Primaris
Healthcare Business Solutions

2019 External Quality Review
Care Management

home state health

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MoHealthNet

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1.0 Purpose and Overview

1.1 Background

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

Managed Care is operated statewide in Missouri in the Central, Eastern, Western, and Southwestern regions. One of the most important priorities of Managed Care is to provide a quality program that leads the nation and is affordable to members. This program provides 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. The total number of Managed Care enrollees by the end of SFY 2019 are 596,646 (1915(b) and CHIP combined). This is a decrease of 16.24 % in comparison to enrollment by end of SFY 2018.

Home State Health is one of the three MCOs operating in Missouri (MO) that provides services to eligible individuals determined by the state agency for the Managed Care Program on a statewide basis. MHD works closely with the MCO to monitor the services being provided to ensure goals to improve access to needed services and the quality of health care services in the Managed Care and state aid eligible populations are met, while controlling the program's cost.

Home State Health's services are monitored for quality, enrollee satisfaction, and contract compliance. Quality is monitored through various ongoing methods including, but not limited to, MCO's Healthcare Effectiveness Data and Information Set (HEDIS®) indicator reports, annual reviews, enrollee grievances and appeals, targeted record reviews, and an annual external quality review. MHD requires participating MCOs 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 the MCOs annually as well. Primaris Holdings, Inc. (Primaris) is MHD's current EQRO and started their five-year contract in January 2018. The External Quality Review (EQR) 2019 covers a period for Calendar Year (CY) 2018.

An EQR means the analysis and evaluation by an EQRO of aggregated information on quality, timeliness, and access to the health care services that an MCO, or their contractors, furnish to Medicaid beneficiaries. Primaris follows the definitions of quality, timeliness, and access to services based on 42 CFR 438.320, 438.206.

1.2 Description of Care Management

The Commission for Case Manager Certification (CCMC) defines "Case 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 (Figure 1). Case managers must possess the education, skills, knowledge, competencies, and experiences needed to effectively render appropriate, safe, and quality services to clients/support systems.

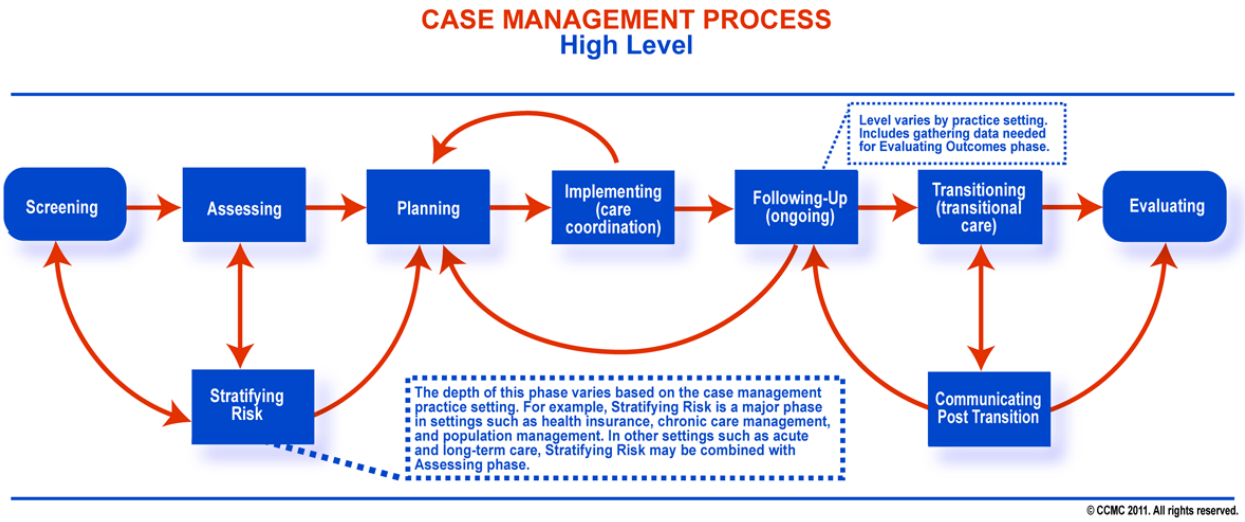

Figure 1: Care Management Process
(https://www.cmbodyofknowledge.com/content/introduction-case-management-body-knowledge)

The term "case" has been replaced by "care" in the MHD Managed Care contract (section 2.11), and hereinafter, stated as care management (CM). This section will be followed as a standard for evaluation of the CM program of Home State Health.
The aim of CM review is to identify contributing issues and key drivers of the program. CM is an umbrella term that encompasses services such as, but not limited to:

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

For EQR 2019, MHD requires Primaris to evaluate the following CM programs of Home State Health:

- Pregnant members (OB).
- Children with elevated blood lead levels (EBLLs).
- Behavioral health (BH) diagnosis leading to hospitalization (including residential treatment program for substance use disorder).

2.0 Methodology

The evaluation of Home State Health's CM program is carried out under the following headings:

Review of Care Management Policies and Procedures
Evaluation of Care Plan
Onsite Interviews
Medical Record Review (MRR)

Review of Care Management Policies and Procedures

In reference to MHD contract section 2.11.1c 5, MCO should have policies and procedures for CM program. Primaris reviewed all the documents submitted by Home State Health and reported the results in Table 1 under section 3.1 of this report.

Evaluation of Care Plan

MHD contract 2.11.1e provides guidelines for the "care plan" as listed below. Primaris followed these guidelines to evaluate the care plan for each of the members included in the samples for medical record review for all three CM programs.

Care plan for ALL eligibles: The MCO shall use the initial assessment to identify the issues necessary to formulate the care plan. All care plans shall have the following components:

- Use of clinical practice guidelines (including the use of CyberAccess to monitor and improve medication adherence and prescribing practices consistent with practice guidelines).
- Use of transportation, community resources, and natural supports.
- Specialized physician and other practitioner care targeted to meet member's needs.
- Member education on accessing services and assistance in making informed decisions about care.
- Prioritized goals based on the assessment of the member's needs that are measurable and achievable.

- Emphasis on prevention, continuity of care, and coordination of care. The system shall advocate for and link members to services as necessary across providers and settings.
- Reviews to promote achievement of CM goals and use of the information for quality management.

Care plan for pregnant women: In addition to the requirements listed above, the MCO shall include the following in the care plans for pregnant women:

- A risk appraisal form must be a part of the member's record.
- Intermediate referrals to substance-related treatment services if the member is identified as being a substance user. If the member is referred to a C-STAR program, care coordination should occur in accordance with the Substance Use Treatment Referral Protocol for Pregnant Women under MHD Managed Care.
- Referrals to prenatal care (if not already enrolled), within 2 weeks of enrollment in CM.
- Tracking mechanism for all prenatal and post-partum medical appointments. Follow-up on missed appointments shall be made within 1 week of the appointment.
- Methods to ensure that Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) screens are current if the member is under age 21.
- Referrals to Women, Infants, and Children (WIC) (if not already enrolled), within 2 weeks of enrollment in CM.
- Assistance in making delivery arrangements by the 24th week of gestation
- Assistance in making transportation arrangements for prenatal care, delivery, and post-partum care.
- Referrals to prenatal or childbirth education where available.
- Assistance in planning for alternative living arrangements which are accessible within 24 hours for those who are subject to abuse or abandonment.
- Assistance to the mother in enrolling the newborn in ongoing primary care (EPSDT services) including provision of referral/assistance with MHD application for the child, if needed.
- Assistance in identifying and selecting a medical care provider for both the mother and the child.
- Identification of feeding method for the child.
- Notifications to current health care providers when care management services are discontinued.
- Referrals for family planning services if requested.
- Directions to start taking folic acid vitamin before the next pregnancy.

Onsite Interviews

Home State Health's officials were interviewed to assess:

- The knowledge of MHD contract and requirements for CM. The guiding principle for CM is that the resources should be focused towards people receiving the services they need, not necessarily because the service is available.
- The focus of CM 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 personnel were interviewed at Home State Health's office in St. Louis, MO, on June 24, 2019, to evaluate the CM program for pregnant members (OB), children with elevated lead levels (EBLLs), and members with behavioral health (BH) diagnosis leading to hospitalization (including residential treatment program for substance use disorder).

- Kelly Peters, RN, Director, Care Management
- Julie Mertz-Lufft, RN, Supervisor, Care Management
- Karin Bryne, RN, CM Supervisor, Care Management
- Chris Hoover, CM Manager
- Anna Novoa, RN, CCM
- Stacey Schulte, RN, Supervisor, Care Management
- Jennifer Jackson, RN, Manager, Care Management
- Paige Hall, RN, Lead Care Manager
- Amanda Stutz, LPC, Manager, Utilization Management
- Shannon Crandall, LCSW, Supervisor, Care Management
- Susan Nay, PhD, Senior Manager, Care Management
- Jessica Orrick, LPC, Care Manger
- Angela Cusanelli, LPC, Care Manager
- Byanka Sallis, LPN, Trainer-Auditor

Medical Record 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 2018 for the three focus areas was submitted by Home State Health. Primaris selected a sample of 30 medical records (maximum limit: required sample size of 20, plus 50% oversample for exclusions and exceptions) by using stratified random sampling method based on Appendix II of 2012,

CMS protocols for EQR). Home State Health was requested to upload all the 30 medical records electronically at Primaris' secure file upload site. The medical records were reviewed during an onsite visit on June 25, 2019. An evaluation tool is created to ensure that the medical records include, at a minimum, the following (Excel workbook attached separately): referrals; assessment; 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 are reviewed by different auditors to assess the degree of agreement in assigning a score for compliance in the evaluation tool.
(Note: Home State Health submits CM Logs to MHD each quarter. Review of these logs is outside the scope of this report.)
The following criteria are used for inclusions/exceptions/exclusions of medical records in the study sample:
Inclusion Criteria

- OB CM

  Anchor date: Members must be enrolled in CY 2018 (at a minimum of 1 full quarter). May include enrolled pregnant members in last month of CY 2017.
  Age: N/A
  Continuously enrolled: No break in enrollment for more than 45 days with the MCO.
  Event/Diagnosis: Pregnancy.
- EBLLs CM

  Anchor date: Should be enrolled in CY 2018 (at a minimum of 1 full quarter.)
  Age: Children who are at least 1 during the measurement year and up.
  Continuously enrolled: No break in enrollment for more than 45 days with the MCO.
  Event/Diagnosis: A venous lead level of 10 µg/dL.
- BH CM

  Anchor date: Members should be enrolled in CY 2018 (at a minimum of 1 full quarter).
  Age: 6 years or older during the measurement year/CY 2018.
  Continuous enrollment: No break in enrollment for more than 45 days with the MCO.
  Event/Dx: Must not have been in CM in CY 2017 (unless a new diagnosis made in 2018). Members should be hospitalized in a psychiatric hospital or be receiving residential treatment for substance use disorder in CY 2018.

