but not limited to, MCO's Health Effectiveness Data and Information Set (HEDIS) indicator reports, annual reviews, enrollee grievances and appeals, targeted record reviews, and annual external quality reviews (EQR). MHD requires participating MCO to be accredited by the National Committee for Quality Assurance (NCQA) at a level of "Accredited" or better. An External Quality Review Organization (EQRO) evaluates MCO annually, as well.

MHD has arranged for annual, external independent reviews of the quality outcomes and timeliness of, and access to, the services covered under each MCO contract. The Federal and State regulatory requirements and performance standards as they apply to MCOs are evaluated annually for the State in accordance with 42 CFR 438.310 (a) and 42 CFR 438.310 (b).

Quality, (42 CFR 438.320 (2)), as it pertains to external quality review, means the degree to which an MCO increases the likelihood of desired outcomes of its enrollees through:

(1) Its structural and operational characteristics.

(2) The provision of services that are consistent with current professional, evidenced-based-knowledge.

(3) Interventions for performance improvement.

Access, (42 CFR 438.320), as it pertains to external quality review, means the timely use of services to achieve optimal outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under §438.68 (Network adequacy standards) and §438.206 (Availability of services).

Timeliness: Federal Managed Care Regulations at 42 CFR §438.206 require the state to define its standards for timely access to care and services. These standards must take into account the urgency of the need for services.

Primaris Holdings, Inc. is MHD's current EQRO, and started their five-year contract in January 2018. Primaris conducted an annual review of Care Management Program of Home State Health on July 9-13, 2018, as per the EQRO contract with MO HealthNet Division (Ref: Code of Federal Regulations (CFR) 438.358 (c)).

The Commission for Care Manager Certification (CCMC) defines "Care Management" as a process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality, cost-effective outcomes.

All services described in the Care Management section (2.11) of the MO HealthNet Managed Care contract will be used as a standard for evaluation of Care Management Program of Home State Health. The aim of the Care Management review is to identify contributing issues and key drivers of the program. The guiding principle for Care Management is that the resources should be focused towards people receiving the services they need, not necessarily because the

service is available. Member Care Management is an umbrella term that encompasses services such as, but not limited to:

- Comprehensive Care Management applying clinical knowledge to the member's condition;
- Care coordination;
- Health promotion services;
- Comprehensive transitional care;
- Individual and family support activities;
- Disease management; and
- Referrals to community and social supports.

The focus areas for evaluation of Care Management program during EQR 2018, mandated by MHD were as follows:

- Pregnant Members (OB);
- Children with Elevated Blood Lead Levels; and
- Serious Mental Illness (Schizophrenia, Schizoaffective disorder, Bipolar Disorder, Post-Traumatic Stress Disorder, Recurrent Major Depression, and moderate to severe Substance Use Disorder).

2.0 Methodology

2.1 Review of Care Management Policies

Primaris reviewed Home State Health's policies on Care Management, including but not limited to their enrollment, stratification processes, communication to members and providers, documentation processes, record-keeping, and standardized Care Management programs. Collectively, a review was done on the overall Care Management process from end-to-end on electronic records integration.

The MCO must have policies and procedures for Care Management which should include:

- A description of the system for identifying, screening, and selecting members for care management services;
- Provider and member profiling activities;

- Procedures for conducting provider education on Care Management;
- A description of how claims analysis will be used;
- A process to ensure that the primary care provider, member parent/guardian, and any specialists caring for the member are involved in the development of the care plan;
- A process to ensure integration and communication between physical and behavioral health;
- A description of the protocols for communication and responsibility sharing in cases where more than one care manager is assigned;
- A process to ensure that care plans are maintained and up-dated as necessary;
- A description of the methodology for assigning and monitoring Care Management caseloads that ensures adequate staffing to meet Care Management requirements;
- Timeframes for reevaluation and criteria for Care Management closure; and
- Adherence to any applicable State quality assurance, certification review standards, and practice guidelines as described in herein.

2.2 Medical Records Review (MRR)

Primaris assessed Home State Health's ability to make available any and all pertinent medical records for the review. A list of members care managed in CY 2017 for the Pregnant Women (OB), Children with elevated Lead Levels, and Serious Mental Illness (Schizophrenia, Schizoaffective disorder, Bipolar Disorder, Post-Traumatic Stress Disorder, Recurrent Major Depression, and moderate to severe Substance Use Disorder) was submitted by Home State Health and Primaris selected Medical Records (oversample for exclusions/exceptions) by using Stratified Random Sampling Method based on Appendix II of 2012, CMS protocols for EQR. (https://www.medicaid.gov/medicaid/qualityofcare/downloads/app2-samplingapproaches.pdf).

A sample of a minimum of 20 Medical Records (MR) for each focus area was reviewed during the onsite visit, July 09-13, 2018. A Care Management Medical Record tool was created and MR were reviewed to ensure that they include, at a minimum, the following *(ref: MHD Managed Care Contract 2.11, Attached: Excel workbook)*

- Referrals;

- Assessment/Reassessment;
- Medical History;
- Psychiatric History;
- Developmental History;
- Medical Conditions;
- Psychosocial Issues;
- Legal Issues;
- Care Planning;
- Provider Treatment Plans;
- Testing;
- Progress/Contact Notes;
- Discharge Plans;
- Aftercare;
- Transfers;
- Coordination/Linking of Services;
- Monitoring of Services and Care; and
- Follow-up

Inter Rater Reliability: 10% of the MR from each focus area were reviewed by different auditors to assess the degree of agreement in assigning a score for compliance in the MR tool.

2.3 Onsite Interviews

Home State Health officials were interviewed to assess:

- The knowledge of MHD Managed Care contract and requirements for Care Management.
- The focus of Care Management services on enhancing and coordinating a member's care across an episode or continuum of care; negotiating, procuring, and coordinating services and resources needed by members/families with complex issues; ensuring and facilitating the achievement of quality, clinical, and cost outcomes; intervening at key points for individual members; addressing and resolving patterns of issues that have negative

quality, health, and cost impact; and creating opportunities and systems to enhance outcomes.

The following persons were interviewed at Home State Health to gather information about the Care Management Program for Pregnant Members (OB), Children with Elevated Lead Levels, and Members with Severe Mental Illness (Schizophrenia, Schizoaffective disorder, Bipolar Disorder, Post-Traumatic Stress Disorder, Recurrent Major Depression, and moderate to severe Substance Use Disorder):

OB: Care Management Program

- Anna Novoa, Medical Trainer;
- Jennifer Jackson, Supervisor Care Management;
- Chris Hoover, Supervisor Care Management; and
- Megan Barton, Vice President Medical Management.

Elevated Lead Level: Care Management Program

- Kelley Peters, Director Care Management;
- Tawania Jackson, Manager Case Management; and
- Stacey Schulte, Supervisor Case Management.

SMI: Care Management Program

- Dr. Susan Nay, Manager, Clinical;
- Shannon McDermott Crandall, Supervisor Clinical; and
- Julie Mertzlufft, Supervisor Care Management.

Care Management Log

Home State Health submits a log of Care Management activities to MHD each quarter.

3.0 Overall Assessment of Care Management Program: Home State Health

The number of members enrolled in all Care Management programs in CY 2017 was 4010. The number of members enrolled in the programs under evaluation was:

- OB: 1930;
- BH: 836 *(note: this number is not for SMI);* and

- Elevated Blood Lead Levels: 287.

3.1 Care management (CM) Policies and Procedures

The following Documents submitted by Home State Health were reviewed to ascertain that they have Care Management policies and procedures to meet the contractual requirement of MHD Managed Care Contract (2.11). Home State Health was found to be 100% compliant.

Table 1: Care Management Policy Review- Home State Health (ref: MHD Managed Care Contract 2.11)

The health plan should have policies and procedures for Care Management. The policies and procedures shall include:	**Yes**	**No**	**Document Name (s)**
1. A description of the system for identifying, screening, and selecting members for Care Management services;	Yes		1. Predictive Modeling Methodology 2. Case Management Program Description 3.CM policy- CC.CM.06
2. Provider and member profiling activities;	Yes		1. Annual Quality Assessment and Performance Improvement Program Evaluation-Home State Health 2017 2. CM supporting document- provider manual

3. Procedures for conducting provider education on Care Management;	Yes		1. Case Management Program Description 2. Annual Quality Assessment and Performance Improvement Program Evaluation-Home State Health 2017
4. A description of how claims analysis will be used;	Yes		1. Case Management Program Description 2. Disease Management Programs
5. A process to ensure that the primary care provider, member parent/guardian, and any specialists caring for the member are involved in the development of the care plan;	Yes		1. Case Management Program Description
6. A process to ensure integration and communication between physical and behavioral health;	Yes		1. Case Management Program Description 2. Annual Quality Assessment and Performance Improvement Program Evaluation-Home State Health 2017
7. A description of the protocols for communication and responsibility sharing in cases where more than one care manager is assigned;	Yes		1. Annual Quality Assessment and Performance Improvement Program Evaluation-Home State Health 2017

8. A process to ensure that care plans are maintained and up-dated as necessary;	Yes		1. Case Management Program Description
9. A description of the methodology for assigning and monitoring Care Management caseloads that ensures adequate staffing to meet Care Management requirements;	Yes		1. Case Management Program Description
10. Timeframes for reevaluation and criteria for Care Management closure; and	Yes		1. Case Management Program Description
11. Adherence to any applicable State quality assurance, certification review standards, and practice guidelines as described in herein.	Yes		1. Disease Management Programs 2.CM supporting document-provider manual
12. Additional Information about CM	Yes		1. Provider Reference Manual (CM page 49) 2.CM policy MO. CM.01-CM Program Description 3. Annual QAPI

3.2 Pregnant Members (OB) Care Management

Home State Health has an award winning program, The Start Smart for Your Baby® (SSFB), which is an effort to improve the health of mothers and their newborns.

The program consists of identifying pregnant members; stratifying them by risk level and impact ability; providing Care Management, care coordination, disease management and intervention as appropriate; and health education for all enrolled pregnant members. SSFB provides participants with the education and tools to reduce their risk of adverse pregnancy outcomes. Members are also eligible to receive incentives for attending their prenatal, postpartum, and well-child visits, based on health plan and state approval. The program helps pregnant members access medical care, educates them on their healthcare needs, assists with

social needs and concerns, and coordinates referrals to appropriate specialists and nurse OB Care Managers as needed.

Goals

The Start Smart for Your Baby® (SSFB) program has goals to improve outcomes:

1. Low birth weight rates (<2500g, <1500g, <1000g);
2. Neonatal and NICU admission rates and days/1000 births;
3. Percentage of deliveries with a Notification of Pregnancy (NOP); and
4. Prenatal and Postpartum (PPC) HEDIS rates.

Member Identification

One of the essential components of the program is the NOP process, which identifies pregnant members and their risk factors as early in pregnancy as possible in order to establish a relationship between the member, provider, and health plan staff. Early identification of pregnant members and their risk factors is the key to better birth outcomes. Receipt of an NOP screening assessment automatically enrolls a pregnant member in the Start Smart for Your Baby® program.

Additionally, members are identified as pregnant from multiple sources including, but not limited to:

- Claims;
- Community Agencies i.e. WIC;
- Disease Management Staff;
- Health Plan staff i.e. Care Manager, Community Health Services, Member Services;
- Hospital Care Manager;
- Inpatient and emergency department census reports;
- Medical Management Staff;
- Member or Family Member;
- Other Providers or Practitioners;
- Pharmacy Data;
- Primary Care Provider (PCP) or OB/GYN;
- Specialists;
- Start Smart internal Reports; and

- Daily 416 Reports- MHD notifications.

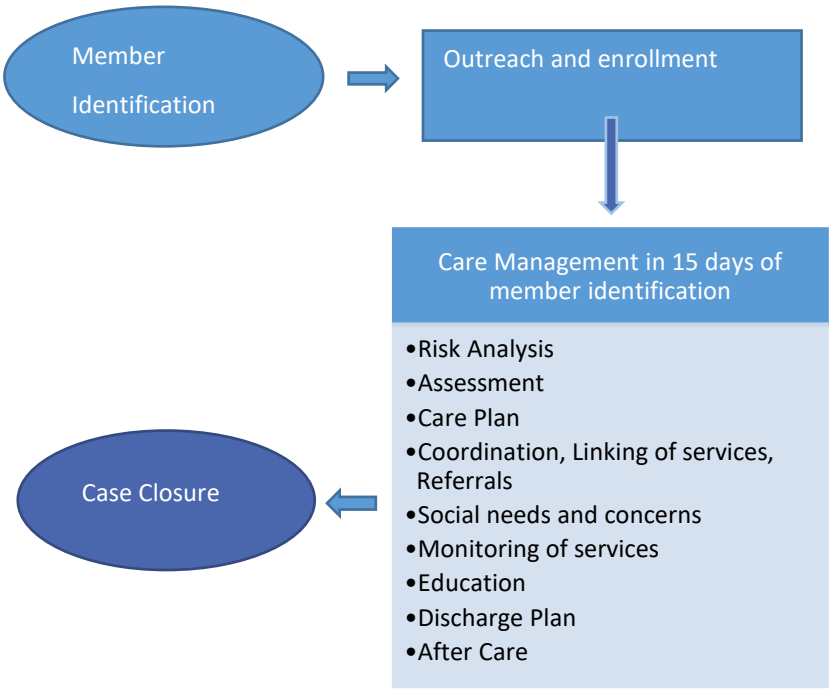
Member Stratification

Once pregnant members are identified and their risk factors collected in the NOP, members are stratified into low, medium, and high risk groups according to their NOP assessment results and claims data. Higher risk members are prioritized for outreach by health plan staff. Particular attention is paid to members with a history of prior preterm delivery. These members have a high risk of recurrent preterm delivery that could be improved by 17 alpha-hydroxyprogesterone caproate (17P) administration.

