Primaris
Healthcare Business Solutions

2019 External Quality Review
Care Management

missouricare
A WellCare Company

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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.

Missouri Care 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.

Missouri Care'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.

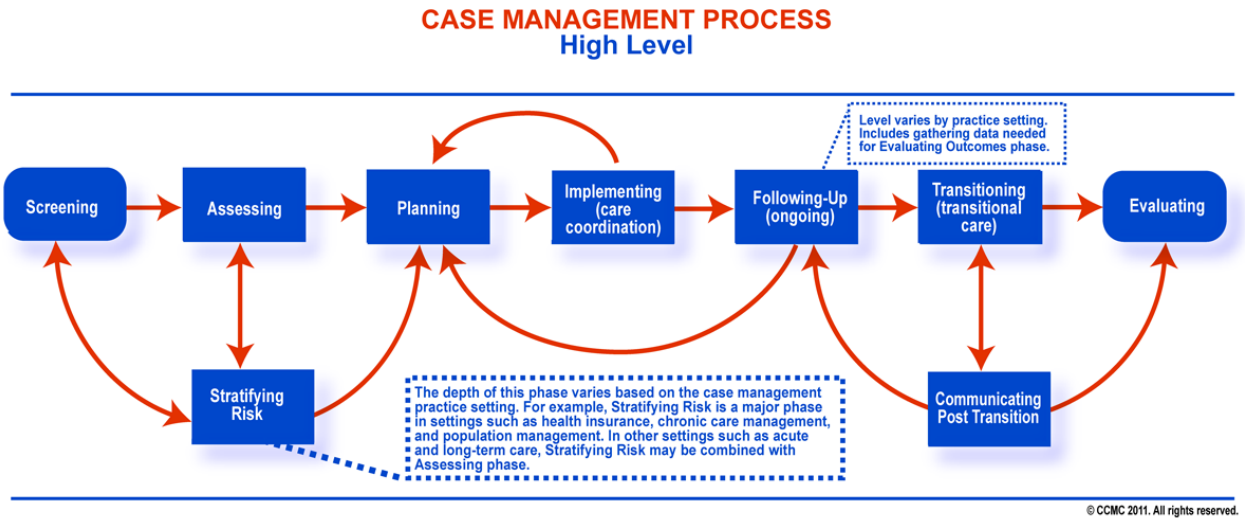

Figure 1: Care Management Process
(https://www.cmbodyofknowledge.com/content/introduction-case-management-body-knowledge)

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 Missouri Care.

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 Missouri Care:

- 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 Missouri Care'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 Missouri Care 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

Missouri Care'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 Missouri Care's office in St. Louis, MO, on June 25, 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).

- Claudia Douds RN, BSN, MHA, VP, Field Health Services
- Rhonda Brown, Director, Behavioral Health Services
- Rachel Cain, RN BSN, Supervisor, Care Management
- Erica Bruns, LPC, MPA, Manager, Behavioral Health
- Kim O'Brien, RN, BSN, CCM

Medical Record Review (MRR)

Primaris assessed Missouri Care'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 Missouri Care. 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). Missouri Care 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: Missouri Care 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

The number of Medicaid Managed Care members enrolled in CY 2018: 250,263
Members enrolled in all CM programs: 2,281 (OB-551; EBLLs-82; BH-702)
CM staff available: Field-4; OB-5; BH-9; Care Coordinators-10
Average case load: 40-75 (Medical: 57; BH: 52)
Maximum number of members that can receive CM: 1800*

*Case Load: Corporate Population Health System has determined a benchmark of 200 cases per nurse per year. Given that benchmark, at full staffing, Missouri Care could open 1800 medical cases per year (however this number does not account for vacancies).
BH has slightly different caseload expectations. They open both field and telephonic cases, so they are expected to open either 8 new field cases or 10 new cases (at least 2 telephonic) or 12 new telephonic cases each month). Thus, Missouri Care is capable of managing between 850-1100 cases total annually (depending on the field/telephonic mix of cases).

3.2 Review of Policies and Procedures

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

Table 1: Missouri Care-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.	●		2019 CM Program Description, C7 CM-MD-1.2 CM Program Description, C7-CM-017-PR-014 Health Risk Assessment (HRA) for Member Outreach, MO29-HS-CM-003 Care Management.
2. Provider and member profiling activities.	●		2018 Annual Evaluation, MO29-HS-UM-021 Physician Profiling/Over and Under-

			Utilization, MO29-HS-CM-003 Care Management.
3. Procedures for conducting provider education on CM.	●		2019 CM Program Description, C7 CM-MD-1.2 CM Program Description, Missouri Care Provider Orientation Presentation -2019, 2018 Missouri Medicaid Provider Manual.
4. A description of how claims analysis will be used.	●		2018 Annual Evaluation, C7-CM-MD-6.0-PR-001 Decrease in Emergency Room Overuse Procedure, C7 CM-MD-1.2 CM Program Description, Missouri Care Provider Orientation Presentation -2019, 2018 Missouri Medicaid Provider Manual.
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.	●		2019 CM Program Description, C7 CM-MD-1.2 CM Program Description.
6. A process to ensure integration and communication between physical and behavioral health.	●		2018 Annual Evaluation, 2019 CM Program Description, C7 CM-MD-1.2 CM Program Description, MO29-HS-CM-003 Care Management
7. A description of the protocols for communication and responsibility sharing in cases where more than one care manager is assigned.	●		2019 CM Program Description, C7 CM-MD-1.2 CM Program Description.

8. A process to ensure that care plans are maintained and updated as necessary.	●		2019 CM Program Description, MO29-HS-CM-003 Care Management.
9. A description of the methodology for assigning and monitoring CM caseloads that ensures adequate staffing to meet Care Management requirements.	●		C7-CM-MD-1.2-PR-006 CM Program Description Process (Telephone Care Manager Caseload).
10. Timeframes for reevaluation and criteria for CM closure.	●		MO29-HS-CM-003 Care Management, MO29-HS-CM-002 Perinatal Case Management, MO29-HS-CM-00I Lead Case Management.
11. Adherence to any applicable State quality assurance, certification review standards, and practice guidelines as described in the contract.	●		2018 Annual Evaluation, C7-QI-026 Provider Clinical Practice Guidelines Policy, C7-QI-026-PR-001 Provider Clinical Practice Guidelines Procedure, C7 CM-MD-1.2 CM Program Description
12. Additional information.	●		QI Work Plan.