Exclusion Criteria: Failure of initial contact with the member in spite of exhausting all means to contact a member-as listed in MHD contract 2.11. There is no exclusion/exception for patient refusal to CM.
Exceptions: The member does not require CM on medical grounds.

3.0 Overall Assessment of Care Management Program

3.1 Facts and Figures

Figure 2 demonstrates the total number of cases opened/identified for CM (OB: 9,951; EBLLs: 166; and BH: 2652) and members actively care managed CY 2018 (OB: 1,543; EBLLs: 147; and BH: 261). (Note: Cases active in CY 2018 could reflect cases opened in a prior year.)

The number of Medicaid Managed Care members enrolled in CY 2018: 235,636
Members enrolled in all CM programs: 20,146 (3,542 actively managed)
CM staff available: 28
Average case load: 50.5 (maximum:60)
Maximum number of members that can receive CM:1680

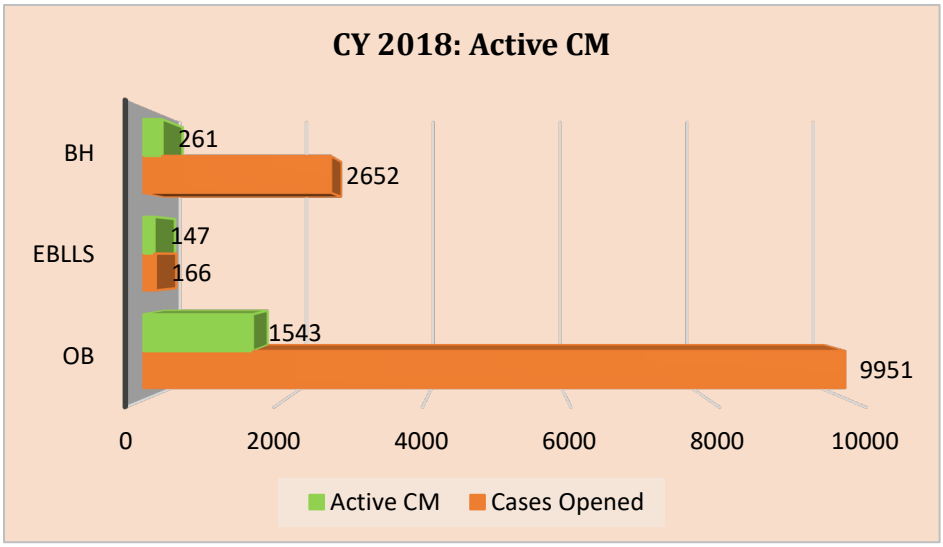

Figure 2: Active Members in CM during CY 2018

3.2 Review of Policies and Procedures

The following policies and procedures are submitted by Home State Health (Table 1). Upon review, Primaris concludes that Home State Health is 100% compliant with all the requirements mandated by MHD contract.

Table 1: Home State Health-Care Management Policy Review			
Policies and Procedures shall include (MHD 2.11.1c5):	Met	Not Met	Document Name(s)
1. A description of the system for identifying, screening, and selecting members for CM services.	●		CM Program Description 2019.
2. Provider and member profiling activities.	●		Home State Provider Manual 2018, 2019 Quality Assurance Performance Improvement Program Evaluation.
3. Procedures for conducting provider education on CM.	●		CM Program Description 2019, Provider Quick Reference Guide, Home State Provider Orientation.
4. A description of how claims analysis will be used.	●		Provider Quick Reference Guide, Home State Provider Orientation.
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.	●		CM Program Description 2019.
6. A process to ensure integration and communication between physical and behavioral health.	●		CM Program Description 2019.
7. A description of the protocols for communication and responsibility sharing in cases where more than one care manager is assigned.	●		CM Program Description 2019, Medical Management Training Plan, Complex Rounds Criteria, Training Transcript.
8. A process to ensure that care plans are maintained and updated as necessary.	●		CM Program Description 2019.
9. A description of the methodology for assigning and monitoring Care Management caseloads that ensures	●		Case Guide Visual, Case Load Population.

adequate staffing to meet CM requirements.			
10. Timeframes for reevaluation and criteria for CM closure.	●		CM Program Description 2019, CM Audit Tool (based on MHD Contract.
11. Adherence to any applicable State quality assurance, certification review standards, and practice guidelines as described in the contract.	●		CM Program Description 2019, CM Audit Tool, Home State Provider Orientation.
12. Additional information.	●		Complex Rounds Criteria, MM Training Plan, Training Transcript.

3.3 Evaluation of Care Plan

Upon interviewing Home State Health officials and reviewing the medical records for all three CM programs, Primaris concludes that Home State Health has policies and procedures based on contractual guidelines for "care plan," and members are managed according to these guidelines. However, the "care plan" per se does not include all the components as listed in the contract. The care managers work with the members and create goals based on the care gaps. Interventions are planned to close these gaps. The care plan is updated once a month.

> *Recommendation: MHD may mandate the MCO to create a checklist with all the requirements listed in MHD contract section 2.11.1e while developing a "care plan" for each member.*

3.4 Pregnant Members/Obstetrics (OB) Care Management

Home State Health's OB CM techniques are designed to extend the gestational period and reduce the risks of pregnancy, premature delivery, and infant disease. The Start Smart for Your Baby® (SSFB) is an award winning program which incorporates the concepts of CM, care coordination, and disease management in an effort to improve the health of mothers and their newborns. The program's multi-faceted approach to improving prenatal and postpartum care includes enhanced member outreach and incentives, wellness materials, intensive CM, provider incentives, and support of the appropriate use of medical resources.

Main Objectives of the Program:

- Decrease infant mortality rates.
- Increase number of women receiving early prenatal care.
- Increase abstinence from alcohol and illicit drugs among pregnant women.
- Increase number of mothers who breastfeed.
- Incorporate clinical and outreach efforts to assist pregnant women with issues that affect their pregnancy such as smoking.
- Offer a premature delivery prevention program by supporting the use of alpha-hydroxyprogesterone caproate (17P) administration.
- Work in conjunction with established healthcare delivery systems, provider community, care coordinators, and community resources.

Member Identification

Members are identified for OB CM from multiple sources including, but not limited to:

- Notification of Pregnancy (NOP) (screening assessment automatically enrolls a pregnant member in SSFB)
- Claims
- Community Agencies e.g., Women, Infant, and Children (WIC)
- Disease Management Staff
- Health Plan staff e.g., 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
- Daily 416 State Notifications

Workflow

Once OB members are identified and their risk factors collected in the NOP, members are stratified into low, medium, and high risk groups. Higher risk members are prioritized for outreach by Home State Health staff. Particular attention is paid to members with a history of prior preterm delivery. Home State Health begins OB CM (field and/or telephonic) within 15 business days of notification of pregnancy (Figure 3).

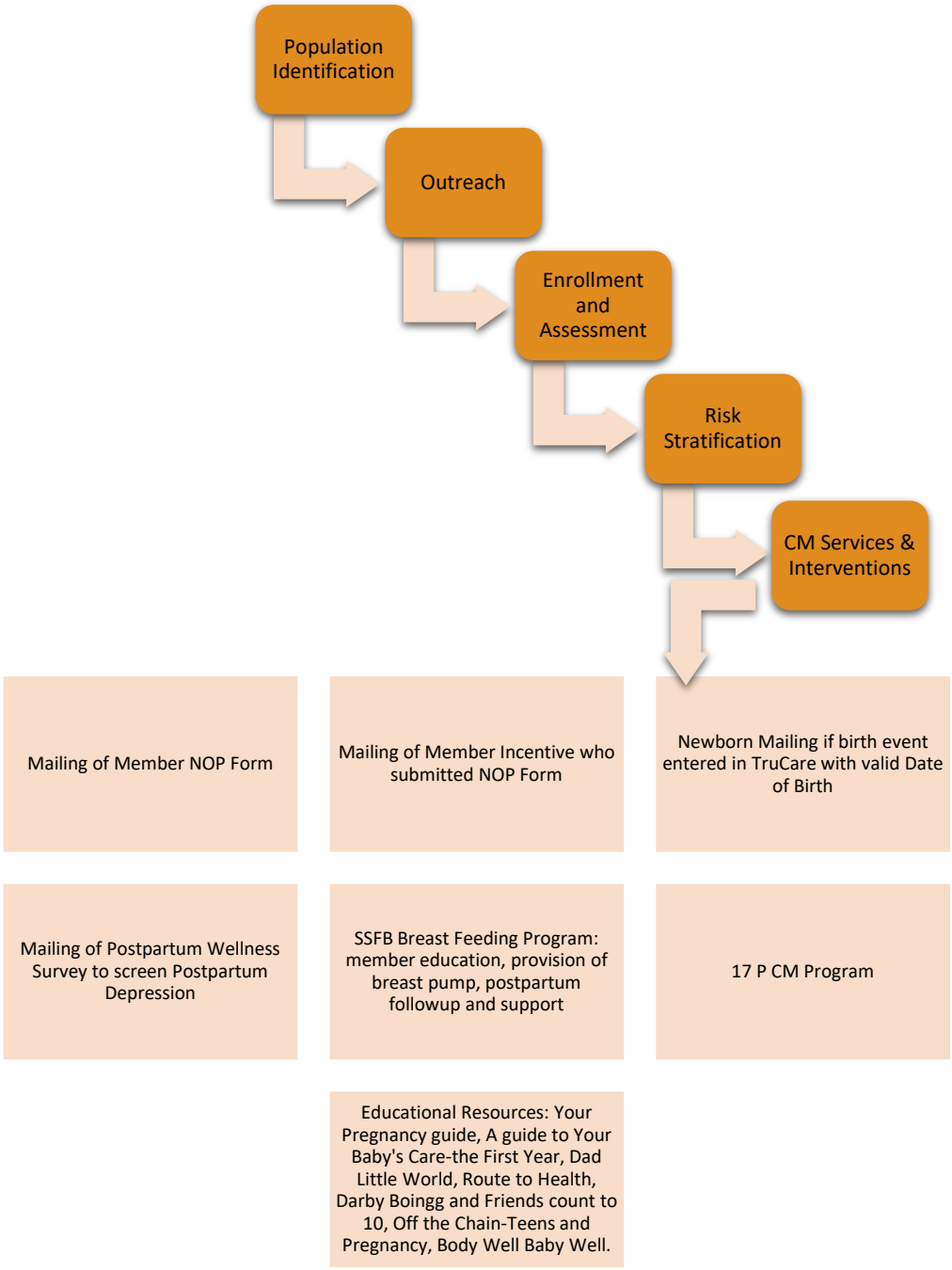

Figure 3: Work Flow of Obstetrics CM Program

For members who are not reachable on MHD provided phone numbers, Home State Health attempts to find them by: outreaching to the OB offices; making calls to pharmacy; home visits at last known address; and missed appointment outreach (from claims data). Some other ways to engage members in OB CM include:

- Denying office visit payments to OB providers who do not submit a NOP form.

- Free diapers to members who enroll in our Substance Use Field Case Management.
- Free applications which offers 24 hour access to a face-to-face (Skype) visit with a dietician or lactation consultant.
- Pre-loaded debit card for members who attend OB appointments.

3.4.1 Findings of OB Medical Record Review

An oversample of 30 medical records is reviewed. Out of these, only 17 medical records are included for evaluation. There are 13 exclusions as the members were not under the CM program for at least a full quarter.

The MRR compliance (%) is reported under the following headings (Figure 4):

a. Diagnosis: 100% compliance.
   The medical records have a documentation of diagnosis for all the 17 cases.
b. First enrollment/Last enrollment date: 100% compliance.
   Upon notification of pregnancy, a case is opened for CM. This is marked as "case start date" in all the medical records. Attempts to outreach an OB member begin and on being successfully contacted, an assessment is completed. An issue is detected during IRR of medical records regarding the enrollment date/case start date (details in section 3.4.2). The case closure/last enrolled date is documented in all medical records.
c. Offer CM within 15 business days of notification of pregnancy: 82% compliance.
   Home State Health has assessed the needs of their members within the timeframe for 14 of 17 cases.
d. Referrals: 100% compliance.
   Referrals are through NOP (11); member-referred (2); state notification (1); eligibility (1); provider (1); and report (1).
e. Assessment: 100% compliance.
   All the required components per MHD contract are included in the assessment questionnaire, namely medical history, psychiatric history, developmental history, psychosocial issues, and legal issues. An assessment is found in all the medical records.
f. Updated care plans: 100% compliance.
   Updated care plans are present all 17 cases.
g. Risk appraisal: 100% compliance.
   This is present in all the 17 cases.
h. Provider treatment plans: Zero compliance.
   The care plans are mailed to the providers and their treatment plan is requested for a better care coordination. It is also made available via Home State Health's website. However, the providers do not respond to the care plan unless the care managers call them as needed. As a result of this identified weakness in the process, additional clarity in the MHD contract would guide MCO success. See Recommendations for All CM.

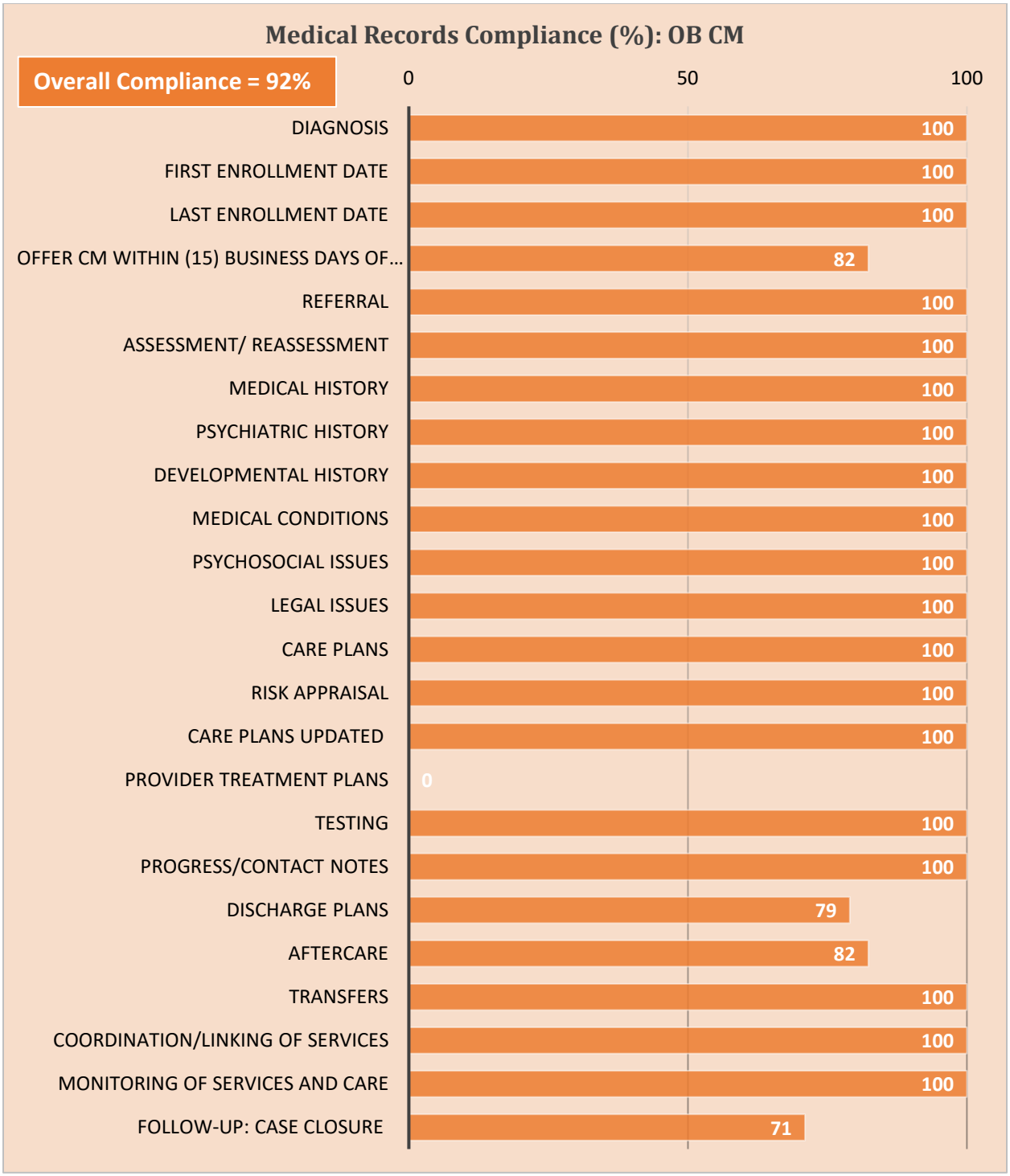

Figure 4: Medical Record Review for OB CM Program

i. Lab tests: 100% compliance.
These are documented in all 17 cases.

j. Progress notes: 100% compliance.

The medical records are updated with the progress of the care given to the members and notes are available for every call/interaction with the members.

k. Discharge plan: 79%
This is available in 11 of 14 cases. It is N/A in 3 cases as they are still open for CM.

l. Aftercare: 82% compliance.
Aftercare is provided in 14 of 17 cases.

m. Transfers: 100% compliance.
This is addressed in all 17 cases. There are no transfers to/from another MCO.

n. Coordination, linking, and monitoring of services: 100% compliance.
Medical records reveal that all 17 cases are linked to community resources and the care has been monitored.

o. Follow up (case closure no sooner than 60 days post-partum): 71% compliance.
Even though post-partum follow-up care is given to all 14 closed cases, 4 cases are closed earlier than 60 days post-partum for Goals Met (1), UTC (2), loss of eligibility (1). This has resulted in a reduced compliance score of 71%.

3.4.2 Conclusions

Oversample of medical records: 30
Exclusions: 13
MRR sample: 17 cases. Out of these 17 cases, 3 remain open for CM in CY 2019 and 14 are closed due to following reasons (Table 2):

Table 2: Case Closure	14
Goals met	10
Unable to contact (UTC)	3
Loss of eligibility	1

Issues & Key Drivers

Issues

- During IRR an issue regarding date of enrollment of members in CM program surfaced. The medical records have a "case start date" which does not correspond to the "enrollment date" provided during an onsite review. On enquiry, Home State Health stated that they open a case at the time of notification of pregnancy and record it as "case start date." Member is considered as "enrolled" when a care manager successfully contacts a member and completes their assessment. However, this date is not identified or stated in the medical records as "enrollment date." One has to assume the date of "assessment" is an "enrollment date." This has led to inconsistencies in documentation of enrollment dates by different auditors.

- The engagement of providers with the care plan is nil (0%). The care plan is available to the providers either through mail/Home State Health's website. However, there is no feedback/acknowledgement received from the provider.
- Care mangers are not able to assess the needs of OB members within 15 days of notification of pregnancy in 3 of 17 cases due to UTC. Only telephonic attempts are made to contact a member.
- Some cases were closed before 60 days post-partum (4 of 14).
- Discharge planning and aftercare is not done in 3 cases due to UTC.

Key Drivers

- Member engagement, motivation.
- Supporting patient's self-management goals.
- Care manager's training and education.
- Use of evidence-based care.
- Holistic, comprehensive, culturally competent approach with awareness and respect for diversity.
- Accurate contact addresses and telephone numbers of primary, secondary, and emergency contacts.
- Providers' involvement with care.
- Elaborate assessment of needs of the members.
- User friendly interface for Electronic Medical Records.
- Team work and coordinated care with care managers, members, providers, community resources.
- Aligning resources with the population needs.