Workflow

Upon identification of a pregnant member, Home State Health begins Care Management within 15 business days. Members who are identified as 'high risk' per NOP form who are not currently engaged with Care Management have an additional outreach in efforts to engage them. For members who are not reachable on MHD provided phone numbers, Home State Health attempts to find them by outreaching to the OB office, calls to the pharmacy, and home visits at last known address. Home State Health offers field and telephonic OB Care Management.

Figure 1: Work flow of Care Management



Member Interventions

- Home State Health mails one time each pregnancy, a letter encouraging members to complete the NOP form and to initiate prenatal care, a SSFB brochure, a NOP assessment, and envelope to facilitate return mailing of the NOP.
- Home State Health mails one time each pregnancy, a mailing of an incentive to members who have submitted a member NOP form, on the member web portal, or called the MCO to notify them of their pregnancy.
- Home State Health mails a 'newborn mailing' to members who have a valid date of birth entered in 'TruCare'. Members with a documented birth status of stillborn or adopted/foster care will not receive a mailing. The mailing contains a congratulations letter, a postpartum wellness survey to screen for postpartum depression, and *The Mother's Guide to Life after Delivery* book which contains newborn and postpartum care educational information. Members who have the opportunity to receive incentives determined by the health plan for completing required postpartum and well child visits also receive information on how to receive rewards in this mailing.
- The Perinatal Depression Screening Program is in place to screen members for perinatal depression as well as educate members in the perinatal period about the risks of depression, the signs and symptoms of depression, and accessing services for treatment of depression.
- The SSFB Breastfeeding program coordinates interventions throughout pregnancy, birth, and infancy to increase breastfeeding initiation and duration. Interventions include member education, providing a breast pump, and postpartum follow up and support.
- The 17P Care Management program consists of identification and evaluation of pregnant members who are potential candidates for 17P treatment in order to reduce their risk of repeat preterm delivery. Each health plan is responsible for identifying members who are eligible for 17P therapy and ensure they are in OB Care Management and contacted by their OB Care Manager or designee on a regular basis.
- High-risk health plan eligible moms and high risk health plan eligible babies are followed for the baby's first year of life as needed.
- Additional Start Smart educational books/resources include:

1. Start Smart for Your Baby® – Your Pregnancy Guide;
2. Start Smart for Your Baby® – A Guide to Your Baby's Care –The First Year;
3. Dad Little Word – Big Deal – Your Guide to the Father Situation;
4. Route to Health – Baby Fuel – Filling Your Baby's Tank with the Right Foods;
5. Darby Boingg and Friends Count to 10 – Board book promoting number and letter recognition;
6. Off the Chain: Teens & Pregnancy – Guide for pregnant teenagers; and
7. Body Well, Baby Well – Risks of Pregnancy, Drugs, Alcohol, and Smoking.

- Other efforts to identify and/or engage the pregnant members include:
    1. Missed appointment outreach (from claims data);
    2. Denying office visit payments to OBs who do not submit a NOP form;
    3. Free diapers to members who enroll in our Substance Use Field Case Management;
    4. Free app which offers 24hr access to a face-to-face (Skype) visit with a dietician or lactation consultant; and
    5. Pre-loaded debit card for members who attend OB appointments.

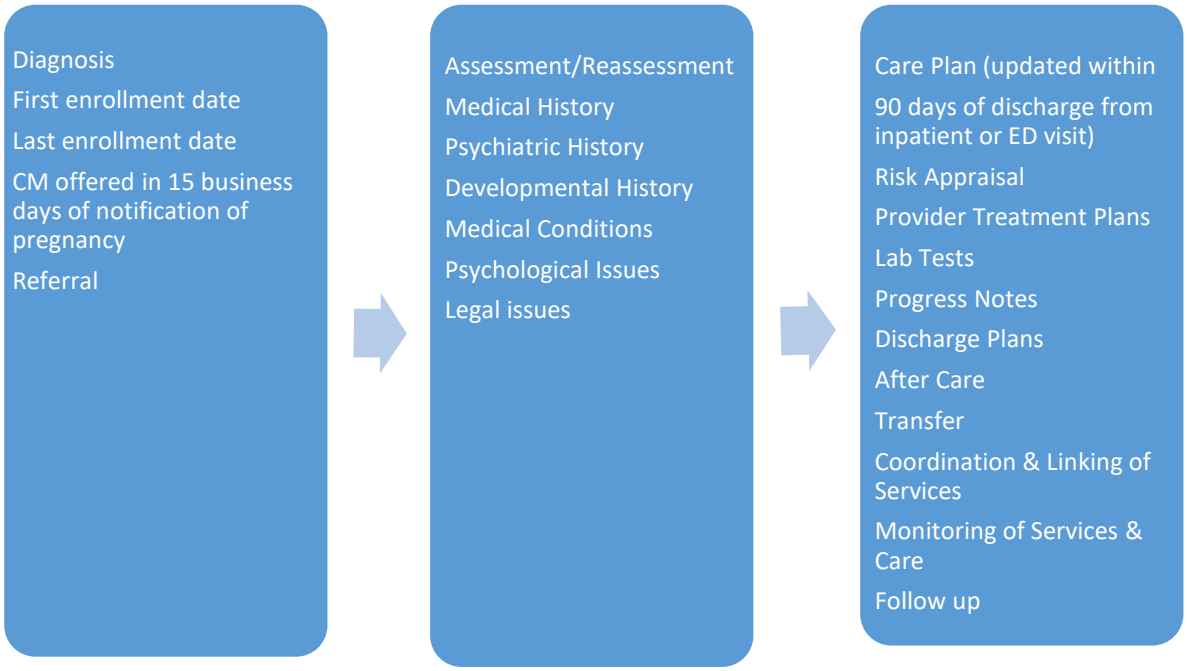
3.2.1 Findings of MRR (Attached: Excel workbook Tab A)

Primaris reviewed 31 MR to get the required sample of 20. 11 out of 31 MR had to be excluded due to following reasons (Table 2):

Table 2: Exclusions/Exceptions	**Number of MR**
Declined Care Management:	3
Unable to Contact (UTC):	5
No Care Management, Care Coordination:	3
Total	**11**

Amongst the 20 medical records which were included in study, the following documentation was validated:

Figure 2: Validation of Medical Records for OB Care Management



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The Medical Record review for Home State Health OB Care Management program revealed the following information:

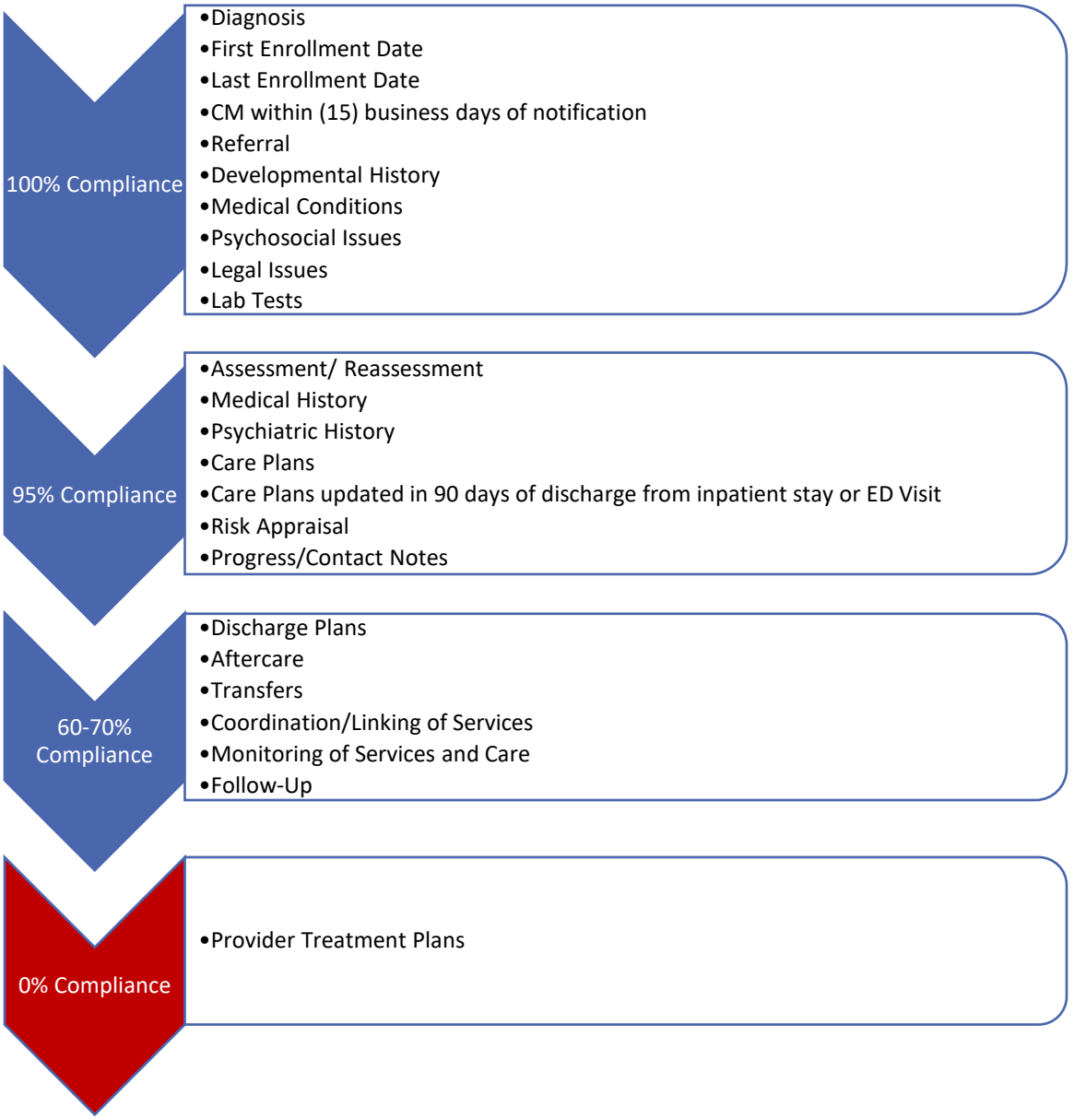


Figure 3: Compliance % for OB Care Management MRR

Figures 4 and 5 are graphical representation of Compliance for areas validated during OB Care Management MRR.