3.3 Evaluation of Care Plan

Upon interviewing Missouri Care officials and reviewing the medical records for all three CM programs, Primaris concludes that Missouri Care has policies and procedures based on contractual guidelines for "care plan," and members are managed according to these

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.

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.

3.4 Pregnant Members/Obstetrics (OB) Care Management

The Obstetrics Care Management program of Missouri Care is an integrated program offered to all identified pregnant women with a goal for the pregnant member to have an uncomplicated pregnancy and deliver a healthy term infant. Missouri Care employs dedicated and specially-trained OB care managers, supported by care coordinators to outreach all pregnant members, conduct assessments, and offer CM. This may be in-person or telephonic outreach, depending on the member's individual needs.

Members are identified in a variety of ways including electronic notification from the state and claims data mining. Upon identification of a member as pregnant, outreach attempts begin in order to explain the benefits of the program. Once a member enrolls in CM program, she is sent educational materials and receives assistance in locating an obstetrician, receives an explanation of Missouri Care's pregnancy incentive program and is encouraged to schedule and keep all prenatal and postpartum appointments.

Services address clinical, behavioral health, and socioeconomic needs. Assessments of both physical and behavioral health are completed with the member and care plans are developed based on the information obtained. Social and behavioral support services are also addressed include smoking cessation classes, alcohol and substance use disorder treatment, services to address spousal/partner abuse and emotional or mental health concerns. Referrals are made and coordinated within the community to support the member's needs including Women, Infants, and Children (WIC) and Comprehensive Substance Abuse Treatment and Rehabilitation (C-STAR) programs.

An important aspect of Missouri Care's CM program is the focus on screening for high-risk pregnancy. Missouri Care's goal is to engage high-risk pregnant women in perinatal care management to reduce complications associated with identified conditions or substance use during pregnancy, including Neonatal Abstinence Syndrome. Once a member has been identified as potentially at a risk, a care manager makes an outreach call to involve the member in high-touch CM. The high-touch care manager works closely with the member, her doctor and other members of her health care team to make sure certain risks are minimized as much as possible and that the member is receiving the care she needs (Figure 2).

Member Interventions

Missouri Care has partnered with *Nurses for Newborns* in the eastern region. The innovative, collaborative partnership allows them to outreach both high and low risk OB members in St. Louis City and Jefferson Counties, areas where the rate of preterm and low

birth weight deliveries are among the highest in the state. Pregnant members in these two counties receive in-home services throughout their pregnancy (if they agree to services), the intensity of which depend on the medical, social, and behavioral health risk factors. In addition, services continue for the mom and her child after delivery and up to the first two years of the child's life. Mother is screened for depression and substance use disorder. Education continues during the two years of enrollment including the importance of well child checks ups/immunizations and appropriate emergency room (ER) use. Discussions are underway with similar organizations in other regions of the state to provide this highly personalized service to more members.

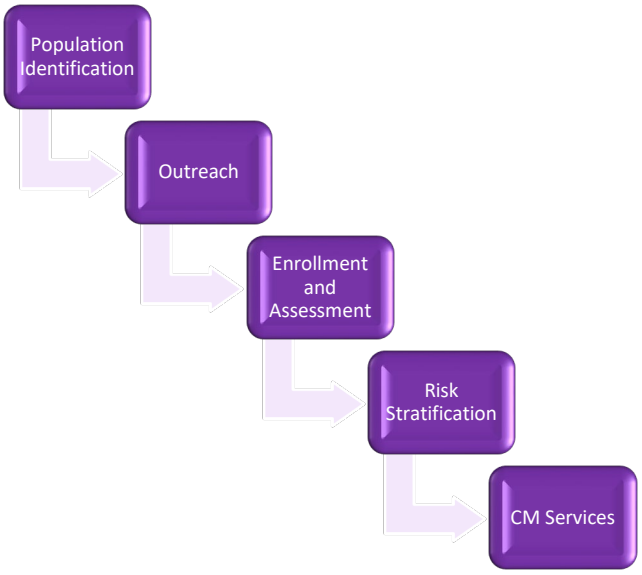

Figure 2: Work Flow of Obstetrics CM Program

3.4.1 Findings of OB Medical Record Review

An oversample of 23 medical records is reviewed. Out of these, 20 medical records are evaluated. There are 3 exclusions: unable to contact (UTC)-1 case; and enrolled in CM for less than a quarter-2 cases.

The MRR compliance (%) is reported under the following headings (Figure 3):

a. Diagnosis: 100% compliance.
   Medical records have a documentation of a diagnosis of pregnancy (high risk/low risk) in all the 20 cases.
b. First enrollment/Last enrollment date: 100% compliance.
   All cases are enrolled within 24 hours of notification of a member's pregnancy and outreach to a member is initiated. First enrollment and last enrollment dates are documented in all medical records.

c. Offer CM within 15 business days of notification of pregnancy: 100% compliance.
   Missouri Care has contacted their OB members within the time frame to assess their needs.
d. Referrals: 100% compliance.
   All the referrals are received through state notifications.