Quality, Timeliness, Access to Health Care and Services

- The overall compliance of OB CM MRR is 92%. Home State Health is able to outreach their OB members to offer CM and complete assessment within 15 business days of notification of pregnancy in 82% cases. Referrals to CM program are 100%, mainly through NOP (11 of 17 cases). The medical records have a documentation of: diagnosis; enrollment date; closure date; assessment inclusive of medical history, psychiatric history, developmental history, psychosocial issues and legal issues; updated care plans; lab testing; progress notes; transfers; coordination, linking, and monitoring of services in 100% of cases. Discharge plan (79%) and aftercare is provided in 82% cases. High risk assessment (risk appraisal/NOP) is available for 100% cases.
    - Home State Health has reported their outreach rate to OB members within 15 days of notification of pregnancy as 97.7%.

Improvement by Home State Health

Table 3: Comparison of OB CM MRR (%) for CY 2017-2018

Criteria	CY 2017	CY 2018
Diagnosis	100	100
First Enrollment Date	100	100
Last Enrollment Date	100	100
Offer CM within (15) business days of notification of pregnancy	100	82
Referral	100	100
Assessment/ Reassessment	95	100
Medical History	95	100
Psychiatric History	95	100
Developmental History	100	100
Medical Conditions	100	100
Psychosocial Issues	100	100
Legal Issues	100	100
Care Plans	95	100
Risk Appraisal	95	100
Care Plans updated	95	100
Provider Treatment Plans	0	0
Testing	100	100
Progress/Contact Notes	95	100
Discharge Plans	60	79
Aftercare	60	82
Transfers	70	100
Coordination/Linking of Services	70	100
Monitoring of Services and Care	70	100
Follow-Up: case closure	70	71

A comparison with previous year (CY 2017) is made to determine the extent to which Home State Health has effectively addressed the recommendations for quality improvement made by the EQRO (Table 3).

An improvement (highlighted green) is noticed in: assessment, medical history, psychiatric history, updated care plans, risk appraisal, progress notes (5% points each); discharge plans (19% points); aftercare (22% points); transfers, coordination/linking, and monitoring of services (30% points each); and follow up care (1% point).
There is a decline (highlighted red) of 18% points in offering CM within 15 business days of notification of pregnancy.

3.4.3 Recommendations

- Enrollment date should be clearly stated in medical records. It is recommended that a member should be considered as "enrolled" when a care manager makes an assessment of the need of the member and this marks the "case start date." The date of notification of pregnancy is not the "case start date." There should not be two different dates for "case start date" and "enrollment date". As per MHD Managed Care Contract, the initial CM and admission encounter shall include an assessment (face-to-face or phone) of the member's needs.
- 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 the primary care provider, Women, Infants, and Children (WIC), and other providers and programs.
  - Sending letters with an address correction request. (Post Offices can be contacted for information on change of address).
- Collaboration with Prenatal Care Provider: CM services must be delivered in close collaboration with the patient's prenatal care provider and when reinforcing and supporting the clinical care plan. OB care managers must communicate regularly with the prenatal care provider about patient progress toward goals, as well as current needs and issues that may impact clinical care. Care managers are a part of the patient's prenatal care team and should regularly visit the Pregnancy Medical Home practices to which they are assigned. They must develop effective practice-specific communication strategies to ensure coordination of care[1].
- Engaging members in CM program: Successful CM programs require a seamless patient enrollment process. Deploying the right team member at the right time has a significant impact on a patient's interest in participation. First, consider designating

[1]https://whb.ncpublichealth.com/provpart/docs/pregCareManual/PregnancyCareManagementStandardizedPlan-Revised2012-11-13.pdf

enrollment responsibilities to staff with a mindset and competencies similar to that of a salesperson. Staff must be able to persuade patient candidates that the program is worth their time and effort. Second, target outreach to all available care settings and patient touch points, allowing patients to be reached at times when they may be more receptive to CM services. Leveraging existing relationships in other care settings, such as in the hospital or a specialist's office, can help encourage patient participation. Finally, tailor messaging to different patient populations to address any unique barriers to enrollment for each. Messaging should account for the health care experience of the members and any potential privacy concerns[2].

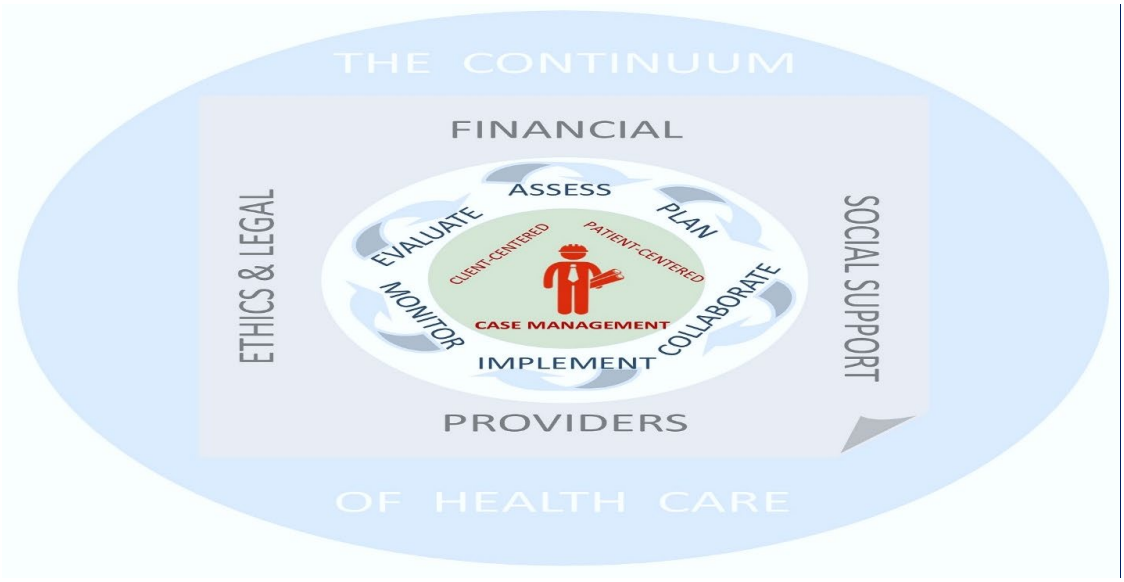

Figure 5: Care Management Continuum of Care
(Source: https://www.compalliance.com/case-management-is-it-a-profession-of-professionals/)

3.5 Children with Elevated Blood Levels (EBLLs) Care Management

Home State Health's EBLLs CM Program:

- Identifies all pediatric members who have unsafe blood lead levels.
- Educate parents and/or member's representative and providers on the importance of lead screening and treatment.
- Facilitates appropriate screening, testing, treatment, repeat testing, and follow-up.
- Help parents/member's representative towards increased self-management of lead values by increasing their knowledge base and comfort level.

[2] https://www.advisory.com/research/care-transformation-center/care-transformation-center-blog/2015/02/enroll-patients-in-care-management

Referrals and identification for EBLLs CM include, but are not limited to, the following:

- Claims data
- ImpactPro predictive modeling
- Primary care provider (PCP)
- Specialist/specialty medical provider (SMP)
- Prior authorization staff
- Care/disease management staff
- Member's parents or representative
- Community agencies
- Other providers, Department of Health and Human Services (DHHS), MHD

Screening and Identification of members for EBLLs:

- Any child under the age of 6 years who resides or spends more than ten hours a week in an area identified as high risk by the DHSS shall be tested annually for lead poisoning.
- All eligible children will be blood tested for lead at age 12 months and 24 months of age.
- Members are eligible for the EBLLs CM Program when a positive blood lead test is equal to or greater than 10 µg/dL.

An outreach to offer CM services is conducted for members with EBLLs in the following timeframes:

10 to 19 µg/dL within 1–3 business days.
20 to 44 µg/dL within 1–2 business days.
45 to 69 µg/dL within 24 hours.
70 µg/dL or greater–immediately.

A care manager coordinates with PCP for an initial confirmation of capillary tests using venous blood in accordance within the MHD stated time frames:

10-19µg/dL–within 2 months.
20-44µg/dL–within two 2 weeks.
45-69µg/dL–within two 2 days.
70 µg/dL–immediately.

Guidelines for a retest and follow up are followed:

10-19gµ/dL–2-3 month intervals.
20-70µg/dL–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.
There are no new exposures.

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

Work Flow

EBLLs CM Program is organized in 3 tiers to best address and stratify the needs of complex population: service coordination; program management; and complex care management. Members are stratified based on an initial assessment (Figure 6). In addition, Home State Health states that they complete documentation in the state's web-based Missouri Health Strategic Architectures and Information Cooperative (MOHSAIC) Lead Application database (Figure 6). (Note: Verification of documentation in this database by Primaris is outside the scope of this report.)

Service Coordination by Program Coordinator (non-clinical staff)	Initial outreach
	Contacts parent/guardian of members having EBLL (venous) to explain the lead CM Program within the required timelines.
	Contacts PCP by phone, explains the lead CM Program, and verifies if the member's lead level has been reconfirmed by venous blood determination.
	Communicates with provider directing member's care and notifies the physician that member is engaged in CM.
	Refers members to program specialist or care manager, schedules follow-up home health visits or second (2) encounter within three (3) months from the initial encounter.
	Uses the web-based Missouri Health Strategic Architectures and Information Cooperative (MOHSAIC) Lead Application to document lead care management activities.

Program Management & Complex Care Management	Verifies and documents member eligibility prior to each outreach attempt.
	Develops individualized plan of care to address the specific needs of the member including retesting, reporting, and monitoring. Implements necessary changes to the plan of care and modifies goals on as needed basis.
	Communicates with physician/physician staff directing member's care and notifies the physician that member is engaged in Lead complex CM.
	Reminders for lead blood draw dates.
	Educates regarding financial resources that may be available for lead abatement assistance through State and Federal funding.
	Documents in the clinical document system a summary of all communications with the member's parent/representative, health care provider(s), community resources, and ancillary personnel associated with the case.
	Updates the clinical documentation system after each contact with the member/representative, pertinent others, and/or if any mailings are sent out.
	Monitors the member's progress by contacting the member at defined intervals, as frequently as needed.
	Use the web-based Missouri Health Strategic Architectures and Information Cooperative (MOHSAIC) Lead Application to document lead case management activities.
	Utilize the DHSS Childhood Lead Poisoning Prevention Program Nurse's Lead Case Management Questionnaire and the Nutritional Assessment forms (attached) to assist in capturing all the required case management elements for documentation.
	A discharge evaluation /case closure and education contact is required to be performed prior to discharge. This can be done once the labs have normalized and at the time the family is informed of the normalization of the lead level.