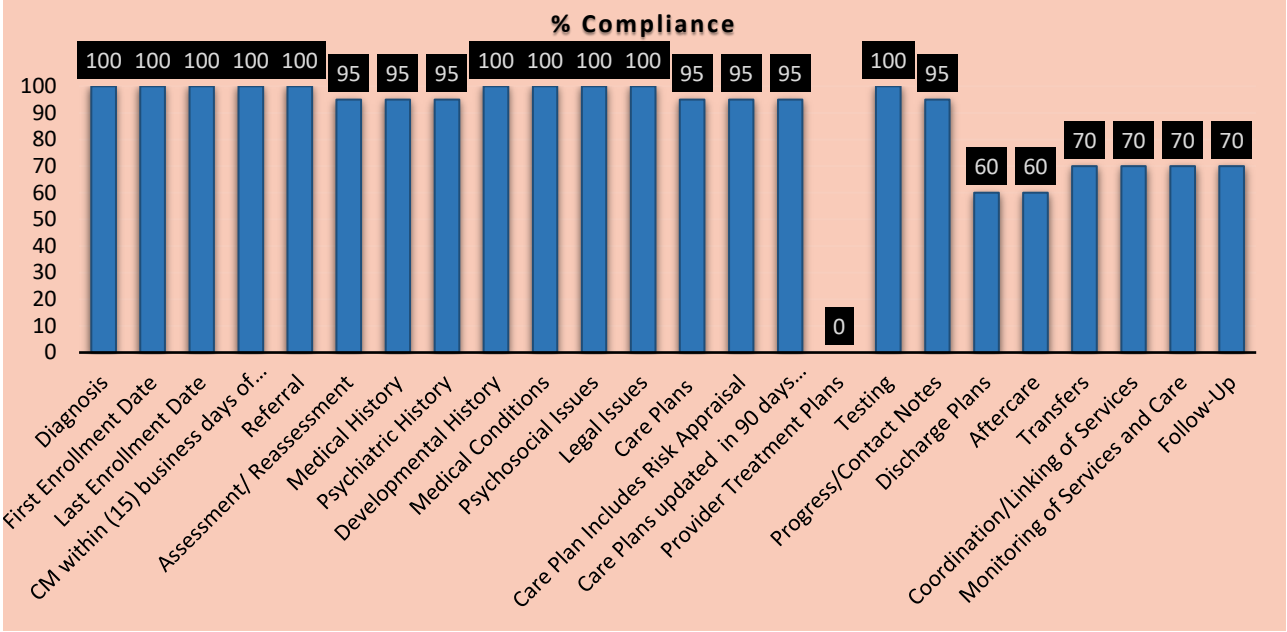


Figure 4: MRR Compliance

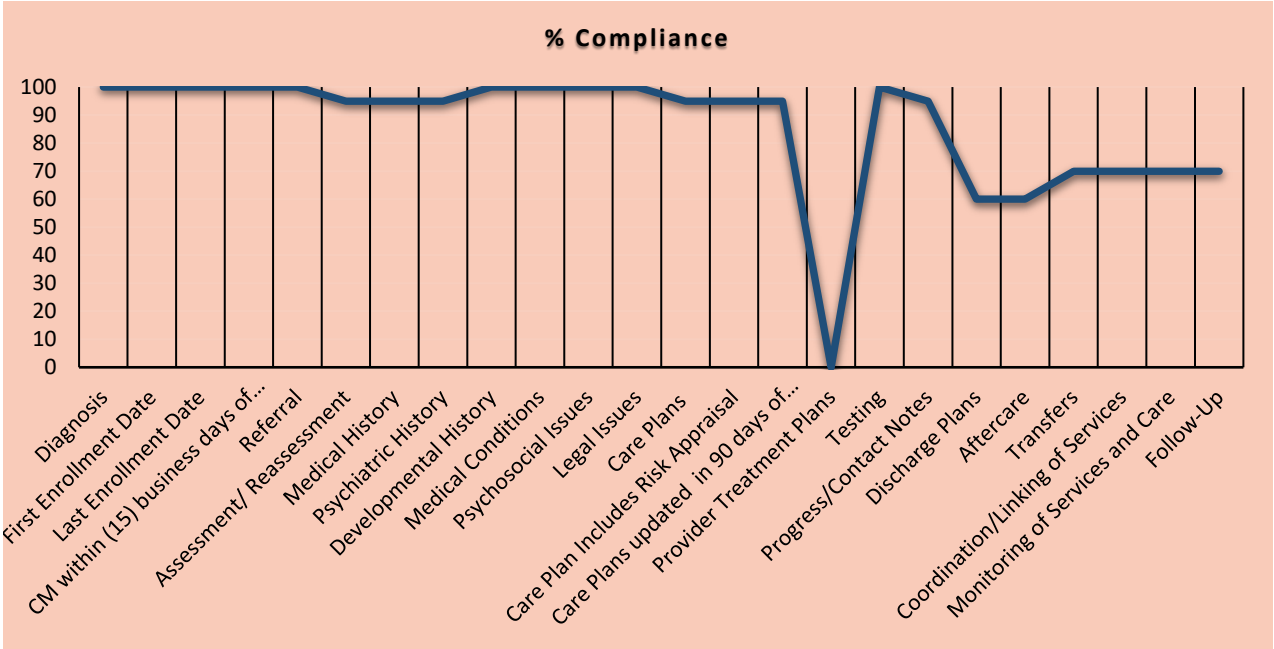


Figure 5: MRR Compliance

3.2.2 Conclusions

Primaris aggregated and analyzed findings from the Interviews, Policies and Procedures, MRR for the OB Care Management to draw conclusions about Home State Health's performance in providing quality, access, and timeliness of healthcare services to members. Overall, evaluation showed that Home State Health has Systems, Policies & Procedures, and Staff in place to ensure that its structure and operations support the processes for providing care and services while promoting quality outcomes.

- **Issues & Key Drivers**

Issues

The Medical Record review was done for 31 pregnant members: out of these 31, Care Management could not be done on 11 of them (35.5%). Home State Health lost the opportunity to provide Care Management to eligible members due to following reasons:

Table 3: Lost Opportunities

Reason	Number of Members	Notes
Declined Care Management	3	Member works, believe no need of Care Management, no time for Care Management.
Unable to Contact (UTC)	5	MCO alleged that 60 % of primary demographic information received from State is incorrect/incomplete.
Care Coordination (No Care Management)	3	Joined late at 34 weeks, needed resources only.

- Home State Health enrolls a member in their OB CM program on the day they make an attempt to contact the member. They call it as an ‘outreach.’ This is contradictory to the contractual requirements of MHD. A member should be considered as ‘enrolled’ on the day of assessment of their needs.
- The focus of Home State Health is more on ‘Outreach’ instead of ‘Assessment’ in order to meet the contractual requirement of “offering Care Management in 15 days of notification of pregnancy.”
- The providers do not respond or acknowledge the treatment plan sent by the Care Manager. They respond only when the Care Manager makes a call on a “need basis.”
- Coordination /Linking of services, Monitoring of Services and Care, Follow up could be done only in 70% cases as the Care Manager could not contact the members in spite of attempting to reach via telephone/letters.
- Discharge Plans and After Care was possible in only 60% of cases as members were not reachable near delivery.

Key Drivers

- Teamwork;
- Medication Management;
- Health Information Technology;
- Patient-Centered Medical Home;
- Establishing accountability and agreeing on responsibility;
- Communicating/sharing knowledge;
- Helping with transitions of care;
- Assessing patient needs and goals;
- Creating a proactive care plan;
- Monitoring and follow-up, including responding to changes in patients' needs;
- Supporting patients' self-management goals;
- Linking to community resources; and
- Working to align resources with patient and population needs.

❖ **Quality, Timeliness Access to Health Care and Services**

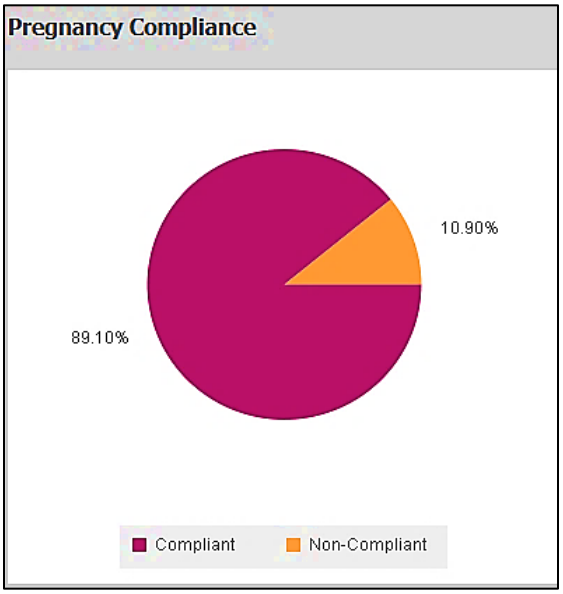
- Home State Health OB Care Management Program was monitored in 24 areas during the MRR. Out of those, 10 areas scored 100%, 7 areas scored 95% for compliance, 6 areas scored 60-70% compliance whereas Provider Treatment Plan scored zero (0).
- After receiving enrollment information from MHD in 834 file, Home State Health made efforts to verify the contact information and address of the members at the onset on successful outreach.
- Home State Health also contracted with a Home Health Agency for some time for Home Visits in CY 2017.
- Home State Health used multiple referral sources in addition to enrollment file to identify OB members; e.g., claims, provider notifications, lab reports, so that access to Care Management and coordination of services could be provided in a timely manner.
- The following information/data has been obtained from Home State Health to reflect their efforts for success of OB Care Management Program in CY 2017.

CY 2017 Care Management OB Outcomes

On May 01, 2017 Home State Health's membership expanded to cover the entire state.

A**.** 15 day outreach to newly OB Members: The Figure 6 below shows that outreach for OB members was 89.10% for the CY 2017.

Figure 6: Outreach Compliance OB members



B. START SMART %

Table 4: Start Smart %

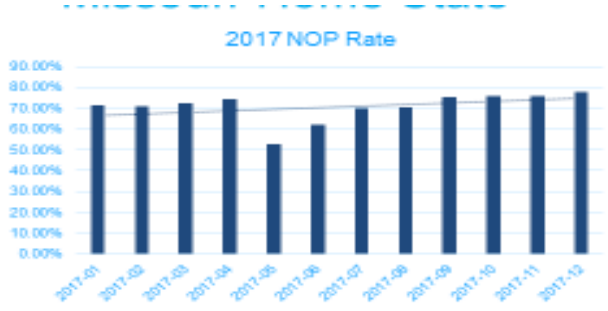
Start Smart (%)	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Total
Deliveries with NOP	70.9	70.8	69.8	73.2	51.9	61.2	68.4	69.4	74.2	74.2	74.9	77.6	69.3
Out reach in 7 days of receiving a High Risk NOP	100	95.6	96.7	93.7	96.5	95	99.1	94.6	91.7	83.5	90.9	100	94.3
Members in CM in 30 days of receving a High Risk NOP	19.7	14.4	14.6	23.2	18	16.3	17.2	21	19.7	24.8	23.8	29.2	19.3

Table 4 shows that in CY 2017, 69.3% of deliveries were with a NOP and 94.3% of high risk NOP cases were outreached in within 7 days. However, the % members who could be engaged in Care Management within 30 days were low (19.3%). There is a need for the MCO to have a different approach to get their pregnant members engaged in their Care Management program. The contractual requirement is to offer Care Management in 15 days of notification of pregnancy.

C. Figure 7 shows the graphical representations for the deliveries with NOP, number of deliveries in CY 2017 and Low Birth Weight (LBW) rate. In the CY 2017, the rate of LBW for managed care population in Home State Health was 8-13%.

The latest published data from The National Center for Health Statistics for Births is for the CY 2016. The LBW rate for United States (US) was 8.2% and for the State of Missouri it was 8.7% which ranked at 14th place (rankings are from highest to lowest).

LBW% was submitted by 26 states in FFY 2016 for Child Core Set Report to Centers of Medicare and Medicaid Services (CMS). 'Mean' was calculated as the unweighted average of all state rates which was 9% (measurement year was CY 2015).



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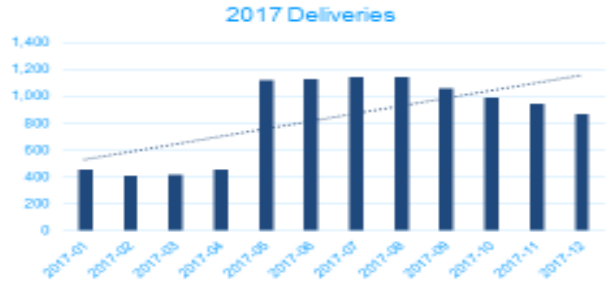


B

C

Figure 7: Home State Health- A: NOP Rate, B: Deliveries, C: LBW Rate

❖ **Improvement by Home State Health**

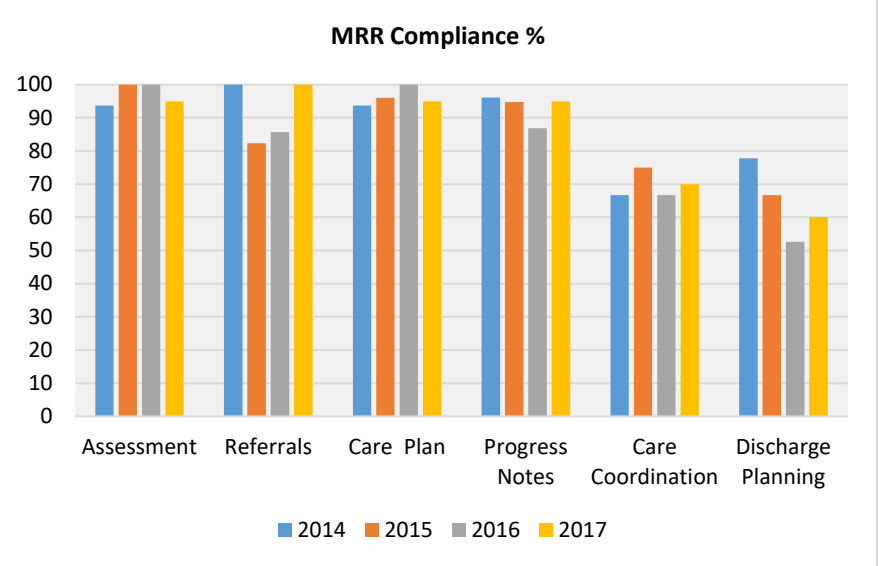
A comparison with previous year (CY 2016) was done to determine the extent to which Home State Health addressed effectively the recommendations for quality improvement made by the EQRO.

- Improvement was noticed for referrals (14.29% points), progress notes (8.16% points), Care Coordination (3.33% points), and Discharge Planning (7.37% points).
- Assessment and Care Plan decreased by 5% points. This was because Home State Health lost contact with the patient after initial screening. The opportunity to do assessment during contact with the patient was not availed.
- Table 5 and Figure 8 show the trend data for a period of CY 2014-CY 2017 and change in % point from CY 2016.