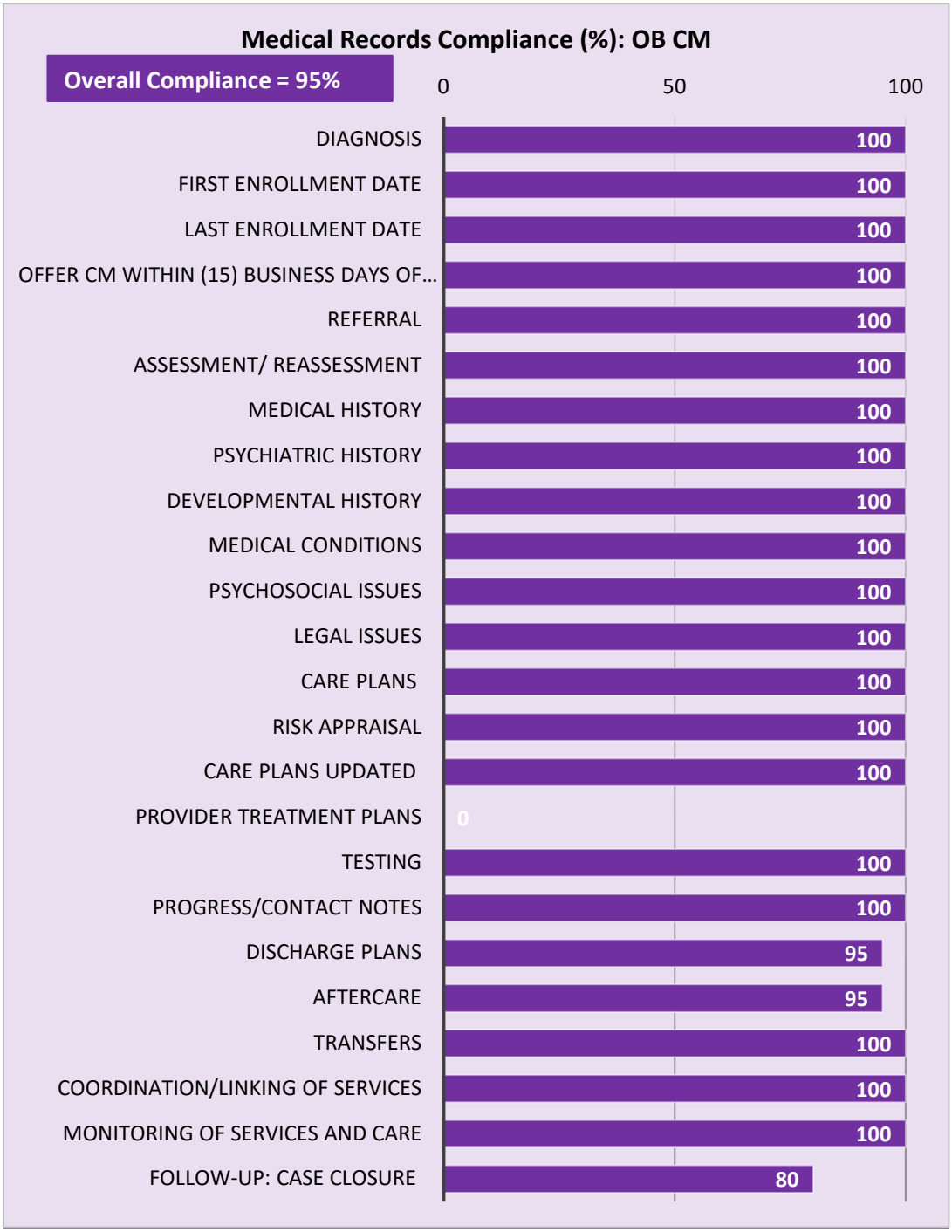

Figure 3: Medical Record Review for OB CM Program

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 20 cases.
g. Risk appraisal: 100% compliance.
   This is present in 20 of 20 cases.
h. Provider treatment plans: Zero compliance.
   The care plans are mailed/faxed to the providers. However, the providers do not respond to the care plan/treatment 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.
i. Lab tests: 100% compliance.
   These are documented in all 20 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, Aftercare: 95% compliance.
   Discharge plan and aftercare is provided in 19 of 20 cases. This is missing in 1 case because of UTC.
l. Transfers: 100% compliance.
   This is addressed in all 20 cases. There are no transfers to/from another MCO.
m. Coordination, linking, and monitoring of services: 100% compliance.
   Medical records reveal that all 20 cases are linked to community resources and the care has been monitored.
n. Follow up (case closure no sooner than 60 days post-partum): 80% compliance.
   A post-partum follow up care is seen in all 20 cases. However, 4 cases are closed within 55-59 days post-partum period for "Goals Met." This has resulted in a reduced compliance score of 80%.

3.4.2 Conclusions

Oversample of medical records: 23
Exclusions: 3
MRR sample: 20 cases. These cases are closed for Goals met (19) and UTC (1).

Issues & Key Drivers

Issues

- The engagement of providers with the care plan is nil (0%). The care plan is available to the providers either through fax/mail/Missouri Care's website. However, there is no feedback/acknowledgement received from the provider.
- Some of the cases were closed (4 of 20) before 60 days post-partum.
- Prenatal and Postpartum Care (PPC) HEDIS Measure
  Timelines of Prenatal Care: Missouri Care achieved a rate of 75.67% in CY 2018 (HEDIS 2019). This is a decline of 5.84% points from the previous year (Table 2).

Table 2: Timeliness of Prenatal Care

HEDIS Year	Timeliness of Prenatal Care %	NCQA Quality Compass 25th Percentile	Annual %point change
2017	77.05	77.66	-0.46
2018	81.51	76.89	4.46
2019	75.67		-5.84

Postpartum Care: Missouri Care achieved a rate of 56.45% in CY 2018 (HEDIS 2019). This is a decline of 0.73% point from the previous year (Table 3).

Table 3: Postpartum Care

HEDIS Year	Postpartum care %	NCQA Quality Compass 25th Percentile	Annual % point change
2017	51.45	59.59	-10.27
2018	57.18	59.61	5.73
2019	56.45		-0.73

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 94%. Missouri Care is able to outreach their OB members to offer CM and complete assessment within 15 business days of notification of pregnancy in 100% cases. Referrals to the CM program are 100% through state notifications. 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 and aftercare is provided in 95% cases. High risk assessment (risk appraisal) is available for 90% cases.
- Missouri Care monitors the effectiveness of the maternity program by monthly CM chart audits, OB outreach rate, HEDIS (Healthcare Effectiveness Data and Information Set) metrics, and Utilization metrics. The following information is reported:
  - OB Outreach in CY 2018 is 94% in Q1 (Jan-Apr); 95% in Q2-Q3 (May-Sept); and 94.5% in Q4 (Oct-Dec).
  - Delivery (Birth) PA
    Missouri Care approved 42.44/1000 PAs for delivery in CY 2018, which has exceeded the benchmark (21.20). This is suggestive of access of care to the members (Table 4).

Table 4: Delivery (Birth) PA

Birth PA	HEDIS 2019	HEDIS 2018	HEDIS 2017
Approved PA/1000	42.44	35.23	47.88
PA benchmark	21.20	37.03	
Approved Days/1000	129.52	135	153.44
Day benchmark	64.80	113.68	

Improvement by Missouri Care

A comparison with previous year (CY 2017) is made to determine the extent to which Missouri Care has effectively addressed the recommendations for quality improvement made by the EQRO (Table 5).

- An improvement (highlighted green) is noticed in: documentation of appropriate diagnosis (10% points); offering CM within 15 business days of notification of pregnancy (40% points); discharge plans and aftercare (25% points).
- There is a decline (highlighted red) of 20% points for post-partum follow-up for 60 days.