Figure 6: Workflow of Elevated Blood Lead Levels CM Program

3.5.1 Findings of EBLLs Medical Record Review

An oversample of 30 medical records is reviewed. Medical records included in the sample for evaluation are 18. There are 12 exclusions: CM not done for at least a full quarter (4); and CM not done in CY 2018 (8).

The MRR compliance (%) is reported under the following headings (Figure 7):

a. Diagnosis: 100% compliance.
   There is a documented evidence of diagnosis in all cases.
b. First enrollment date: 100% compliance.
   Case start date is the same as the date of notification even though the member with EBLL has not been contacted. There seems to be an issue which is discussed later in section 3.5.2 of this report.
c. Last enrollment date: 100% compliance.
   There are 12 closed cases and 6 are still open for CM in CY 2019.
d. Offer CM within time frames for EBLLs: 17% compliance.

Care Mangers attempt to outreach a member within 24 hours of notification from the state most of the time. The members are not available for an assessment or do not answer the phone. This results in a delay in assessing the members within the contractual time frame.

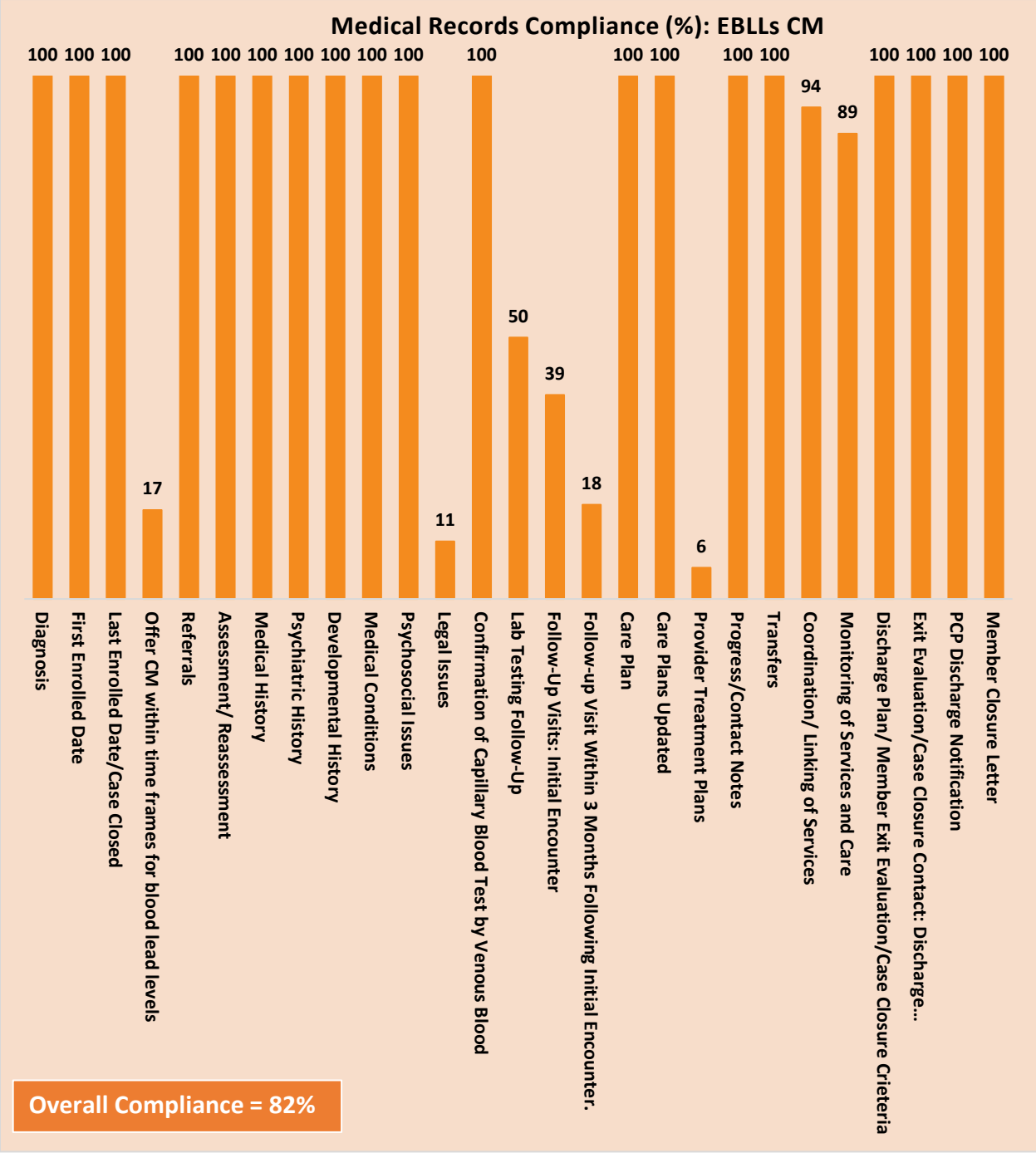

Figure 7: Medical Record Review for Elevated Blood Lead Levels CM Program

e. Referrals: 100% compliance.
   Home State Health has received referrals from state in all 18 cases.
f. Assessment: 100% compliance.
   The lead assessment is complete in all cases. An assessment includes medical history, psychiatric history, developmental history, psychosocial and legal issues. The compliance of all these elements is 100% except for legal issues (11% compliance). Home State Health states that the advanced directives/legal issues are not addressed in the medical records due to the age of member/child (minor).
g. Confirmation of capillary blood test by venous test within the time frame per MHD guidelines: 100% compliance.
   In 16 of 18 cases, venous blood lead levels are available at the time of state's notification to the MCO. For the remaining 2 of 18 cases, Home State Health complied with the requirement.
h. Follow up on EBLLs within the time frame per MHD guidelines: 50% compliance.
   This is evident in 9 of 18 cases. For the remaining cases: 6 cases have a follow up lab test done outside of the given timeframe; and 3 cases do not have a repeat lab test.
i. Home visits: 39% compliance for first visit, 18% compliance for second visit.
   Home State Health contracts with home health agencies for various home services including lead assessment and subsequent visits.
j. Care plan with updates/progress notes: 100% compliance.
   An updated care plan is found in all 18 cases. Detailed notes on every contact with the member are present in all medical records.
k. Provider treatment plan: 6% compliance.
   The engagement of providers with the care managers in developing a care plan is nil. Home State Health mails the care plans to the providers. These are also made available via Home State Health's website. However, the care managers do not receive any feedback from them. Care managers contact providers when there is an issue with the member's care (e.g., missed appointments for blood lead levels). There is 1 of 18 cases in which a provider has corresponded with Home State Health regarding authorization of services. As a result of this identified weakness in the process, additional clarity in the MHD contract would guide MCO success. See Recommendations for All CM.
l. Transfer: 100% compliance.
   This is addressed in all the medical records. Only 1 case is transferred to Local Public Health Agency (LPHA) due to loss of eligibility with Home State Health.
m. Coordination and linking of services: 94% compliance.
   In 17 of 18 cases, the members are linked to PCPs, community resources, home health services, home remediation services, LPHAs.
n. Monitoring of services: 89% compliance.

Well visits, immunizations, appointments, services by LPHAs are monitored in 16 of 18 cases. In 2 cases the monitoring is not done due to UTC followed by loss of eligibility.

o. Discharge plan and exit evaluation/case closure contact: 100% compliance.
Education on prevention of re-exposure to lead, nutrition, and environmental maintenance is discussed over phone or during face- to-face encounters. Discharge planning and exit evaluation are done in 11 cases. Out of remaining 7 cases: this is N/A for 6 cases as they are open for CM in CY 2019; and 1 case lost eligibility.

p. Notification to providers/members: 100% compliance.
In 12 of 12 cases, the providers and members have been sent a written notification about child's condition and case closure (N/A for 6 open cases).

3.5.2 Conclusions

Oversample of medical records: 30

Exclusions: 12

MRR sample: 18 cases. Out of 18 cases, 6 remain open for EBLLs CM in CY 2019 and 12 are closed due to goals met (8) and loss of eligibility (4).

Issues and Key Drivers

Issues

- As stated earlier for the OB CM Program, same issue related to case start date/enrollment date is detected for EBLLs CM program as well. Medical records have a "case start date" which do not correspond to the "enrollment date" provided during an onsite review.
- The CM is offered within the time frames based on the EBLLs in 17% cases (3 of 18 cases). In 83% cases (15 of 18 cases) CM is offered but outside of the mandated time frame. Unsuccessful contact with a member is main cause of delay.
- The timely follow up of repeat blood lead levels is done in 50% cases (9 of 18). For the remaining 9 of 18 non-compliant cases: 6 cases have a follow up blood test but outside of the mandated timeframe; 3 cases did not have a repeat blood test done (refusal by PCP in 1 case). Provider's knowledge about the retesting blood lead levels per Centers for Medicare and Medicaid Services (CDC)/MHD guidelines appears to be an issue.
- Initial home visit is made in 39% cases (7 of 18) within the timeframe and in 16% cases (3 of 18) outside of the time frame. Second home visit is made in 18% cases (3 of 17). The MCO makes several attempts to contact the members. The members do not respond to the calls/not keep their appointments. There seems to be a lack of understanding about the impact of lead on the health of their child.
- Provider engagement with the care plan is negligible.

Key Drivers

- Education of parents/guardians of children about harmful effects of lead, preventive measures, importance of timely BLL testing, and usefulness of CM services.
- Maintaining high motivation of clients throughout their CM.
- Education, skills, knowledge, competencies, and experience of care managers.
- Coordination between providers, care managers, and environmental risk assessors, home remediation service agencies, and local health agencies.
- Feedback from the member/guardian about CM services.
- Updated contact information.
- Creating proactive care plan with self-management goals.
- Providers' education about CDC guidelines for EBLLs CM.