Table 5: Trend Data for MRR: 2014-2017 EQR

%MRR Compliance %	2014	2015	2016	2017	% point Change
Assessment	93.75	100	100	95	-5
Referrals	100	82.35	85.71	100	14.29
Care Plan	93.75	95.99	100	95	-5
Progress Notes	96.15	94.74	86.84	95	8.16
Care Coordination	66.67	75	66.67	70	3.33
Discharge Planning	77.78	66.67	52.63	60	7.37

Figure 8: MRR Compliance trends (CY 2014-2017)



3.2.3 Recommendations

- Despite Home State Health's belief that merely reaching out to a member constitutes "enrollment" in care management, this is completely contrary to the contract language, and inconsistent with the expectations of MHD. Home State Health enrolls a member in the OB-Care Management program, on the day they make an attempt to contact a member. It is recommended that a member should be considered as 'enrolled' when the Care Manager makes an assessment of the need of the member. As per MHD Managed Care Contract, The initial Care Management and admission encounter shall include an assessment (face-to-face or phone) of the member's needs.

- The Assessment should be completed within 15 days of notification of pregnancy. Care management for pregnancy is included in the current Performance Withhold Program. This allows MHD to emphasize the importance of timely case management for this critically important condition.
- Face to face contact for complex cases.
- Before closing a case for UTC, at least three (3) different types of attempts should be made prior to closure for this reason. Where appropriate, these should include attempts to contact the member's family. Examples of contact attempts include (MHD Managed Care Contract 2.11f (1)):
    - Making phone call attempts before, during, and after regular working hours;
    - Visiting the family's home;
    - Checking with primary care provider, Women, Infants, and Children (WIC), and other providers and programs; and
    - Sending letters with an address correction request. (Post Offices can be contacted for information on change of address).
- The engagement of provider in the 'Care Plan'. Home State Health sent letters to the providers about new patients' enrollment and Care Plan but no response was received from them. This opportunity to collaborate with provider at early stage can be tapped. Involving the provider in engaging members in their care would increase the success of pregnancy outcomes.
- Patient-centered education: https://www.managedcaremag.com/archives/2017/9/three-components-missing-many-population-management-strategies recommends:
  To assess and account for cognitive factors that affect member's ability to understand their health needs, care goals, and recommended interventions. Does a member have the cognitive ability to support her Care Plan? Does she or he have the knowledge necessary to understand not only what constitutes a Care Plan but also why and how it can be followed? Gaining this level of insight requires structured and timely interaction with the patient. Both must be embedded in the Care Management fabric of the OB Program. Only after there is a clear picture of a patient's cognitive skills and knowledge base is it possible to provide the patient

with the appropriate level of educational information and outreach. If people truly understand their Care Plans, adherence improves and have better outcomes.

- Patient-centered technology: https://www.managedcaremag.com/archives/2017/9/three-components-missing-many-population-management-strategies

  Many Medicaid Managed Care Organizations have member portals—and nearly all of them have members who rarely, if ever, use the portals. The reason is remarkably basic: Most people in Medicaid plans use smartphones rather than home computers to connect to the Internet. Smartphone apps, *not* web-based member portals, is the way to serve Medicaid plans and their members.

  By identifying how patients are willing to engage, Home State Health can procure and configure technology that optimally support these preferred engagement channels. In turn, these expanded lines of communication between care teams and patients can ensure the timely flow of information and education.

- Frequency of follow-up, availability of psychosocial services, assistance with financial issues and active engagement of the care manager and the member are important characteristics of Care Management interventions.

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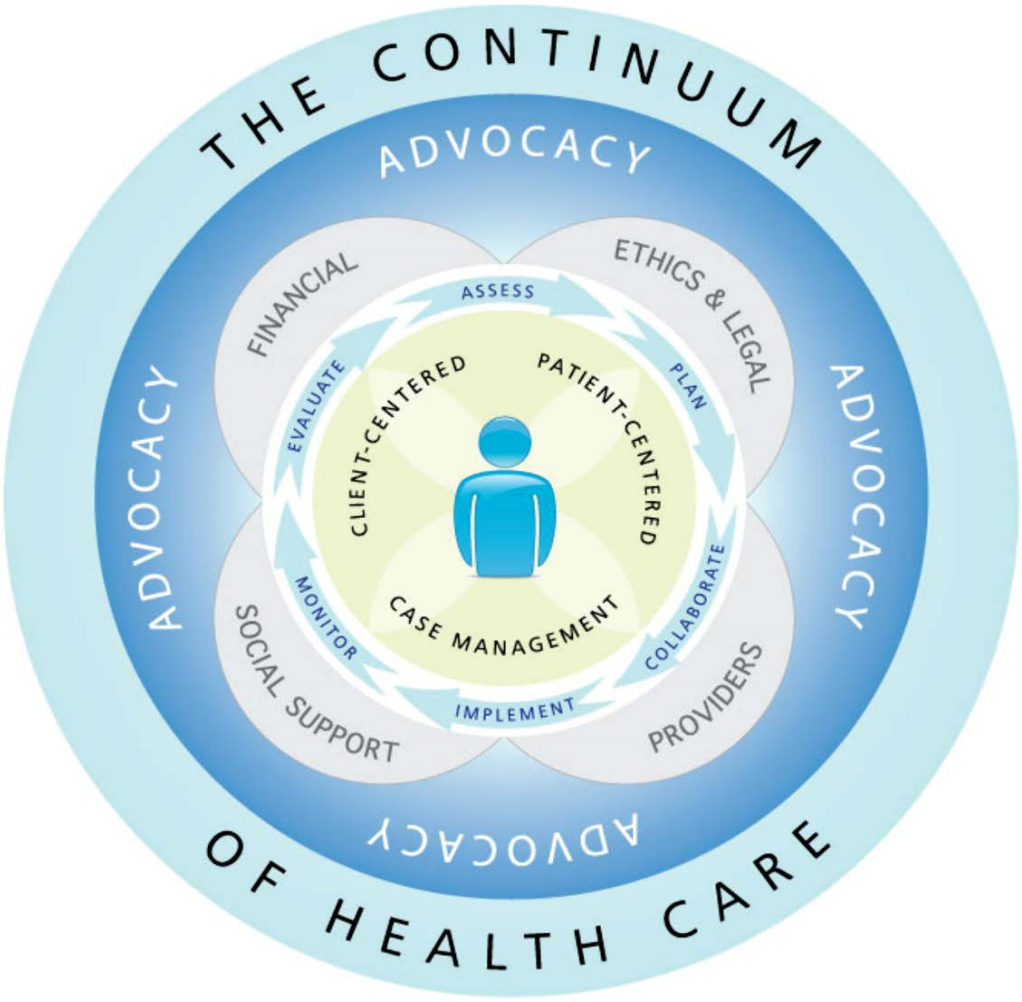
Figure 9: The Continuum of Health Care and Professional Case Management (Ref: Standards of practice for case management- CMSA case management society of America)



3.3 Children with Elevated Blood Levels Care Management

Lead Case Management Overview

Goals

- Identify all pediatric members who have an elevated blood lead levels.
- Educate guardians and/or members and providers on the importance of lead screening and treatments.

- Facilitate appropriate screening, testing, treatment repeat testing and follow-up per MHD guidelines.
- Facilitate guardians and/ or members towards increased self-management of lead values by assisting and increasing their knowledge and comfort level.

Lead Care Management Flow Process

Referrals and identification for Lead Care Management include but not limited to, the following:

- Primary Care Provider (PCP);
- Specialist/Specialty Medical Provider (SMP);
- Hospital Case Manager;
- Case/Care/Disease Management staff;
- Member's parent or representative;
- Community agencies;
- Other providers, Department of Health (DOH), Department of Health and Human Services (DHHS), MO HealthNet Division (MHD); and
- MCO Lead File.

Screening and Identification of members for elevated lead levels:

- Any child under the age of six (6) years visiting for ten (10) hours per week or more, a high-risk area is tested annually for lead.
- All eligible children are blood tested for lead at age twelve (12) and twenty four (24) months of age.
- Members identified through a referral or data source with identified lead levels are enrolled in the Lead Care Management Program.
- Members are eligible for the Lead Care Management Program when there is a positive blood lead test equal to or greater than ten (10) micrograms per deciliter (elevated blood lead level, or EBLL).

Identified Members

Lead Care Management outreach to offer Care Management services for those members with elevated blood levels occur within the following timeframes:

- 10 to 19 ug/dL within 1–3 days;

- 20 to 44 ug/dL within 1–2 days;
- 45 to 69 ug/dL within 24 hours; and
- 70 ug/dL or greater – immediately.

For the identified members, a lead Care Management coordinates with the PCP for an initial confirmation test, according to the following timeframes:

- 10-19 ug/dL - Within two (2) months;
- 20-44 ug/dL - Within two (2) weeks;
- 45-69 ug/dL - Within two (2) days; and
- 70+ ug/dL – Immediately.

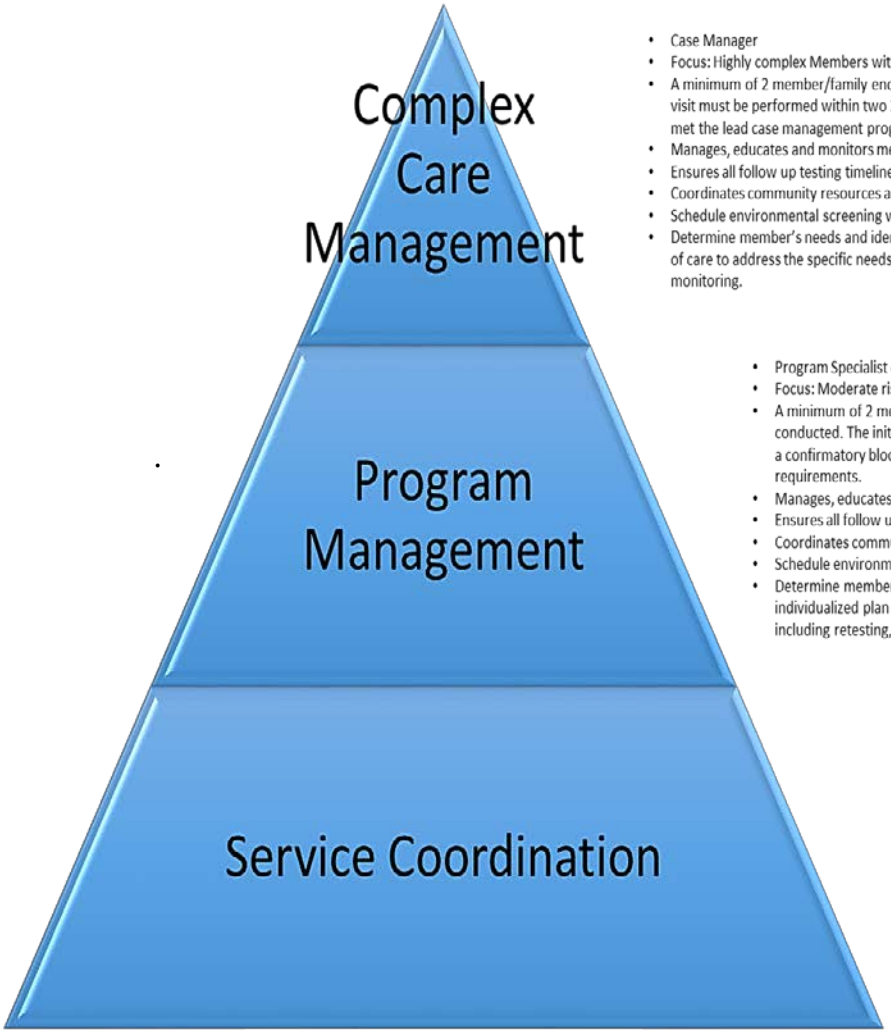
The lead Care Management verifies that the follow-up testing for children with confirmed EBLL are performed as follows:

- 10-19 ug/dL - 2-3 month intervals;
- 20-70+ ug/dL -1-2 month intervals, or depending upon the degree of the EBLL, by physician discretion until the following three conditions are met:
  - BLL remains less than 15 ug/dL for at least 6 months;
  - Lead hazards have been removed; and
  - There are no new exposures.

Staffing Model

Home State Health Lead Care Management Program is organized in 3 tiers to best address and stratify the needs of this complex population. Members are stratified based on an initial assessment. An increase in complexity and need is exhibited as one travels up the triangle. Members, based on experience, the members typically do not stay in one tier but move down the triangle as conditions improve and move up the triangle if needs increase. Also, the experience and qualifications of staff increases from the bottom of the triangle to the top which enables the plan to best address the specific needs of each member.