Table 5: Comparison of OB CM MRR (%) for CY 2017-2018

Criteria	CY 2017	CY 2018
Diagnosis	90	100
First Enrollment Date	100	100
Last Enrollment Date	100	100
Offer CM within (15) business days of notification of pregnancy	60	100
Referral	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	100
Care Plans	100	100
Risk Appraisal	100	100
Care Plans updated	100	100
Provider Treatment Plans	0	0
Testing	100	100
Progress/Contact Notes	100	100
Discharge Plans	70	95
Aftercare	70	95
Transfers	100	100

Coordination/Linking of Services	100	100
Monitoring of Services and Care	100	100
Follow-Up: case closure	100	80

3.4.3 Recommendations

- 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 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

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

any unique barriers to enrollment for each. Messaging should account for the health care experience of the members and any potential privacy concerns[2].

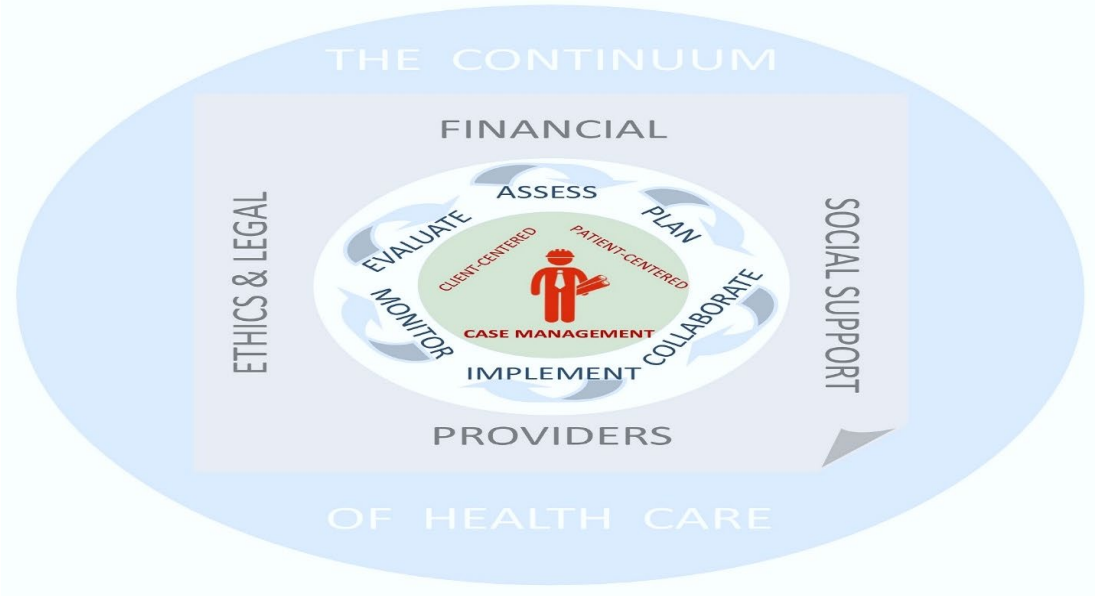

Figure 4: Care Management Continuum of Care

(Source: https://www.compalliance.com/case-management-is-it-a-profession-of-professionals/)

3.5 Children with Elevated Blood Levels (EBLLs) Care Management

Missouri Care's CM for EBLLs include all members with identified blood lead levels of 10 µg/dl or greater. The care team involves a care manager, primary care providers (PCP), Department of Health and Senior Services (DHSS), Home Health Agencies (HHA) and/or the Local Public Health Agencies (LPHA). Outreach is conducted for members with EBLLs in the required time frames noted below:

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 confirmation of capillary tests using venous blood is done 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.

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

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

Upon a successful contact, an assessment is completed by the care manager. Care plan is developed that assists with the required coordination to achieve a goal for a lead level of less than 10 µg/dl. The care manager coordinates home visits, environmental assessments, and ongoing reviews of the member's EBLLs with the PCP.

Care manager continues to work with the member/guardian and all parties involved, providing education, interventions, and making adjustments to the care plan as needed until all lead hazards have been removed and the member's lead level decrease to a level of less than 10 µg/dl. Once this lead level is attained, the member is discharged from EBLLs CM. An exit counseling is performed that includes the member's lab results, the discharge date of care management, the reason for case closure, and a follow-up phone number for the care manager. Care manager also works closely with the PCP ensuring that repeat lead levels are completed within the required timeframes. Information from the home health visit and the environmental assessment is shared with the PCP along with the member's care plan.

Members with EBLLs are offered two home visits – one that occurs at the time of notification of the elevated lead level and a follow-up home visit that is offered within three months following the initial home visit. Missouri Care collaborates with HHAs and LPHAs to assist with these home visits. The initial visit includes an education on lead poisoning, an assessment of the member/family, recommendation of interventions to mitigate the lead poisoning. The follow-up visit includes an assessment and review of the member's progress and parental compliance with recommended interventions and reinforcement of the lead poisoning education. The DHSS Childhood Lead Poisoning Prevention Program Nurse's Lead Care Management Questionnaire is used by the HHAs and LPHAs in the initial home visit. Home visit information is faxed to the care manager which is included in the member's open case file and is used to coordinate the care. Completed forms are

maintained in the document center of EMMA.
If a member terminates with the MCO while enrolled in EBLLs CM program, the transition of care process is completed. A member enrolling in another MCO is notified of the member's lead level and status of care. For members transitioning to MHD, the care manager will notify the LPHA where the member resides. The member/guardian and providers are notified of the termination of coverage and are provided with contact information of the receiving MCO or the LPHA.
All communications and interventions are documented in the member's record in Missouri Care's Enterprise Medical Management Automation (EMMA) CM platform including initial visit, follow-up visits, contact with the child's PCP, and the exit visit. In addition, Missouri Care states that they complete documentation in the state's web-based Missouri Health Strategic Architectures and Information Cooperative (MOHSAIC) Lead Application database (Figure 5). (Note: Verification of documentation in this database by Primaris is outside the scope of this report.)