Quality, Timeliness, and Access to Health Care Services

- The overall compliance of EBLLs CM MRR is 82%. Home State Health has scored: 100% in documentation of diagnosis, enrollment and case closure dates, referrals, assessment (including medical history, psychiatric history, developmental history, psychosocial issues), a confirmation of capillary BLL level with venous BLL within the time frame, updated care plans, progress notes, transfers, discharge plan, exit evaluation, PCP and member discharge notifications; 94% for coordination and linking of services; 89% for monitoring of services and care.
- Initiative is taken by care managers to call the providers for confirming appointments of their members and to follow up with their blood lead levels. The care managers also educate the providers about the CDC/MHD recommended timeframes for retesting EBLLs.
- Home State Health measures EBLLs CM Program effectiveness by the percent of eligible members screened (Table 4): 100% of members with venous blood lead levels 10 µgm/dl or greater need to be assessed and referred for lead abatement, or documentation must be on file that the necessity for lead abatement procedures has been assessed and/or that the remediation has occurred.

Table 4: Eligible Members Screened for Lead in CY 2018

Metric	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Number of members with EBLLs ≥10 µgm/dl	30	54	75	36
% of Timely outreach to members	100	100	100	100

- Additionally, Home State Health evaluates CM program by using HEDIS measures for Lead Screening in Children (LSC) (Table 5). The rate has increased from 60.74% (CY 2017) to 61.26% (CY 2018) which an increase of 0.52% point.

Table 5: Lead Screening Rates from H 2017-H 2019

HEDIS Year (HY)	Lead Screening In Children (LSC) Rate	NCQA Quality Compass 25th Percentile	NCQA Quality Compass 50th Percentile	Year over Year Percentage Point Change
H2017/ CY 2016	56.30%	59.65%	71.38%	
H2018/ CY 2017	60.74%	62.53%	73.13%	4.44
H2019/ CY 2018	61.26%	Pending	Pending	0.52

Improvement by Home State Health

A comparison with previous year (CY 2017) is made to determine the extent to which Home State Health has effectively addressed the recommendations for quality improvement made by the EQRO (Table 6).

An improvement (highlighted green) is noticed in: assessment including medical history, medical conditions, psychosocial issues, psychiatric history, developmental history (5% points each); confirmation of capillary blood test by venous blood test within the time frames (5% points); follow up home visits-Initial encounter (4% points), updated care plan (10% points); discharge plan, exit evaluation and discharge documentation (84% points each); PCP discharge notification (34% points).

There is a decline (highlighted red) noticed in: offer CM within timeframes for blood lead levels (33% points); addressing legal issues in assessment (84% points); Lab testing follow up (45% points); second home visit (2% points); provider treatment plans (94% points); coordination and linking of services (6% points); monitoring of services (11% points).

Table 6: Comparison of EBLLs CM MRR (%) for CY 2017-2018

Criteria	CY 2017	CY 2018
Diagnosis	100	100
First Enrolled Date	100	100
Last Enrolled Date/Case Closed	100	100
Offer CM within Time Frames for BLLs	50	17
Referrals	100	100

Assessment/Reassessment	95	100
Medical History	95	100
Psychiatric History	95	100
Developmental History	95	100
Medical Conditions	95	100
Psychosocial Issues	95	100
Legal Issues	95	11
Confirmation of Capillary Blood Test by Venous Blood within Timeframe	95	100
Lab Testing Follow Up	95	50
Follow-Up Visits: Initial Encounter	35	39
Follow-up Visit within 3 Months Following Initial Encounter.	20	18
Care Plan	90	100
Care Plans Updated	90	100
Provider Treatment Plans	90	6
Progress/Contact Notes	100	100
Transfers	100	100
Coordination/Linking of Services	100	94
Monitoring of Services and Care	100	89
Discharge Plan/Member Exit Evaluation/Case Closure Criteria	16	100
Exit Evaluation/Case Closure Contact: Discharge Documentation	16	100
PCP Discharge Notification	66	100
Member Closure Letter	100	100

3.5.3 Recommendations

For Home State Health

- Enrollment date should be clearly stated in medical records. It is recommended that a member should be considered as "enrolled" when a care manager makes an assessment of the need of the member and this marks the "case start date." The date of notification of EBLL is not the "case start date." There should not be two different dates for "case start date" and "enrollment date". As per MHD Managed Care Contract, the initial CM and admission encounter shall include an assessment (face-to-face or phone) of the member's needs.
- Contact Guardian/Member: Different modes of outreach should be used at different times of the day and different days of the week to increase opportunities of actually reaching the member/guardian to initiate the CM process. The number of days for

which a case will remain open even after UTC should be decided. Language barriers may present obstacles for the initial contact of the member/guardian. Local community-based resources may be necessary to facilitate initial contact and confirm effective follow-up (Table 7).

Table 7: Methods to Contact Members

Methods Used for Contact Information	Methods to Verify/Update Contact Information
Phone 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 Call member/guardian at differing times and days	Inquire WIC contact Inquire economic assistance contact Inquire Child Protection contact Inquire Primary Care Provider Inquire US Postal Service for forwarding the recent address Inquire contact person/guardian listed at admission

- The member/guardian should be explained about the significance of home visits by the care managers and how this would help in tailoring the care plan.
- Lead Poisoning Education: In addition to mailing educational materials to the parents/guardians, they should receive explanations about risks; how children are exposed to lead; products containing lead; preventive measures; healthy diets; effects of lead on children, adults, and pregnant women; testing and reporting guidelines; methods of testing; and treatment. This may help in generating member awareness about significance of their involvement in CM program.
  Providers should be educated regarding a follow up on venous BLLs within the time frame as per Centers for Disease Control and Prevention (CDC) guidelines/MHD contract guidelines.
- Provider engagement: The MCO should have a point of contact at every provider's office to discuss and share the care plan.
- Ref to https://www.cdc.gov/nceh/lead/casemanagement/managingEBLLs.pdf for additional information management of EBLLs.

For MHD

MHD is currently required to follow the DHSS State Regulation 19 CSR 20-8.030 for EBLLs CM guidelines. Primaris recommends MHD to work with the DHSS to consider the facts below for amending their guidelines for EBLL CM program.

References: https://www.cdc.gov/nceh/lead/acclpp/lead_levels_in_children_fact_sheet.pdf
https://www.cdc.gov/nceh/lead/acclpp/blood_lead_levels.htm
https://www.cdc.gov/nceh/lead/acclpp/actions_blls.html
New Recommendations to Define Elevated Blood Lead Levels:
"In January 2012, a committee of experts recommended that the CDC change its "blood lead level of concern." The recommendation was based on a growing number of scientific studies that show that even low blood lead levels can cause lifelong health effects.
The committee recommended that CDC link lead levels to data from the National Health and Nutritional Examination Survey (NHANES) to identify children living or staying for long periods in environments that expose them to lead hazards. This new level is based on the population of children aged 1-5 years in the U.S. who are in the top 2.5% of children when tested for lead in their blood. Currently, that is 5 micrograms per deciliter of lead in blood. CDC's "blood lead level of concern" has been 10 micrograms per deciliter. The new value means that more children will be identified as having lead exposure earlier and parents, doctors, public health officials, and communities can take action earlier. The committee also said, as CDC has long said, that the best way to protect children is to prevent lead exposure in the first place."

3.6 Behavioral Health (BH) Care Management

Home State Health provides both episodic and complex CM, based on member needs and the intensity of service required. CM program manages comorbidities and addresses the whole person, not simply the primary condition (Figure 8).

Integrated Care Team (ICT) Staffing Model

Care Coordination (CC) and CM teams are generally comprised of multidisciplinary clinical and nonclinical staff. This integrated approach allows non-medical personnel to perform non-clinical based health service coordination and clerical functions and it permits the Missouri licensed professional staff to focus on the more complex and clinically-based service coordination needs. A BH practitioner is involved in implementing, monitoring, and directing the BH care aspects of Home State Health's CM program. A CM Supervisor for BH services is either a Missouri-licensed Mental Health Clinical Nurse Specialist, Mental Health Nurse Practitioner, or a Missouri licensed psychologist. Care managers 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. The clinical staff consults with and/or seeks advice from the Medical Director as indicated.

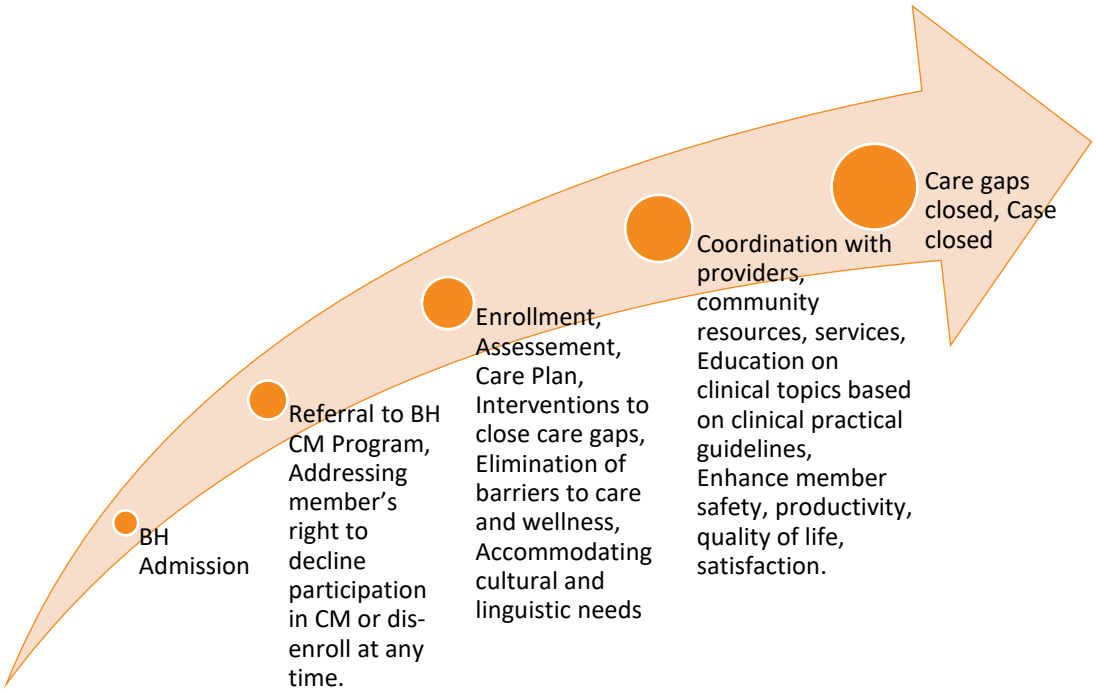

Figure 8: Workflow of Behavior Health CM Program

Referrals

Hospital staff, e.g., hospital discharge planning and emergency room staff, is notified of Home State Health's CM Program during interactions with Utilization Management (UM) staff throughout the utilization review process. Hospital staff is encouraged to inform Home State Health UM staff if they feel a member may benefit from CM services; UM staff then facilitate the referral. Home State Health UM staff work closely with CM staff on a daily basis and can initiate a referral for CM verbally or through a reminder/task in the clinical documentation system when a member is identified through the UM processes, including prior authorization, concurrent review, discharge planning, and cases discussed in rounds.