Figure 10: Lead Care Management Triangle



3.3.1 Findings of MRR (Attached Workbook Tab B)

Primaris, reviewed 36 MR and 20 of them were open for Care Management in CY2017. 16 out of 36 records were excluded for the following reasons:

Table 6: EXCLUSIONS/ EXCEPTIONS	NUMBER OF MR
State notifies of increased capillary Blood Lead Level (BLL) followed by notification of decreased venous BLL	5
Venous level drawn and within normal parameters	6
Unable to contact member	2
Not enrolled in Care Management	3
TOTAL	**16**

Amongst the 20 medical records which were included in study, the following documentation was validated:

Figure 11: Validation of Medical Records for Lead Care Management

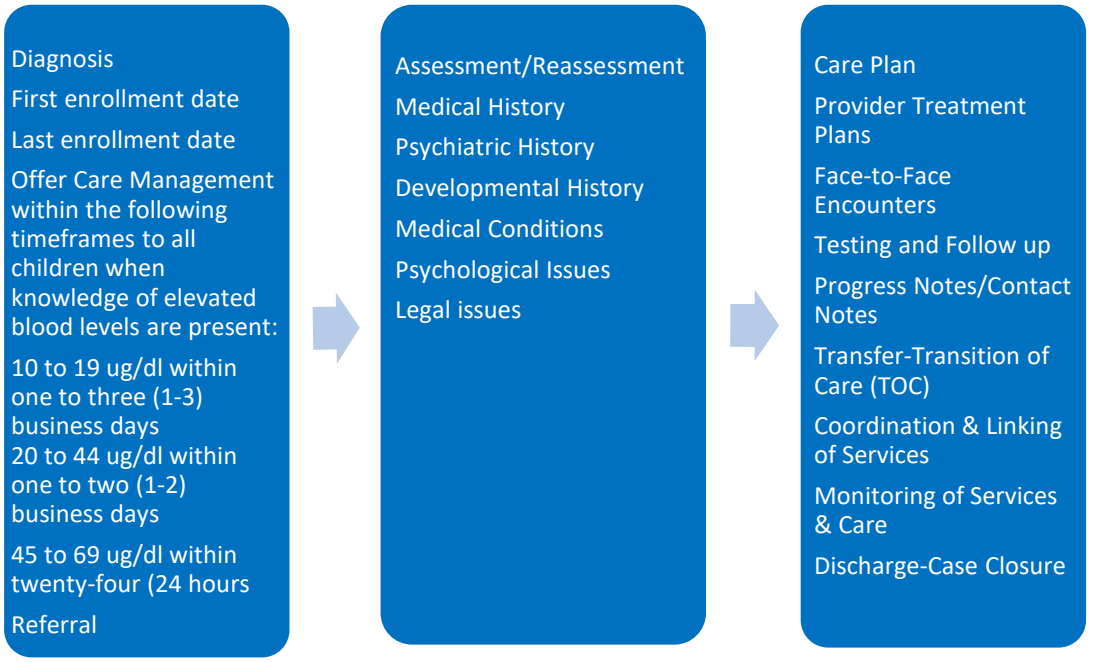
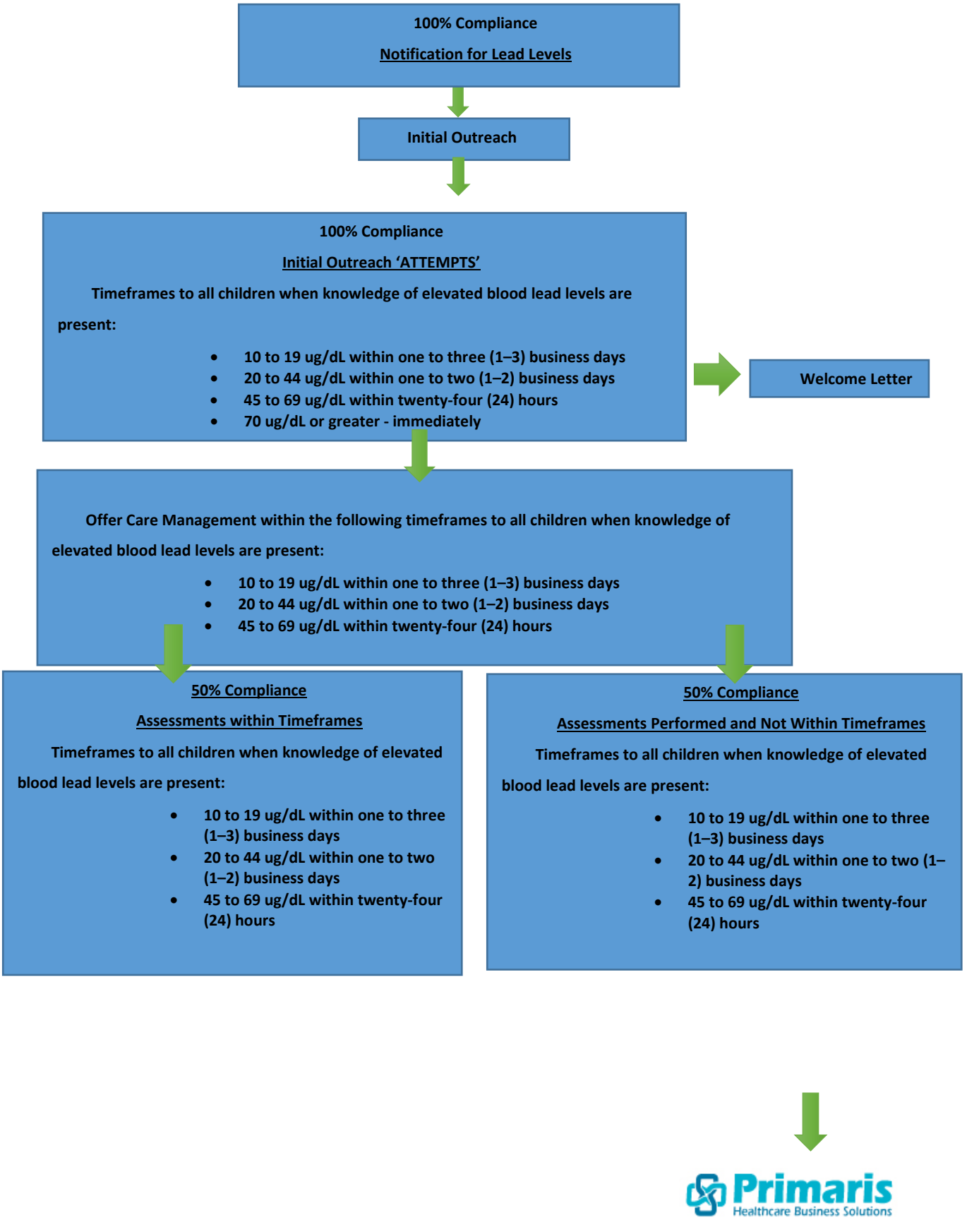


Figure 12: Lead Care Management Flowchart with MRR Findings



Care Management: Home State Health

95% Compliance

- Medical History
- Psychiatric History
- Developmental History
- Medical Conditions
- Psychosocial Issues
- Legal Issues

Reasons Assessments Not Performed Within Timeframes

- Unable to Contact
  - Inaccurate member information
  - No Answer
- Member/Guardian Refusal

100% Compliance

Referrals

Sources Used to Contact Member

- Member Directory
- PCP
- Other Resources, Claims, WIC, State, etc.

20% Compliance

Two (2) Face-to-Face Encounters

Initial and Follow-Up/2nd Visit

35% Compliance

Initial Visit: A minimum of two (2) member/family encounters, both face-to-face. Initial visit must be performed within two (2) weeks of receiving a confirmatory blood lead level that met the lead Care Management requirements.

20% Compliance

Follow-Up Visit

Follow-up visit or second (2nd) encounter within three (3) months following the initial encounter. Assessment and review of the child's progress, parental compliance with recommended interventions, reinforcement of lead poisoning education, member education, and the medical regime should be performed at that time.

Reasons Visits Are Not Within Timeframe

- Unable to Contact
  - Inaccurate member information
  - No Answer
- Member/Guardian Refusal

55% Compliance

Visits Performed and Not Within Timeframes

95% Compliance

Testing

Ensure that the Childhood Blood Lead Testing and Follow up Guidelines are followed as required:

- **10-19µg/dL – two to three (2-3) month intervals.**
- **20-70+µg/dL – one to two (1-2) month intervals, or depending upon the degree of the elevated lead level, by physician discretion until the following three conditions are met:**

- **BLL remains less than 15µg/dL for at least 6 months;**
- **Lead hazards have been removed; and**
- **There are no new exposures.**

When the above conditions have been met, proceed with retest intervals and follow-up for BLLs 10-19µg/dL.

100% Compliance

Progress/Contact Notes

30% Transfers-

TOC in 2017

100% Compliance

Coordination/Linkin

100% Compliance

Monitoring of Services and

90% Compliance

Provider Treatment

Discharge Plans

Case Closures Met Criteria

17% Compliance

Exit Evaluation/Case Closure Contact to Member/Guardian Prior to Discharge

An exit evaluation/case closure and education contact is required to be performed prior to discharge. This contact can occur via telephone or in person by the care manager.

100% Compliance

Exit Evaluation/Case Closure Contact to Member/Guardian

Discharge Documentation/Closure letter

67% Compliance

Exit Evaluation/Case Closure Contact to PCP

Discharge Documentation/Closure letter

Care Management: Home State Health

The MRR for Home State Health Lead Care Management revealed the following information:

a. Offer Care Management and Assessments

Home State Health receives the notification/referral of the elevated blood level. The Care Manager then offers Care Management within the timeframe below according to the elevated blood lead levels:

- 10 to 19 ug/dL within 1–3 days;
- 20 to 44 ug/dL within 1–2 days;
- 45 to 69 ug/dL within 24 hours; and
- 70 ug/dL or greater – immediately.

Home State Health's initial 'outreach' attempts to contact the member/guardian for Lead Care Management was 100%. Although 'attempts' were done, the Care Managers success rate to contact the member/guardian to offer case management and perform an assessment was only 50%. They were 'unable to reach' due to 'no answer' and/or 'inaccurate member's contact information'. The Care Managers continued to contact outside sources to obtain correct contact information.

b. Member Engagement and Care Planning

The care managers face difficulty in member/guardian engagement for Care Management services. Welcome letters are initially sent to the member/guardian regarding Care Management. An educational pamphlet, "Lead Poisoning" is Included in the initial "Welcome" letter.

c. Provider Engagement and Care Planning

Care plans are implemented with members after the completion of the initial assessment. Communication with physician/physician staff for the member's care is ongoing during the Care Management process. Care Managers notify the provider that the member is engaged in the Lead Care Management. Home State Health is 90% compliance for care plans.

d. Childhood Blood Lead Testing and Follow-Up

Home State Health is 95% compliant. The Care Managers educate the member/guardian the importance of follow-up blood testing.

e. Referrals

Home State Health maintains 100% compliance with referrals. The Care Managers made attempts for referrals for services. The participation of the member engagement remains a challenge.

f. Two (2) Face-to-Face Encounters

The initial face-to-face encounter within 2 weeks of receiving a confirmatory blood level is 35% compliance. The compliance for the second visit within 3 months is 20%. The Care Managers utilized outside sources such as home health, lead assessor to promote the face-to-face encounters. The barriers documented by the Care Managers are 'unable to reach' and 'member/guardian refusal'. Initial visits for face-to-face encounters do not occur as frequently as required. Although referrals were initiated, the initial face-to face and follow-up encounters required continuous attention.

g. Coordination and Linking and Monitoring Services

The coordination, linking and monitoring of services are documented in the progress/contact notes with 100% compliance.

h. Discharge Plans/Case Closures

A member/guardian exit evaluation for case closure can occur via phone or face-to-face encounter. 'Unable to reach member/guardian' presents a challenge for meeting the criteria for conducting a contact exit evaluation. Member exit evaluation/case closure was 16.666%. In addition to meet the criteria for discharge plans, a case closure letter is required to be sent to member/guardian and PCP when applicable. The member closure letter criteria was 100%. PCP discharge notification was 66.666%.