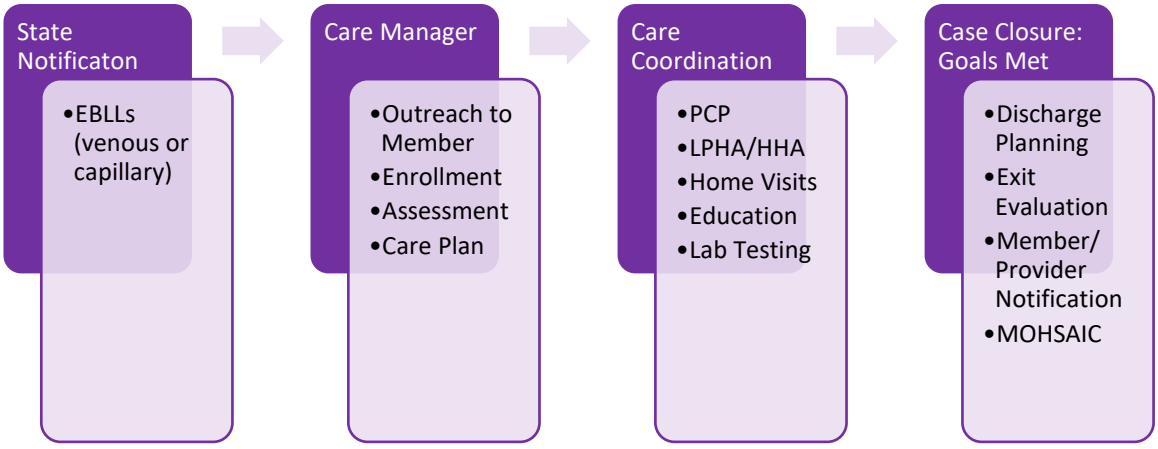

Figure 5: Workflow of Elevated Blood Lead Levels CM Program

3.5.1 Findings of EBLLs Medical Record Review

(Excel Workbook Tab B)
An oversample of 23 medical records is reviewed in order to obtain the required sample size of 20 medical records. Exclusions are 3 (no CM done in CY 2018).
The MRR compliance (%) is reported under the following headings (Figure 6):

a. Diagnosis: 100% compliance.
   There is a documented evidence of diagnosis in all cases.
b. First enrollment date: 100% compliance.
   Cases are enrolled in CM on the day care manager is able to contact a member and is able to complete an assessment.
c. Last enrollment date: 100% compliance.

There are 12 closed cases and 8 are still open for CM in CY 2019.

d. Offer CM within time frames for EBLLs: 55% 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.

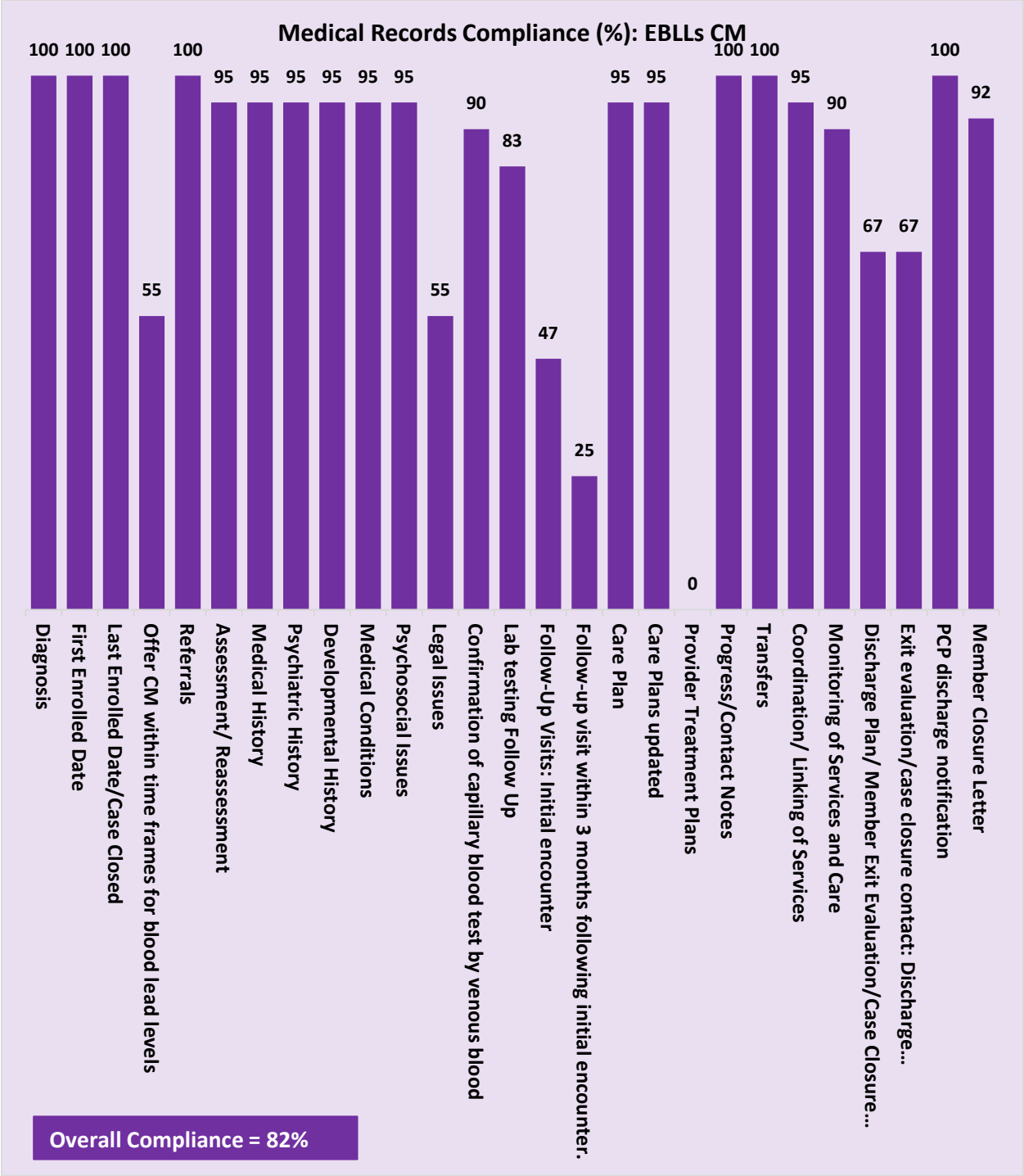

Figure 6: Medical Record Review for Elevated Blood Lead Levels CM Program

e. Referrals: 100% compliance.
   Missouri Care has received referrals from state in all the 20 cases.
f. Assessment: 95% compliance.