3.6.1 Findings for BH Medical Record Review

An oversample of 30 medical records have been reviewed. Only 15 of them are included in the sample to assess the CM of members with BH diagnosis leading to hospitalization (including residential treatment program for substance use disorder). The remaining 15 cases are excluded: no CM for at least a full quarter (7 cases); and no Inpatient (IP) admissions (8 cases).

The MRR compliance (%) is reported under the following headings (Figure 9):

a. Diagnosis: 100% compliance.
   There is a documentation of diagnosis in all 15 cases. Major depression is the admitting diagnosis in 7 of 15 cases. The other reasons for hospital admissions are disruptive

mood disregulation disorder (4), schizophrenia (1), suicide attempt (1), generalized anxiety disorder with pregnancy (1), substance use disorder (1).

b. First enrollment date: 100% compliance.
   The case start date is when the care managers are notified of admission by UM system.
c. Last enrollment date: 100% compliance.
   All closed cases (11 of 15) have documented case closure date. Remaining 4 cases are open for CM in CY 2019.

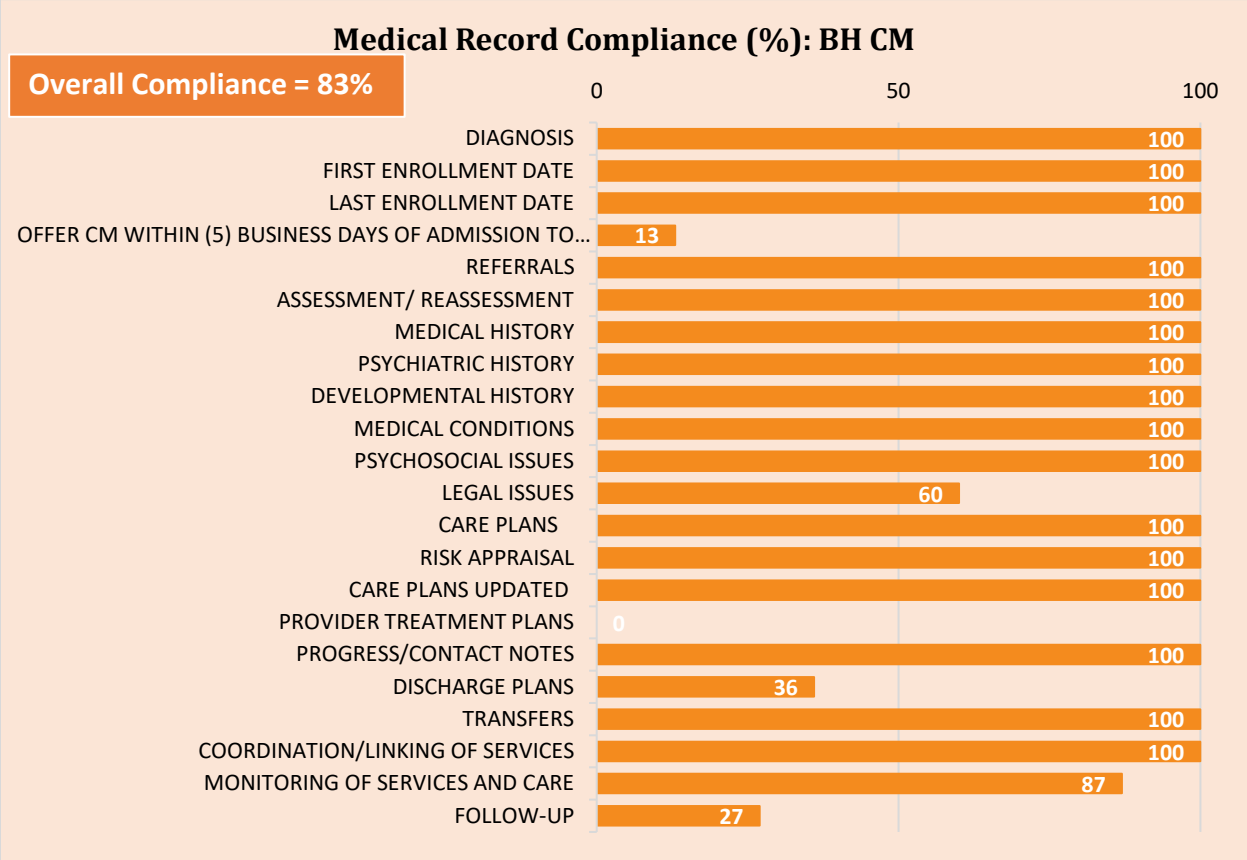

Figure 9: Medical Record Review for Behavioral Health CM Program

d. Assessment of the members for CM within 5 business days of admission to a psychiatric hospital or residential treatment program: 13% compliance (Figure 10).
   MHD has mandated Primaris to focus on this section.
   Various reasons attributable for low compliance are:
   - The care manager is not permitted to meet the patient during hospital stay.
   - Patient's condition does not allow a conversation with care manager for an assessment.

- The care manager is not able to successfully contact the patient in spite of several attempts (minimum 4). Efforts to outreach begin within 24 hours of discharge of a patient from the hospital.

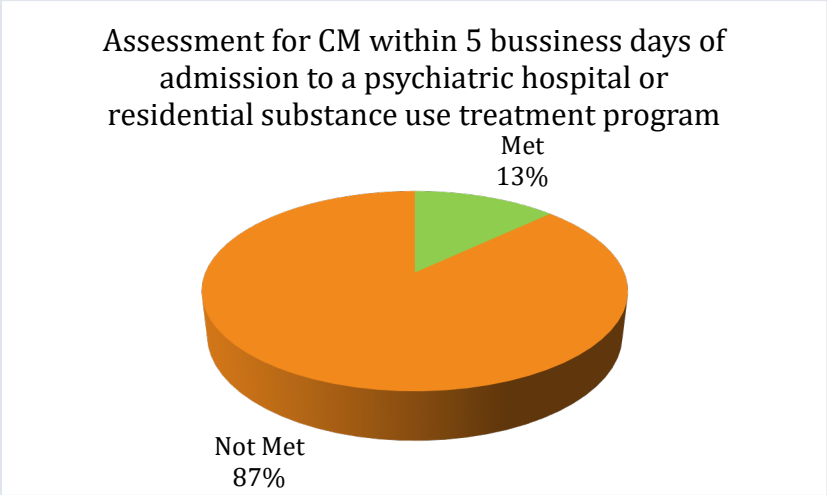

Figure 10: Assessment for CM within 5 business days of admission to a psychiatric hospital or residential substance use treatment program

e. Referrals: 100% compliance.
   All cases included in the study are referred by UM system. Some other sources of referral are BH crisis line, member self-referrals, and reports.
f. Assessment: 100% compliance.
   All the cases have an assessment which includes medical history, psychiatric history, developmental history, psychosocial issues (each 100% compliance) and legal issues (60% compliance).
g. Care plan with updates/progress notes: 100% compliance.
   The care manager discusses the needs with the member and develops a care plan with interventions directed at closing those care gaps. The providers are contacted, if necessary. The care plan is updated on a monthly basis and progress notes are maintained for each member.
h. Risk appraisal: 100% compliance.
   High risk assessment is available for all 15 cases.
i. Provider treatment plan: Zero compliance.
   Care plan is sent to PCP in 47% cases (7 of 15). It is not sent to PCP in 53% cases (8 of 15). No response is received from providers unless a care manager calls the provider when needed and hence the compliance for this category is scored zero. As a result of this identified weakness in the process, additional clarity in the MHD contract would guide MCO success. See Recommendations for All CM.

j. Testing: N/A
Home State Health informed Primaris that BH patients are recommended for lab tests only in a few cases, e.g., patients on mood stabilizing drugs (lithium) where the therapeutic levels are required to be monitored. There are no cases with a recommendation for a drug test. Hence, this section is considered N/A.

k. Transfer: 100% compliance.
This section is addressed in all the medical records.

l. Coordination and linking of services: 100% compliance.
Care managers coordinate with PCPs, BH providers, therapists, social workers, transportation, interdisciplinary care team, counseling services to ensure full support and a complete recovery of their patients.

m. Monitoring of services and care: 87% compliance
Care managers monitored services and care received by the members regarding preventive health visits, dental services, medications, immunizations for 13 of 15 cases (UTC-2 of 15 cases).

n. Discharge plan and Follow up: 36% compliance, 27% compliance respectively.
Discharge planning is done in 4 of 11 cases. The remaining 7 cases do not have a discharge plan due to UTC (4), refusal to CM (1), and loss of eligibility (2).

o. Follow up: 27% compliance.
This is done in 3 of 11 cases. Remaining 8 cases could not be followed up due to UTC (5), refusal to CM (1), loss of eligibility (2).