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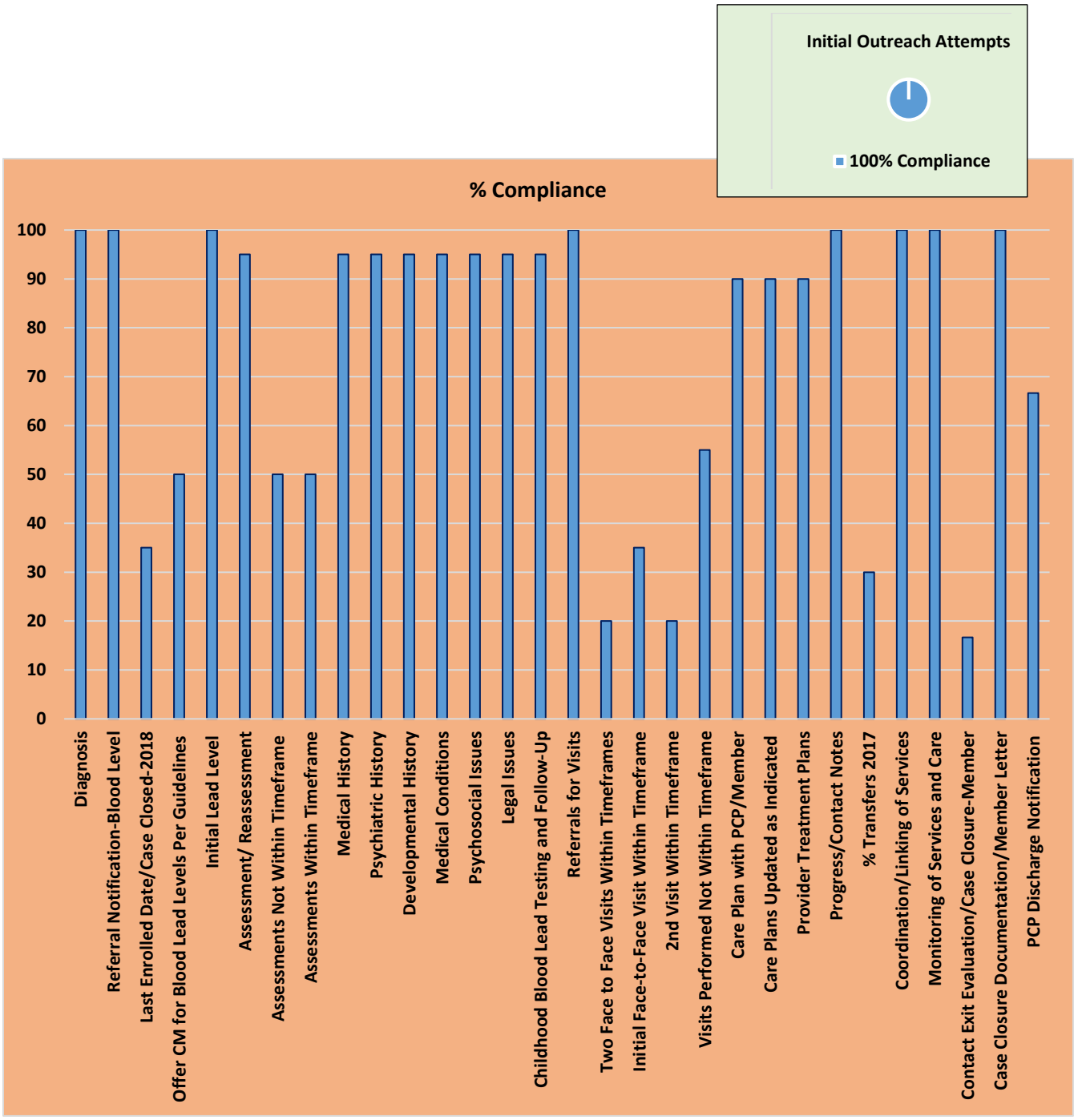
Figure 13: Compliance Graph for Lead Care Management MRR



3.3.2 Conclusions

Primaris aggregated and analyzed findings from the Interviews, Policies and Procedures, MRR for the Lead Care Management Program to draw conclusions about Home State Health's performance in providing quality, access, and timeliness of healthcare services to members. Overall, evaluation showed that Home State Health has Systems, Policies & Procedures, and Staff in place to ensure that its structure and operations support the processes for providing care and services while promoting quality outcomes.

❖ **Issues and Key Drivers**

Issues

Thirty six (36) MR were reviewed (oversampling due to exclusions/exceptions) to get the required sample of 20. Home State Health was unable to meet all the guidelines for Care Management for 31 cases eligible members due to the following reasons:

Table 7: Issues

Criteria/Guideline	Reason	Number of Members
Offer Care Management per Guidelines with Assessment	Declined	1
	UTC	9
Face-to-Face Encounters (Initial and/or Follow up)	Declined	5
	UTC	11
Discharge/Case Closure-Exit Evaluation with member	UTC	5

Key Drivers

Table 8: Key Drivers

Key Drivers	Intervention	Failure Mode & Effect Analysis
MCO Member Directory Care Coordination	Accurate Member Directory Contact Information Internal Process Changes within MCO	Unable to contact patient for care planning: • Offer Care Management within timeframe with assessments • Face-to-Face Encounters • Follow-Ups • Exit Evaluation/Case Closures
Coordination/Resources	Focused Member Outreach by the Targeted Provider Member Engagement/Member Outreach and Incentive	Unsuccessful member engagement: • Member refuses • Lack of investment in the member's healthcare needs • Member is not aware of the importance of follow-up
Provider Engagement	Internal Process Changes at PCP Office Improve Provider Processes	Unsuccessful provider engagement and care planning

❖ **Quality, Timeliness and Access to Health Care Services**

Home State Health Lead Care Management program was reviewed in 22 areas during the medical record review. Eighteen (18) areas scored 90% or higher for compliance. One (1) area, case closure-PCP notification was 67% compliance. One (1) area, offer case management within timeframe with assessment was 50% compliance. One (1) area, face-to-face-encounters scored 20-35% compliance. In addition, one (1) area for contact exit evaluation/case closure-member was 17% compliance.

The use of these findings would help to understand the opportunities for improvement that would have a positive impact on the care, services, and outcomes for members.

Home State Health Lead Program Effectiveness: Program effectiveness is measured by the percent of eligible members screened. HEDIS reporting measures for lead are used as an additional measurement of effectiveness.

Outreach:

Table 9: Outreach in CY 2017

Metric	Quarter 1 2017	Quarter 2 2017	Quarter 3 2017	Quarter 4 2017
# of member with Elevated Blood Lead Level 10+	20	108	80	52
% of Timely outreach to members with Blood Lead Level 10+	100%	100%	100%	100%

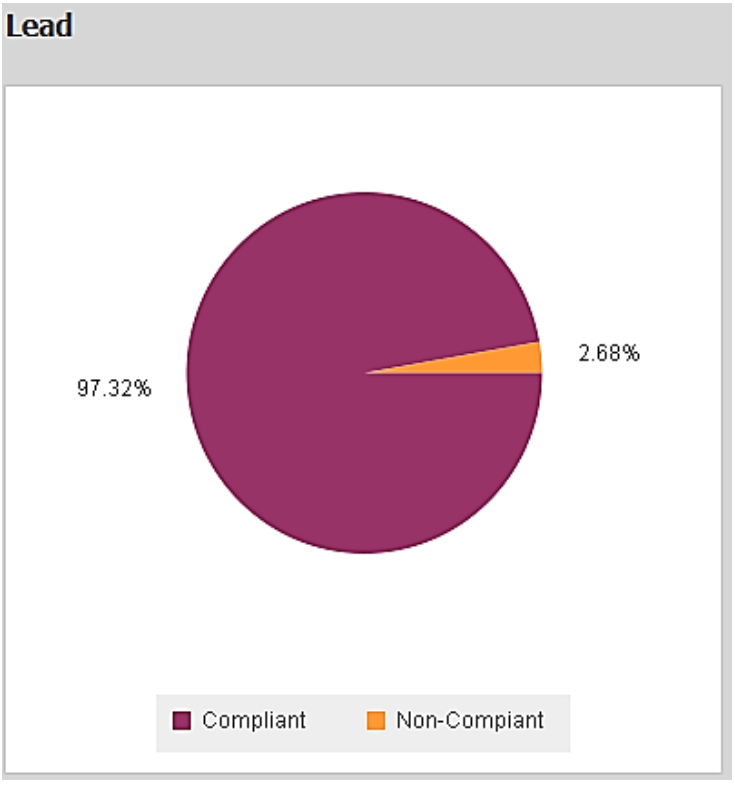
Analysis:

In CY 2017, Home State Health achieved 100% in timely outreach to members with a confirmed blood lead level of greater than 10ug/dL. Timely outreach is defined as follows:

- 10 to 19 ug/dL within 1–3 days;
- 20 to 44 ug/dL within 1–2 days;
- 45 to 69 ug/dL within 24 hours; and
- 70 ug/dL or greater – immediately.

In 2018, a new clinical dashboard has been created to track timely outreach compliance. YTD Home State Health is 97.32% complaint with all Lead outreach (Figure 14).

Figure 14: Outreach in CY 2018 YTD



Improving Childhood Lead Screening Rates:

In July of 2017, Home State Health began developing a performance improvement project (PIP) related to improving the childhood lead screening rates for their members under two (2) years of age. For the purpose of this study, Home State Health will assess blood lead level rates in accordance with the HEDIS technical specifications for the next three measurement years. HEDIS 2017 (CY 2016) final Lead Screening in Children (LSC) are used as the baseline measurement. During this study Home State Health will determine if the implementation of the proposed interventions, focused on Home State Health members aged 0 to 2 years, will increase the rate of blood lead level screenings completed on or before the second birthday by three (3) percentage points.

Home State Health has chosen the NCQA Quality Compass 50th percentile benchmark for this monitor from the H2017 version and will assess performance against these benchmarks for the duration of the study.

Table 10: Lead Screening Rates from H 2017-H 2018 (CY 2016-CY 2017)

HEDIS Year	Home State Health Lead Screening In Children (LSC) Rate	2017 NCQA Quality Compass 25th Percentile	2017 NCQA Quality Compass 50th Percentile	Year to Year Percentage Point Change
2017	56.30%	59.65%	71.38%	Baseline
2018	60.74%	59.65%	71.38%	4.44%

Home State Health H2018 (CY 2017) results are based on Hybrid methodology with the final audited LSC rate being 60.74% or 4.44 percentage points higher than H2017 (CY 2016). These findings reflect meeting the goal of increasing 3 percentage points year over year. Based on these findings, the interventions employed were effective and will be continued into H2019 (Table 10).

❖ **Improvement by Home State Health**

The following are strategies are adopted by Home State Health for improvement:

Promote Member Education/Participation

- Integrate lead education into the SSFB program, testing and passage of lead via breast milk.
- Partner with Health Departments/Daycares to promote education and screenings.
- Partner with community programs such as Parents as Teachers, Catholic Charities, Midtown Neighborhood Opportunities Corp, Crisis Nursery, Women's Shelters.
- Partner with WIC clinics for lead screenings.
- Add information to Home State Health member portal or Home State Health member home page.
- Add the lead brochure to the Welcome Packet.
- Use a texting campaign that targets parents of children under 2.
- Add information to local church bulletins.
- CentAccount reward for Lead level screening.

Promote Provider Education/Participation

- Provide quarterly member rosters to PCP with children due for lead screenings and have open care gaps.

- Provider education on lead screening/testing policies and guidelines.
- Quarterly provider fax blast with lead education (Let's Get the Lead Out).
- Provide CentAccount reward information to provider offices.
- P4P incentives for closing LSC and other care gaps.
- Provide suggested Anticipatory Guidance speaking points for PCPs.
- Provide PCP offices with Best Practice guidelines for performing a capillary blood lead test.

A comparison with previous year (CY 2016) was done to determine the extent to which Home State Health addressed effectively the recommendations for quality improvement made by the EQRO. The details are provided in the Table 11, below:

- Referrals improved from the previous years;
- 'Offer Care Management per the guidelines with an assessment' decreased;
- Face to Face encounters for initial visit and follow-up decreased; and
- Contact exit evaluation with member/guardian and PCP discharge notification decreased.

Table 11: Comparison Chart for Compliance Improvement from CY 2016

CY 2016 Data Elements Reviewed	CY 2016 % Compliance	CY 2017 Data Elements Reviewed	CY 2017 % Compliance	Notes
		Diagnosis	100%	Diagnosis documented
		Referral Notification of Blood Lead Level	100%	Referral for blood lead levels documented
		Case Closures in 2017	0%	No case closures in 2017
		Case Closures in 2018	35%	6 cases closed in 2018

		% Transition of Care Cases in 2017/Transfers	30%	6 cases for Transition of Care (TOC) in 2017 1 case for Transition of Care (TOC) in 2018
		Contact Exit Evaluation with Member/Guardian	16.67%	6 cases for case closures
		Case Closure Documentation to Member/Guardian	100%	6 cases for case closures
		PCP Discharge Notification	66.67%	6 cases for case closures
Transition/Closing	**100%**	***Total for Discharge Criteria***	***61%***	**Meeting criteria for exit/closure case**
		Initial Lead Levels from referral	100%	Initial lead levels documented
		Outreach 'Attempts'		Initial 'Attempts' made within timeframe of blood lead levels
Intro to CM	**100%**	**Offer CM for Lead Levels per Guidelines with Assessment**	**50%**	**Direct contact with member/guardian to offer CM within guidelines and perform assessment**
Assessments	**95%**	**Total Assessment Performed (within and not within timeframe)**	**95%**	**Total assessments performed during care management process(within and not within initial direct contact to offer CM)**
		Medical History	95%	Documentation present on assessment

		Psychiatric History	95%	Documentation present on assessment
		Developmental History	95%	Documentation present on assessment
		Medical Conditions	95%	Documentation present on assessment
		Psychosocial Issues	95%	Documentation present on assessment
		Legal Issues	95%	Documentation present on assessment
		Childhood Blood Testing/Follow-Up	95%	Follow-up blood testing documented
Care Planning	**85%**	**Care Plans (Member/PCP Involvement)**	**90%**	**Care Plans documented**
Face-to face	**94.74%**	**Face-to-Face-Initial Encounter within 2 weeks**	**35%**	**Initial face-to face encounters performed**
		Face-to-Face-2nd Visit within 3 months of 1st encounter	**20%**	**2nd visits performed**
		Total visits performed within and not within timeframes	**50%**	**Total visits performed within and not within per guidelines**
Care Coordination	**0%**	**Member Engagement**	**50%**	**Member engagement/involvement**
PCP Involvement	**90%**	**Provider Treatment Plans**	**90%**	**Provider involvement with care**

		Coordination/Linking Services	100%	Documentation present
		Monitoring of Services and Care	100%	Documentation present
Referrals	**75%**	**Referrals**	**100%**	**Documentation present**
Progress Notes	**100%**	**Progress/Contact Notes**	**100%**	**Documentation present**

Table 12 shows the % compliance of Medical Records from CY 2014- CY 2017 for the Children with Elevated Blood Lead Levels CM Program. Two areas 'offer CM within Time frame' and 'Referrals' have shown drastic decrease by 50% point and 25% point from the CY 2016.