The lead assessment is complete in 19 of 20 cases. An assessment includes medical history, psychiatric history, developmental history, psychosocial and legal issues. The compliance of all these elements is 95% except for legal issues (55% compliance). Missouri Care documents 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: 90% compliance.
   In 18 of 20 cases, confirmation of venous blood lead levels are available within the timeframe. Most of these cases (17 of 18) are reported with venous blood lead levels at the time of notification to the MCO by the state.
h. Follow up on EBLLs within the time frame per MHD guidelines: 83% compliance.
   This is evident in 15 of 18 cases. For 2 cases, it is N/A as these are closed due to low venous level (l.0-4.0 µgm/dl) reported at the time of confirmation of capillary lead levels.
i. Home visits: 47% compliance for first visit, 25% compliance for second visit.
   Missouri Care contracts with home health companies for various home services including lead assessment and subsequent visits.
j. Care plan with updates: 95% compliance.
   An updated care plan is seen in 19 of 20 cases.
k. Progress notes: 100% compliance.
   Detailed notes on every contact with the member are present in all 20 medical records.
l. Provider treatment plan: Zero compliance.
   The engagement of providers with the care managers in developing a care plan is nil. Missouri Care sends care plan to the providers and 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). 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.
m. Transfer: 100% compliance.
   This section is addressed in all the medical records. There are no transfers to another state or another MCO. However, 1 member is termed with the MCO.
n. Coordination and linking of services: 95% compliance.
   In 19 of 20 cases, the members are linked to dental services, PCPs, Interdisciplinary care team (ICT), therapy services, HHA, home remediation services, LPHAs.
o. Monitoring of services: 90% compliance.
   Services (well visits, immunizations, home visits, remediation services, appointments) are monitored in 18 of 20 cases.
p. Discharge plan: 67% compliance

All cases are mailed an "education package" on prevention of re-exposure to lead, nutrition, and environmental maintenance. These are discussed over the phone or during face- to-face encounters. Discharge plan is seen in 8 of 12 cases. Some cases (8) are marked as N/A as they are still open for CM in CY 2019.

q. Exit evaluation/case closure contact: 67% compliance.
Exit evaluation is done in 8 of 12 cases. It is marked as N/A for 8 cases as they are still open for CM.

r. Notification to providers/members: 100% compliance for provider notification/92% compliance for member notification.
In 12 of 12 cases, the providers have been sent a written notification about child's condition and case closure. Most members (11 of 12) are notified in writing about case closure (N/A for 8 open cases).

3.5.2 Conclusions

Oversample of medical records: 23

Exclusions: 3

MRR sample: 20 cases. Out of 20 cases, 8 remain open for EBLLs CM in CY 2019 and12 are closed due to the following reasons (Table 6):

Table 6: Case Closure	12
Goals met/low blood lead levels	9
Lost eligibility	2
Unable to contact (UTC)	1

Issues and Key Drivers

Issues

- The CM is offered within the time frames based on the EBLLs in 55% cases (11 of 20 cases). In 40% cases (8 of 20 cases) CM is offered but outside of the mandated time frame. Unsuccessful contact with a member is the main cause of delay. Remaining 5% noncompliance (1 of 20 cases) is because of UTC.
- The timely follow up of repeat blood lead levels is done in 83% of cases (15 of 18), initial home visit is done in 47% cases (9 of 19), and a second visit is done in 25% cases (4 of 16). 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 zero. The care plan is sent to the providers, but no response/advice is received.

- Discharge plan and exit evaluation is done in 67% (8 of 12) of cases. For the remaining cases, the care managers are not able to contact the members.
- Out of the 2 members who lost eligibility with the MCO, 1 member is not notified about case closure.

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%. Missouri Care has scored: 100% in documentation of diagnosis, enrollment and case closure dates, referrals, transfers, and PCP discharge notifications; 95% cases have an assessment, an updated care plan, progress notes, coordination and linking of services; 90-92% cases have a confirmation of capillary BLL level with venous BLL within the time frame, monitoring of services, member notification of case closure; and 83% cases have a follow up lab tests on blood lead levels.
- 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.
- Missouri Care states that they measure the effectiveness of the EBLLs CM by chart audits for compliance as well as HEDIS metrics. Lead screening, as a HEDIS care gap, is discussed with primary care providers during Quality Practice Advisor (program) care gap meetings as well as during CM/PCP communications.
  Table 7 indicates an improvement of 2.75% points in lead screening in children in HY 2019/CY 2018 (59.20%) as compared HY 2018/CY 2017 (56.45%).

Table 7: Lead Screening Rates from H 2017-H 2019

HEDIS Year (HY)	Missouri Care Lead Screening In Children (LSC) Rate	NCQA Quality Compass 25th Percentile	NCQA Quality Compass 50th Percentile	Year over Year Percentage Point Change
2017	56.94%	59.65%	71.38%	
2018	56.45%	62.53%	73.13%	-0.49%
2019	59.20%			2.75%

Improvement by Missouri Care

A comparison with previous year (CY 2017) is made to determine the extent to which Missouri Care has effectively addressed the recommendations for quality improvement made by the EQRO (Table 8).

An improvement (highlighted green) is noticed in: offer CM within 15 business days of notification of pregnancy (5% points); assessment including medical history, medical conditions, psychosocial issues (40% points); psychiatric history, developmental history (35% points); confirmation of capillary blood test by venous blood test within the time frames (5% points); follow up home visits-first visit (25% points), second home visit (8% points); updated care plan (55% points); and discharge plan, exit evaluation and discharge documentation (12% points).

There is a decline (highlighted red) noticed in: Lab testing follow up (2% points); provider treatment plans (40% points); coordination and linking of services (5% points); monitoring of services (90% points); member closure letter (8% points).

Table 8: 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 blood lead levels	50	55
Referrals	100	100
Assessment/Reassessment	55	95
Medical History	55	95
Psychiatric History	60	95
Developmental History	60	95
Medical Conditions	55	95

Psychosocial Issues	55	95
Legal Issues	55	55
Confirmation of Capillary Blood Test by Venous Blood within Timeframe	85	90
Lab Testing Follow Up	85	83
Follow-Up Visits: Initial Encounter	22	47
Follow-up Visit Within 3 Months Following Initial Encounter.	17	25
Care Plan	40	95
Care Plans Updated	40	95
Provider Treatment Plans	40	0
Progress/Contact Notes	100	100
Transfers	100	100
Coordination/Linking of Services	100	95
Monitoring of Services and Care	100	90
Discharge Plan/Member Exit Evaluation/Case Closure Criteria	55	67
Exit Evaluation/Case Closure Contact: Discharge Documentation	55	67
PCP Discharge Notification	100	100
Member Closure Letter	100	92

3.5.3 Recommendations For Missouri Care

Table 9: 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

- 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 9).
- Member engagement: Member/guardian should receive an explanation about the significance of home visits by the care managers and how this would help in tailoring their 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

The mission of the Missouri Care's CM Model is to support members in receiving the "Right Care at the Right Time in the Right Setting." The goal of CM is to decrease fragmentation of healthcare service delivery, facilitate appropriate utilization of available resources, and optimize member outcomes through education, care coordination and advocacy services for the medical and/or behavioral health compromised populations served. CM strives to meet the needs of the medically compromised population with a model that focuses on a full range of physical health, behavioral health, social and community based support of a member in a coordinated and member-centered manner.