3.6.2 Conclusions

Oversample of medical records: 30

Exclusions: 15

MRR sample: 15 cases. Of these 15 cases, 4 are open for CM in CY 2019 and 11 are closed under BH CM program due to the following reasons (Table 8):

Table 8: Case Closure	11
Goals met	3
Lost eligibility	2
Unable to contact (UTC)	5
Declined CM	1

Issues and Key Drivers

Issues

- The success rate of the MCO to initiate CM assessment of their members within 5 business days of admission to a psychiatric hospital/residential treatment program

is only 13%. Several post-discharge outreach attempts are made before a care manager is able to enroll a member in CM program and begin an assessment. Most common reason noted for this delay in assessment is "UTC-phone call not answered."

- Providers are not engaged in the care plan. However, when care managers call provider offices to confirm compliance of the members with their scheduled appointments, they get a feedback/response.
- The ability to stay in contact over a long term is a challenge in tracking member's care. Sometimes, the members become overwhelmed with too many people involved in their care. They lack the understanding of their roles and opt out of care management. Refusal to CM after enrollment is 7% (1 of 15 cases) and 33% cases are closed because of UTC (5 of 15). Members do not respond to the calls by the care managers. This leads to decreased discharge planning (36% compliance) and Follow up (27% compliance).
- Follow-Up After Hospitalization for Mental Illness (HEDIS Measure): 7-Day Follow-Up rate in CY 2018 is 31.54% versus 37.78% in CY 2017 (a decrease of 6.24% points). Similarly, 30-Day Follow-Up in CY 2018 is 52.74% versus 55.93% in CY 2017 (a decrease of 3.19% points).

Key Drivers

- Early engagement of care manager with the members.
- Accurate contact information of members/secondary contacts/guardians when the patient is in the hospital.
- Educating members and providers about the significance of CM program.
- Training care managers/linguistic and cultural competency.
- Supporting patient's self-management goals.
- Provider engagement.
- Linking to community resources.
- Medication management.

Quality, Timeliness, and Access to Health Care Services

- The overall compliance for BH CM MRR is 83%. Home State Health has scored 100% in documenting their medical records with diagnosis, enrollment and case closure dates, referrals, assessments, updated care plans, progress notes, and coordination and linking of services.
- Readmission Rates: BH Readmission Rates within 30 days are consistent around 15% and Readmission Rates within 90 days are maintained around 25% throughout the CY 2018 (Figure 11). The readmission rates within 30 days in CY 2017 varied from 9-19% throughout the year.

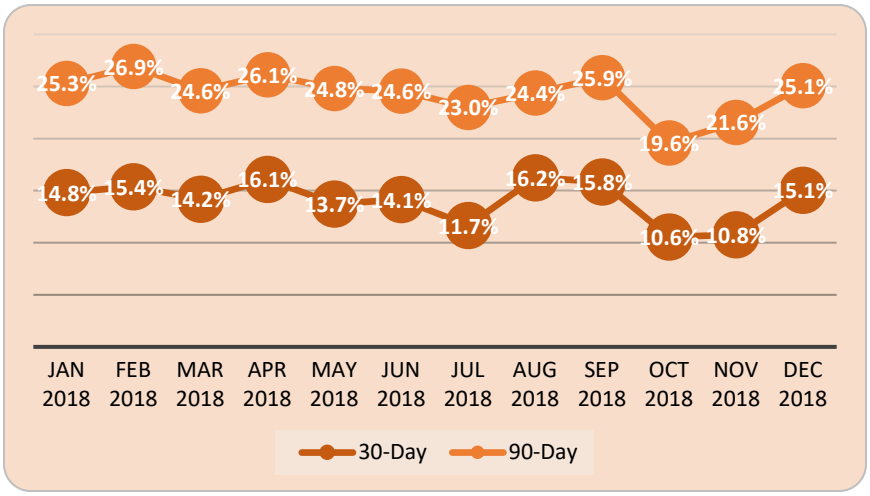

Figure 11: BH (Medicaid) Readmission Rates CY 2018

Improvement by Home State Health

A comparison with previous year (CY 2017) is made to determine the extent to which Home State Health has effectively addressed the recommendations for quality improvement made by the EQRO (Table 9). (Note: In CY 2017 the focus was on CM offered to patients with a diagnosis of serious mental illness and in CY 2018 the focus is on CM offered to members post-psychiatric hospitalization/residential substance use treatment program. Common/relevant criteria applicable to both these focus areas have been included in the table.)

There is an increase (highlighted in green) of 5% points for compliance in medical records addressing: transfers; and coordination and linking of services.

There is a decrease % compliance (highlighted in red) noted in: assessment of members for CM within 5 business days of admission to a psychiatric hospital or residential substance use treatment program (87% points); information on legal issues (40% points); provider treatment plans (95% points); discharge plans (59% points); monitoring of services and care (13% points); and follow up (63% points).

Table 9: Compliance % BH CM	CY 2017	CY 2018
Diagnosis	100	100
First Enrollment Date	100	100
Last Enrollment Date	100	100
MCO assess members for CM within 5 business days of admission to a psychiatric hospital or residential substance use Tx program	100	13

Referrals	100	100
Assessment/ Reassessment	100	100
Medical History	100	100
Psychiatric History	100	100
Developmental History	100	100
Medical Conditions	100	100
Psychosocial Issues	100	100
Legal Issues	100	60
Care Plans	100	100
Care Plan Includes Risk Appraisal	100	100
Care Plans updated as indicated or w/in 90 days of discharge from inpatient stay or ED Visit	100	100
Provider Treatment Plans	95	0
Progress/Contact Notes	100	100
Discharge Plans	95	36
Transfers	95	100
Coordination/Linking of Services	95	100
Monitoring of Services and Care	100	87
Follow-Up	90	27

3.6.3 Recommendations

- CM Assessment within 5 days of psychiatric hospital/residential treatment program: Most of the referrals for BH CM are during concurrent review. It is best to engage with the member for an assessment during hospitalization. Home State Health should work with the hospital authorities for permission for the care managers to visit patients during hospital stay.
- Engagement of providers: There is a need to educate providers about the role of care managers in management of the BH members. These care managers are capable of providing holistic care which can reduce inpatient readmission rates, emergency room utilization, increase the rates: follow-up after hospitalization for mental illness; and follow-up after emergency department visit for mental illness. This would improve the member outcomes of care and lead to significant cost savings. This savings could be used for incentivizing providers-a step towards engagement.
- BH providers (psychiatrists, psychologists, psychiatric nurses, clinical social workers, mental health counselors, and other professionals) who provide treatment to patients with a mental health condition may share protected health information (PHI), including mental health information, in order to treat patients and prevent them from harming themselves or others. Health Insurance Portability and

Accountability Act of 1996 (HIPAA) helps mental health professionals by allowing them to make decisions about when to share mental health information based on their professional judgment about what is in the best interests of the patient or what is needed to prevent or lessen a risk of harm.[3] Under HIPAA, both the MCO and providers are defined as covered entities.[4] Covered Entities are not required to obtain individual consent or authorization for the use and disclosure of regular Protected Health Information (PHI) for purposes of treatment, payment and health care operations where there is an existing relationship between the member, the MCO, and the provider. [5] However, the care manager can obtain a written consent from the member so that a care plan can be shared with the provider (BH/PCP). Additionally, care managers must also recognize when some patients with severe mental illness may not have the capacity to make decisions regarding the sharing of their information, as in the case of intoxication or temporary psychosis.[6]

- Appropriate discontinuation of service[6]: Care management is a service with an ultimate goal that, at some point, the client will no longer need the help of his or her care manager. Care continued beyond this point often wastes valuable time-both the patient's and the care manager's-and limited community resources. Instead, the client should be counseled on his or her possible "graduation" from behavioral health care management.
- All the BH care plans should be shared with PCP even if there is no medical diagnosis. This is an important step in integration of BH and general health.
- Medication management errors and adherence issues are known causes of frequent ED use, hospitalization and readmissions. Network pharmacists and pharmacy techs are critical members of the care team in the performance of medication reconciliation, comprehensive medication reviews, resolution of drug therapy problems, closing the gaps on adherence issues, and other medication-related interventions. Primaris recommends care managers to work with their pharmacy for a better member outcome.
- Strength-Based Approach: A care manager should focus on resolving problems through the cultivation of the positive aspects of a client's life that promote mental well-being rather than on specific pathology. Points of focus should include the

[3] https://www.hhs.gov/sites/default/files/hipaa-helps-prevent-harm.pdf
[4] *See* 45 CFR 160.103 which states "Covered Entity means (1) a health plan (2) a healthcare clearing house (3) a healthcare provider who transmits any health information in electronic form in connection with a transaction covered by this subchapter."
[5] *See* 45 CFR 164.506. "A Covered Entity may disclose PHI to another Covered Entity for purposes of health care operations activities of the entity that receives the information, if each entity has or had a relationship with the individual who is the subject of the PHI being requested, the PHI pertains to such relationship and the disclosure is… for a purpose listed in paragraph (1) or (2) of the definition of healthcare operations."
[6] https://www.socialsolutions.com/blog/3-behavioral-health-case-management-best-practices/

client's personal strengths and talents, positive interpersonal relationships in the client's life, identifying realistic goals and discussing possible ways of achieving them[6].

- Average case load[7]: According to CMSA there are many factors that determine the case load capacity and care load calculation of a care manager. Because of the multiple factors and complexity of determining the appropriate caseload, CMSA has created a Case Load Capacity Calculator Tool. Home State Health can utilize this online tool to optimize their staff load for any CM program and improve member outcomes.

Recommendations for All CM

In regards to low compliance with Provider Treatment Plans, it is recommended that Home State Health add an acknowledgement clause with the submission of the care plan to the provider which confirms their support of the care plan unless they reach out to Home State Health within 30 days to express concerns or offer changes. By including this statement on every treatment plan, Home State Health will be closing the loop and rates for provider treatment plan can greatly improve. Discussions with the MHD reveal clarifications on this topic must also be made in the managed care contract. Currently, the managed care contract does not clearly define "provider treatment plans." The MHD confirms it will clarify this expectation through the next contract amendment, which will allow for a clearer path to contract compliance.

[7] https://casemanagementstudyguide.com/ccm-knowledge-domains/case-management-concepts/case-load-calculation/