Table 12: Compliance Trend % from CY 2014-2017

MRR Compliance %	2	2	2	2	% point
Offer Care Management within	5	9	1	5	-50
Assessment	5	7	9	9	0
Care Planning	8	7	8	9	5
Referrals	7	4	7	1	25
Face-to-Face Encounters	4	7	9		
Face-to-Face Encounter Initial				3	
Face-to-Face Encounter Follow				2	
Progress Notes	9	7	1	1	0
Discharge Planning	1	5	1		
Contact Exit Evaluation/Case				1	
Case Closure				1	
PCP Discharge Notification				6	

3.3.3 Recommendations

Suggested Methods to Contact Guardian/Member

- In cases where the member/guardian cannot be contacted by phone and no response to the initial letter, a visit should be made to the location.

- Language barriers may present obstacles for the initial contact of member/guardian. Local community-based resources may be necessary to facilitate initial contact and confirm effective follow-up.
- Different modes of outreach should be used at differing times of the days and different days of the week to increase opportunities of actually reaching the member/guardian to initiate the case management process.

Table 13: Methods to Contact Members

Existing Methods Used for Contact Information	Methods to Verify/Update Contact Information
• Call • Send a letter • Send a certified letter • Make a home visit • Text or email (follow agency policies; may require prior consent) • Local community-based resources	• Inquire WIC contact • Inquire economic assistance contact • Inquire Child Protection contact • Inquire Primary Care Provider • Inquire US Postal Service for forwarding address • Inquire contact person listed at admission if applicable • Call member/guardian at differing times and days

Suggested Methods for Member Participation

- Ensure anticipatory guidance to parents for blood levels approaching $\geq$ 10ug/dl.
- Children with blood levels below 10 ug/dl are important targets for educational interventions.
- Ensure that an elevated blood lead level environment health investigation is conducted.
- Encourage guardian to test siblings and household contacts for lead poisoning.
- Refer family to developmental and community resources such as: developmental programs, health, and housing and/or social services when appropriate.

Suggested Methods for Provider Participation

- Ensure a notification letter is sent to physician along with a copy of the member/guardian notification letter and informatics letters.
- Educating physician/staff on proper steps for capillary blood lead level (finger sticks) per the protocol.

- Suggest a main contact at provider office to engage in member/guardian's plan of care.

Continue Lead Poisoning Education

- Risks;
- How are children exposed to lead;
- Lead in products;
- Member/Guardian Jobs and Hobbies;
- Prevention Measures;
- Healthy Diets;
- Effects of lead on children, adults, and pregnant women;
- Testing and Reporting;
- Methods of testing; and
- Treatment.

Resources

CMSA Case Management Society of America
http://www.cmsa.org/

CDC-Childhood Lead Poisoning Prevention Program
https://www.cdc.gov/nceh/lead/publications/books/plpyc/chapter6.htm

Lead Poisoning Prevention Manual
https://health.mo.gov/living/environment/lead/manual/index.php

CDC-Lead-Case Management Document
https://www.cdc.gov/nceh/lead/casemanagement/casemanage_main.htm

State Strategies to Improve Childhood Lead Screening and Treatment Services under Medicaid and CHIP
https://nashp.org/wp-content/uploads/2018/04/Childhood-Lead-Screening.pdf

3.4 Serious Mental Illness (SMI) Care Management

As per MHD Managed Care Contract (2.11), Serious Mental Illness (SMI) includes Schizophrenia, Schizoaffective disorder, Bipolar Disorder, Post-Traumatic Stress Disorder, Recurrent Major Depression, and moderate to severe Substance Use Disorder.

Integrated Case Management Staffing Model of Home State Health

Care Coordination/Care Management (CC/CM) teams are comprised of multidisciplinary clinical and nonclinical staff (Nurse Case Managers, Program Coordinators, Social Workers, Behavioral Health Specialists, and Connection Representatives). This integrated approach allows non-medical personnel to perform non-clinical based health service coordination and clerical functions, and permits the Missouri licensed professional staff to focus on the more complex and clinically-based service coordination needs. The title "Care Manager" is for nurses and licensed social workers. Based on the diagnosis/needs of the member, a nurse or social worker is assigned as the "lead" for the management of that member. Staff are co-located and refer to each other as needed to maintain one point of contact with the member while being able to provide holistic and comprehensive care. Care managers also work closely with the concurrent review staff to coordinate care when members are hospitalized and assist with discharge planning. The teams utilize a common clinical documentation system to maintain centralized health information for each member that includes medical, behavioral health, and all other services the member receives.

Screening and Assessment

Member outreach is initiated telephonically at the earliest possible opportunity, but in all cases within 30 days of identification for Care Management. Home State Health provides an assessment for all members experiencing one (1) of the events listed below within thirty (30) days of:

- The date upon which a member receives the projected discharge date from hospitalization or rehabilitation facilities:
    - After hospital readmission; or
    - After a hospital stay of more than two (2) weeks; and
    - After a psychiatric inpatient hospitalization.
- Receipt of a diagnosis of co-occurring behavioral health and substance abuse as identified through analysis of utilization data.
- Serious mental illness (schizophrenia, schizoaffective disorder, bipolar disorder, PTSD, recurrent major depression, and moderate to severe substance use disorder).

- Home State Health assesses members for Care Management within five (5) days of admission to a psychiatric hospital or residential substance abuse treatment program.

Care Management team obtain consent to complete the screening and/or initial assessment once member contact is made. The gathered information is reviewed to build a Care Plan. The initial assessment and Care Plan are completed no later than 30 days after a member, or caregiver acting on member's behalf, agrees to participate in complex Care Management. Outreach may also occur to treating providers and individual practitioners when appropriate. Each Care Management team member contributes different skills and functions to the management of the member's case. Other key participants in the development of the care plan may include:

- Member;
- Member authorized representative or guardian;
- PCP and specialty providers;
- Home State Health Medical Directors;
- Hospital discharge planners;
- Ancillary providers (e.g., home health, physical therapy, occupational therapy);
- Behavioral health providers;
- Representatives from community social service, civic, and religious based organizations (e.g., United Cerebral Palsy; food banks; WIC programs; local church groups that may provide food, transportation, companionship); and
- Other non-health care entities (e.g., Meals on Wheels, home construction companies).

3.4.1 Findings for MRR (Attached Excel Workbook Tab C)

Primaris reviewed 23 MR (oversample) to audit 20 records for Care Management in CY 2017. 3 out of 23 records were excluded for the following reasons:

Table 14: EXCLUSIONS	NUMBER OF MR
Dx not applicable: General Anxiety	1
Dx not applicable: Screening for Other Disorder	2
TOTAL (non SMI dx)	**3**

Of the 20 cases reviewed, 19 out of 20 cases had a diagnosis of SMI at the time of hospitalization. One (1) was self-referred through the help line.

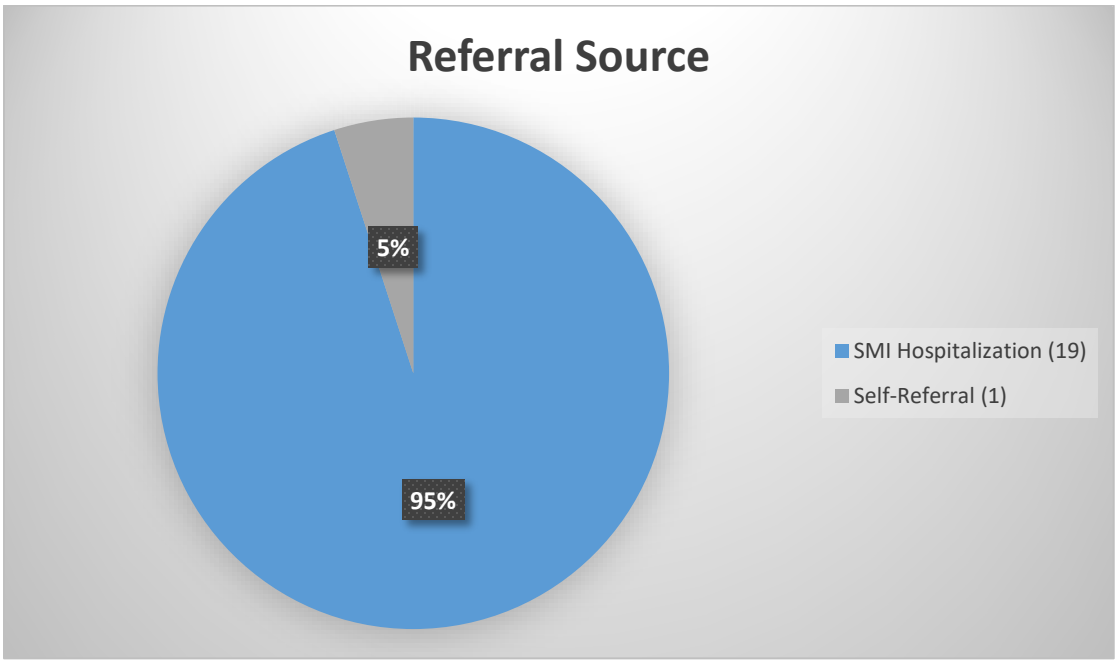


Figure 15: Distribution of the referral process to Care Management

Primaris validated the following information for SMI quality review (Figure 16):

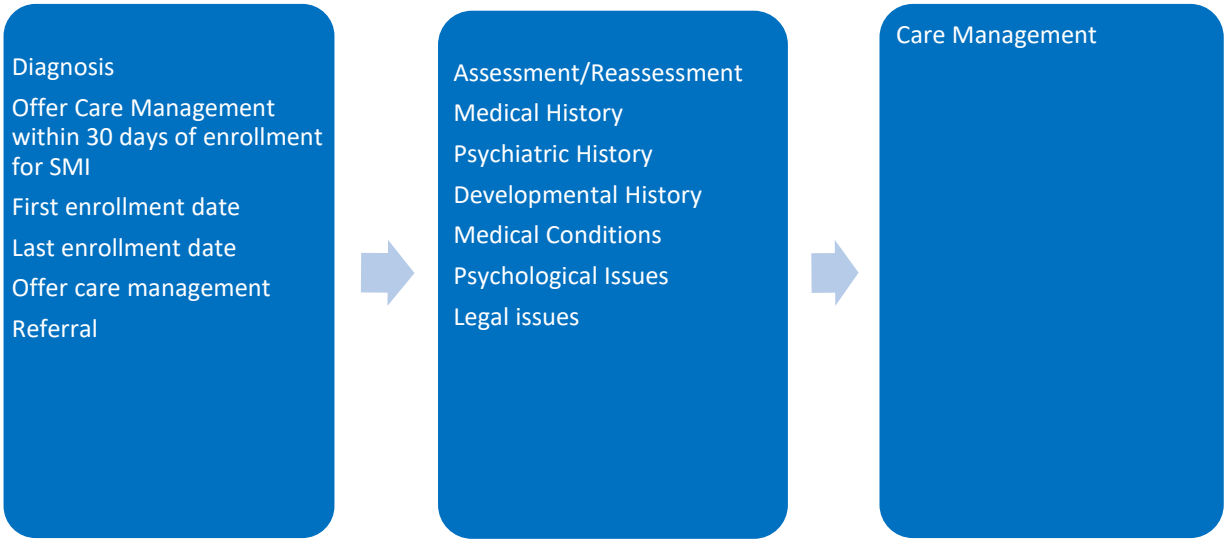


Figure 16: Validation of MR for SMI Care Management

Care Management: Home State Health

The Medical Record Review for Home State Health SMI Care Management program revealed the following information:

a. Offer Case Management and Assessments (100% Compliance)

Home State receives the notification/referral of member hospitalization through the Utilization Management process:

- Behavioral health diagnosis meeting the serious mental health list.
- Medical diagnosis that reveals a co-morbidity of serious mental health.

Phone call made by member to the MCO member call line creates a member self-referral into Care Management.

b. Member Referral (100% Compliance)

The Care Manager refers the member to Care Management as well as other services they may need.

c. Assessment (100% Compliance)

The Care Manager assesses the member for services if the member agrees for Care Management. This step analyzes the member's needs and begins the Care Management process.

d. Provider Engagement and Care Planning (95% Compliance)

The Care Plan is implemented with members after the completion of the initial assessment. Communication with physician/physician staff for the member's care is ongoing during the Care Management process. Care Managers notify the provider that the member is engaged in the Serious Mental Illness Management and remain in communication with providers as allowed.

e. Testing (100% Compliance)

Testing in SMI is utilized on a need basis. When needed, compliance is high. Testing for risky behaviors is vital and Care Managers follow up with providers to document test results.

f. Discharge Plan (95% Compliance)

The Care Managers encourage the member/guardian to stay engaged until goals are met. At the end of the plan, there are additional steps created in case follow up or additional services are needed in the future. If the member needs to return to care, this step demonstrates how to get services as needed.

g. Aftercare (95% Compliance)

The 'aftercare' is the member's responsibility to continue with services as recommended by the combination of providers, hospital, and case management. To get the 'aftercare' the member has to continue till the end the plan in full compliance and availability, as per the Care Plan.

h. Transfers (95%), Linking (95%) and Monitoring Services with Provider and Member Participation (100%) compliance.