The CM team consists of registered nurses, licensed clinical social workers, social workers, and care coordinators. The care managers use a high touch community based approach (a combination of face to face and telephonic outreach) during a relationship with the member.

Behavioral health CM is integrated in the overall care model of Missouri Care. The goals and objectives of the behavioral health activities are congruent with the Clinical Services Organization Health model. The behavioral health population requires additional focused attention to the assessment, care planning, and discharge planning which leads to the development of special arrangements and procedures with the provider networks to arrange for and provide certain services. Some members require coordination of services after discharge from acute care facilities to transition back into the community. This includes coordination to implement or access services with Network behavioral health providers or Community Mental Health Clinics (CMHCs) also called Community Service Boards (CSB). Members with a severe and persistent mental illness receive intense or targeted CM services by community mental health providers or integrated care from a Behavioral Health Home (BHH).

Missouri Care's BH CM program employs comprehensive and integrated services to members, including: outreach to all members admitted for acute behavioral health

treatment, provider and community referrals; consultation about additional resources, including education and vocational support; Department of Mental Health and Community Support waiver guidance; and care gap monitoring. Field care management is available to members living near Kansas City, Springfield, Columbia, and St. Louis. Additionally, many of the care managers visit members while they are in the hospital.

Missouri Care assesses members for CM within five (5) business days of admission to a psychiatric hospital or residential substance use treatment program, as well as members referred to the program, identified through data sources, or identified via The Law (Missouri Care's proprietary algorithm which is the utilization management (UM) referral process). Mental health status, including cognitive functions and psychosocial factors such as the ability to communicate, understand instructions and process information about a member's illness and substance abuse history are essential components of the initial assessment. The PHQ-9 and CAGE or CRAFFT assessments are conducted to provide additional data within the assessment process (Figure 7).

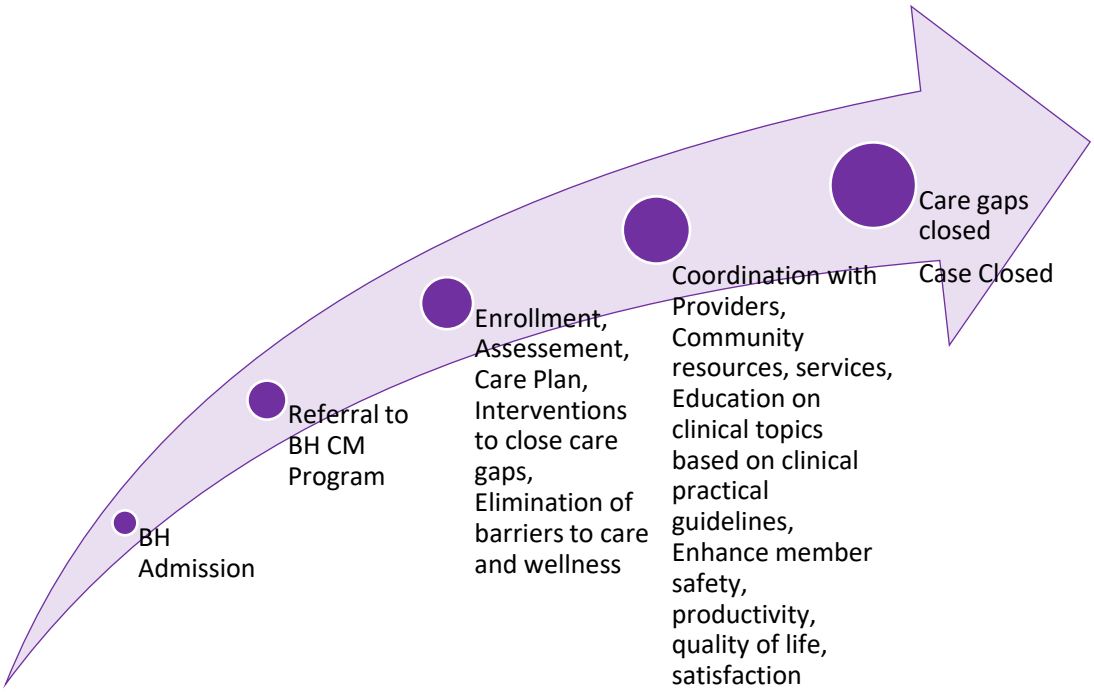

Figure 7: Workflow of Behavior Health CM Program

Interventions: Pilot projects in CY 2018

- Emergency Room (ER) Diversion/Youth Emergency Room Enhancement: BH Inpatient (IP) Facility and Community Mental Health Center (CMHC) partner with Missouri Care for a triage system and resource to discuss alternative treatment options to a BH IP admission. Diversion alternatives include BH Outpatient

providers, CMHC/Certified Community Behavioral Health Clinics (CCBHC), or Telehealth.

- Follow-up to Hospitalization Pilot: Missouiri Care BH CM conducts in-person assessment with member within seven days of discharge from BH IP treatment.
- High Volume Field CM Pilot: One field BH CM partners with a high volume behavioral health inpatient facility to improve CM enrollment and engagement with aftercare compliance.
- Intensive Family Intervention Services – Crisis Stabilization Pilot: 90-day intensive in-home program provided to at-risk members by licensed clinicians at St. Louis Center for Family Development (now Sparlin Mental Health).

3.6.1 Findings for BH Medical Record Review

A sample size of 20 medical records is reviewed to assess the CM of members with BH diagnosis leading to hospitalization (including residential treatment program for substance use disorder).