The member's connection to other available service organizations is a vital part of their plan. The providers, organizations, outpatient facilities, all work together to reach the plan goals.

i. Follow Up (90% Compliance)

A case closure letter is sent when a case is closed. The provider may also be notified. The Care Manager follow up is the final step of case closure to ensure the member feels the goals were met satisfactorily or they wanted the case to be closed for an agreed upon reason such as Care Management from another organization.

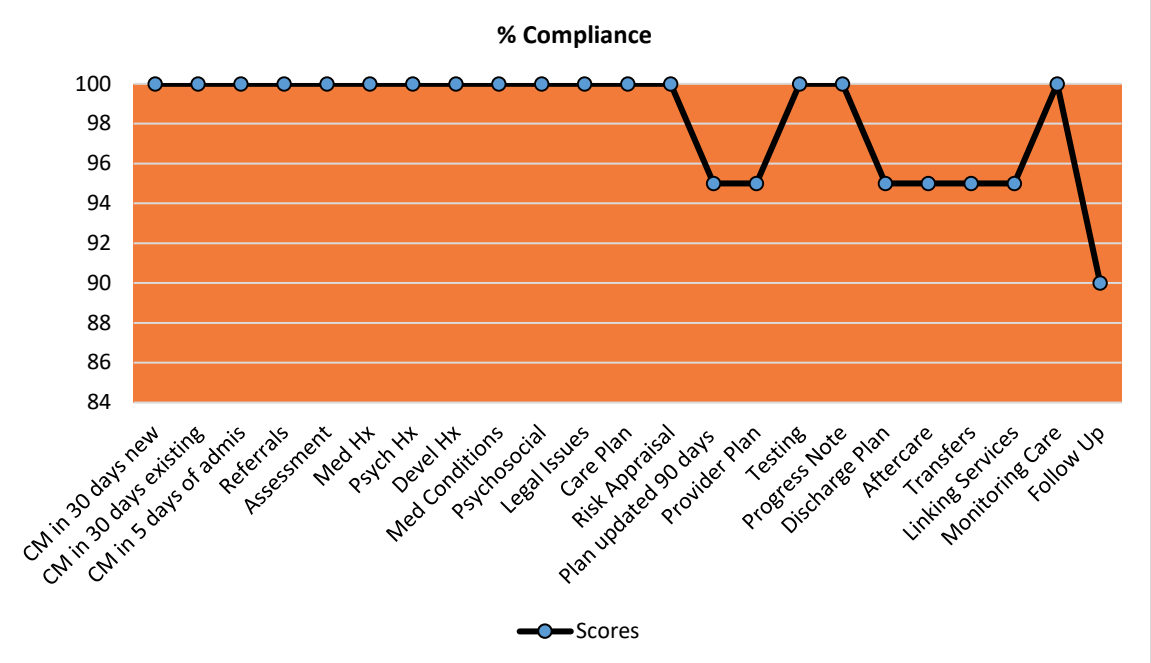


Figure 17: Compliance Graph for SMI Care Management MRR

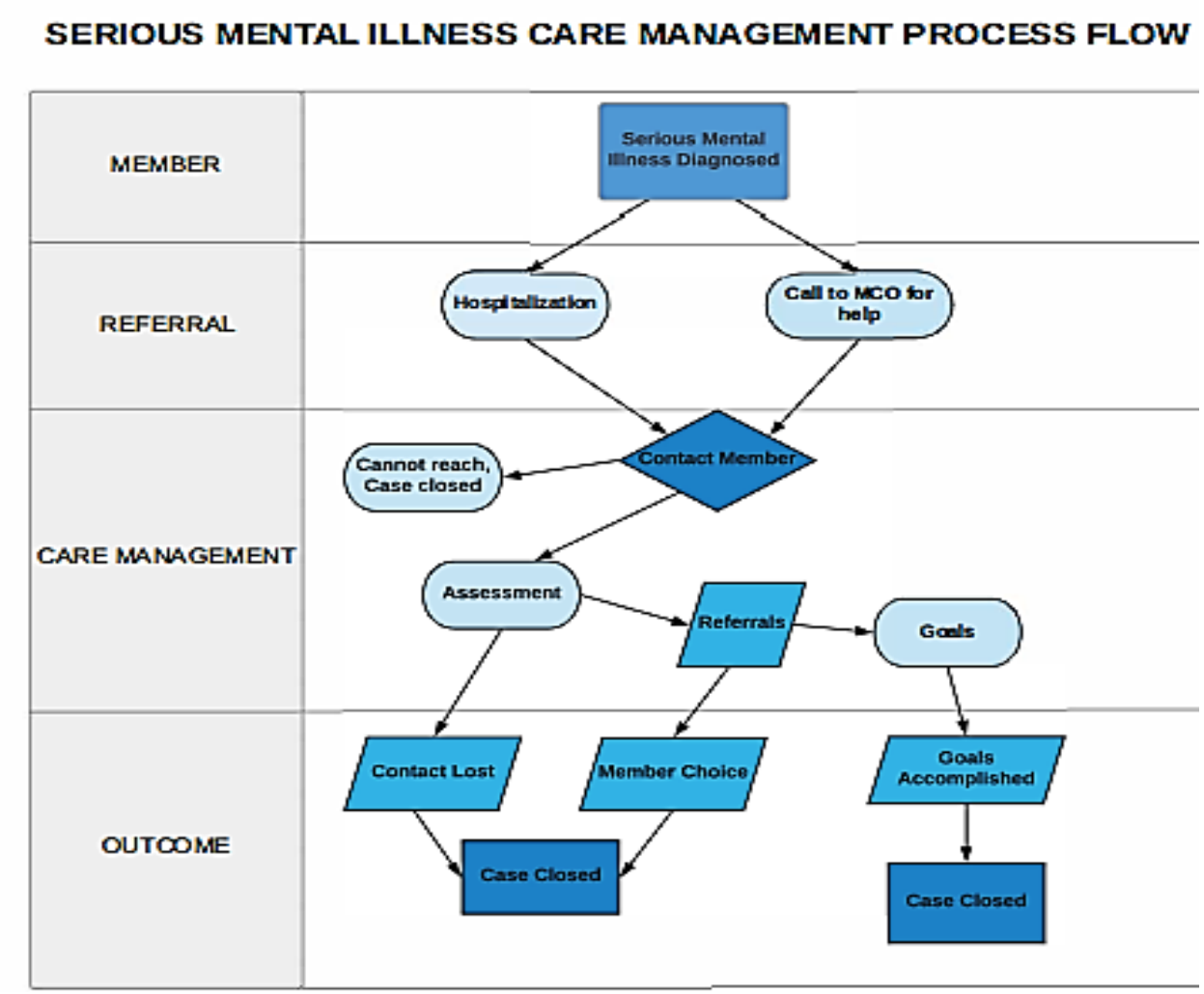


Figure 18: Flow Chart for Home State Health

3.4.2 Conclusions

Primaris aggregated and analyzed findings from the Interviews, Policies and Procedures, MRR for the SMI Care Management Program to draw conclusions about Home State Health's performance in providing quality, access, and timeliness of healthcare services to members. Overall, evaluation showed that Home State Health has Systems, Policies & Procedures, and Staff in place to ensure that its structure and operations support the processes for providing care and services while promoting quality outcomes.

Observations:

- 19 out of 20 were open initially to assessment and Care Management
- 1 left the hospital without consent;
- Many members had multiple cases opened during the calendar year of 2017;
- All were assessed within the timeframe (5 days), most were within the first 24 hours in inpatient stay; and
- Most members concluded their case with a successful end.

Table 15: Observations

Reasons cases were closed	1 – Member noncompliance 1 – Member choice
Variances	Age Gender Diagnosis Pre-hospitalization to post-hospitalization dx Ability to get needed services/providers
Similarities	Open to Care Management Family seeking care/information

❖ **Issues and Key Drivers**

Issues

- Identification of members for SMI Care Management: This remains a challenge as there is no guidance as to what constitutes SMI except for a list of diagnoses. In some cases, a member with a diagnosis on the list may be doing well while another member with a diagnosis not on the list may prove to be seriously ill and need help. For example, a member with autism not on the list of diagnoses threatened the lives of others and earned an additional diagnosis on the list eventually during an inpatient stay. Another patient with major depression and substance abuse as co-morbidity may be doing well and may stay out of the hospital with little care need for all of the year because of good medical management and good family involvement despite qualifying for Care Management.

- Providers often do not share vital information with the MCO. They do not understand the role of the Care Manager in the member's care. There is often a lack of communication or teamwork.
- The cost and the resources for SMI Care Management sometimes become a limiting factor for the MCO to provide 100% quality care to its members.
- The ability of Care Manager to reach SMI members becomes an issue over time. These members often do not have accurate addresses. They change or refuse to provide phone numbers. They do not have emergency contact numbers. They often are not at home when Care Managers make appointments to visit or do not agree to home visits. The ability to stay in contact over a long term is a challenge in tacking member's care. The Care Manager utilized the connection with a member's provider if available. Sometimes the members got overwhelmed with too many people involved in their care. They lacked the understanding of their roles and opted out of Care Management.

Key Drivers

- Team work and Coordination;
- Work to align with patient and population needs;
- Linking to community resources;
- Provider Engagement;
- Medication Management;
- Behavioral Health Home; and
- Supporting patients' self-management goals.

❖ **Quality, Timeliness, and Access to Health Care Services**

- Overall compliance for SMI Care Management MRR was 98.2% Home State Health met most of the contractual requirements for managing the members with SMI.
- The members selected for Care Management were the hospitalized members. If a member had serious mental illness but was not hospitalized they did not receive Care Management.
- The Table 16 shows all the BH services received by members in CY 2017.

Table 16: Number of Members receiving BH Services in CY 2017

MISSOURI	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17
Members Receiving BH Services	1,863	1,778	1,967	1,915	6,369	5,828	5,370	6,143	6,085	6,630	6,345	5,707
Penetration Rate	1.8%	1.7%	1.9%	1.8%	2.3%	2.1%	1.9%	2.2%	2.2%	2.4%	2.3%	2.1%

Special needs of members with Serious and Persistent Mental Illness (SPMI)

Home State Health collects data on the challenges surrounding coordination and continuity of care for members with serious and persistent mental illness through assessment of the HEDIS measure, Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD). This measure assesses the percentage of members 18-64 years of age with schizophrenia or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year. Use of this measure is key to ensuring that members with high acuity special healthcare needs are receiving the proper monitoring and service coordination for both their behavioral and physical health conditions. This metric is an important indicator of care provided for members who are impacted by both mental and physical health conditions. The high screening rate indicates that most members with a diagnosis of Schizophrenia or Bipolar Disorder are going to their physician on a regular basis.

HEDIS rates show an improvement from 2016 to 2017 for Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications (SSD). Home State Health primarily addresses the needs of this population through Care Management/care coordination interventions. Home State Health and the Managed Behavioral Health Organization (MBHO) have been working towards a more integrated Care Management model, which focuses equally on medical and behavioral health needs, regardless of which condition is primary, and works with members to help them understand that mental health impacts all areas of their health and quality of life.

Table 17: SSD Rates for CY 2016-2017

HEDIS MEASURE	2016	2017
Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications (SSD)	**80.5%**	**81.29%**

❖ **Improvement by Home State Health**

Home State Health tracks the co-morbidity of schizophrenia and bipolar patients who have diabetes as well. There are more co-morbidities that may be affecting these members long term. Ongoing efforts in this area would produce more data over time.

SMI Care Management Program was not reviewed during previous years by an EQRO, so no trend data is available for comparison purpose.

3.4.3 Recommendations

- Home State Health could expand its Care Management referral base to coordinate with Utilization Management and seek other means of finding SMI members other than through hospitalization. Members who have serious diagnoses through co-morbidity or frequent visits to providers or are taking multiple behavioral health medications could be sought out for additional Care Management profiling.
- The State could come up with a system to clarify SMI for the MCOs. Diagnoses alone often leaves members uncared for several of those who need attention. Also the list could be broadened to include other diagnoses that appear often on the co-morbidity list such as autism which can be a behavior disorder if severe enough. Family distress is a trigger as well which might be a measurement to identify the need.
- While it is agreed there is no acceptable scale to determine the scope of seriously mentally ill patients, a uniformity among members across the state would help devise a plan to better utilize services. There are some tools in place such as the Burden Assessment Scale or BAS created in 1994 for the state of New Jersey developed to help determine the burden placed on

the families of these patients who have a serious mental illness. (https://www.sciencedirect.com/science/article/pii/0149718994900043).

- The Missouri Department of Mental Health has a number of systems in place that could be utilized and/or transposed for the purpose of creating a uniform system of diagnosing the seriously mentally ill and drawing attention the ones needing Care Management more rapidly to prevent or reduce inpatient stays. They have tools such as the Priority of Need (PON) system that enables them to decide a ranking of highest need. (https://dmh.mo.gov/docs/dd/ponfaq.pdf).

(NOTE: Please see the excel work book attached for Care Management MRR)