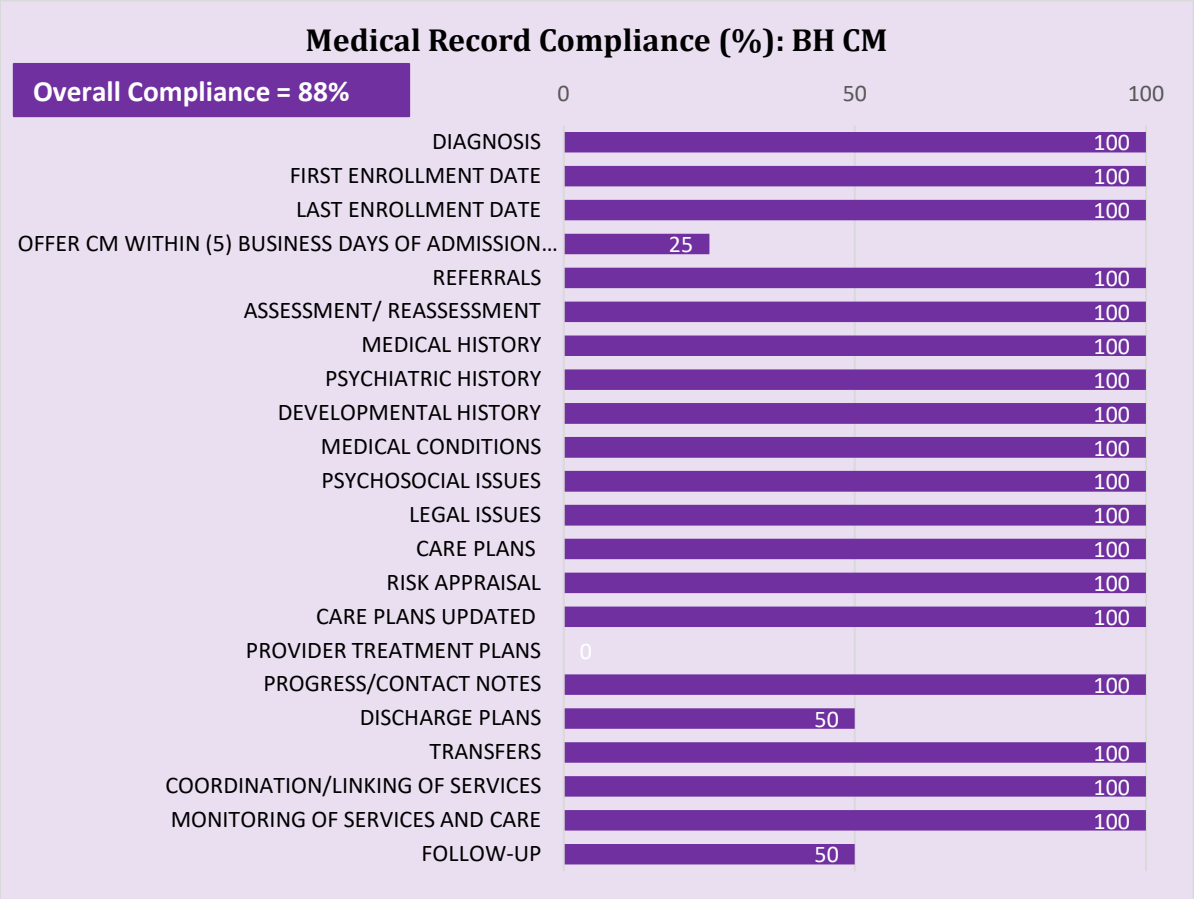

Figure 9: Medical Record Review for Behavioral Health CM Program

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

a. Diagnosis: 100% compliance.

There is a documentation of diagnosis in all the 20 cases. Major depressive disorder is the admitting diagnosis in 6 of 20 cases. The other reasons for hospital admissions are disruptive mood disregulation disorder, bipolar disorder, post-traumatic stress disorder, attention deficit hyperactivity disorder, and stimulant use disorder. These conditions co-occur with each other.

b. First enrollment date: 100% compliance.

The cases are enrolled on the first day of successful outreach with the patient. The care managers are able to contact the patients at various times: during the hospital stay; immediately after discharge; or much later after the discharge.

c. Last enrollment date: 100% compliance.

All the 20 cases are closed.

d. Assessment of the members for CM within 5 business days of admission to a psychiatric hospital or residential treatment program: 25% compliance (Figure 8).

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 for a conversation with care manager for an assessment.
- The care manager is not able to successfully contact the patient in spite of several attempts. Efforts to outreach begin within 24 hours of discharge of a patient from the hospital.

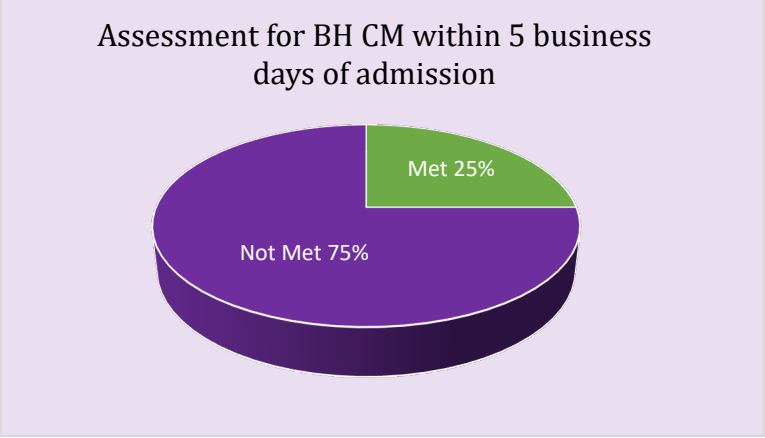

Figure 8: Assessment for CM within 5 business days of admission to a psychiatric hospital or residential substance use treatment program

e. Referrals: 100% compliance.

Most of the cases (16 of 20) are referred during concurrent review, some cases are self-referred (3 of 20) and one is detected from Law (algorithm).

f. Assessment: 100% compliance.
   All the cases have an assessment which includes medical history, psychiatric history, developmental history, psychosocial and legal issues.
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 20 cases.
i. Provider treatment plan: Zero compliance.
   Care plan is sent to PCP in 25% cases (5 of 20). It is not sent to PCP in 75% cases (15 of 20) because either there is no medical diagnosis or there is no written consent of member to share the BH details. There is no response 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
   Missouri Care 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/monitoring of services: 100% compliance.
   Care managers coordinate with PCPs, BH providers, therapists, social workers, transportation, interdisciplinary care team to ensure full support and a complete recovery of their patients.
m. Discharge plan and Follow up: 50% compliance.
   This is done in 10 of 20 cases. The remaining 10 cases do not have a discharge plan and follow-up because of UTC (7), refusal to CM (1), and loss of eligibility (2).

3.6.2 Conclusions

Oversample of medical records: Nil

Exclusions: Nil

MRR sample: 20 cases. All cases are closed under BH CM program due to the following reasons (Table 10):

Table 10: Case Closure	20
Goals met	9
Lost eligibility	2
Unable to contact (UTC)	7
Declined CM	2

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 25%. 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. The care plan is not sent to the PCPs if there are BH issues, as a written consent is not obtained from the member. 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 15% (2 of 20 cases) and 35% cases are closed because of UTC (7 of 20). Members do not respond to the calls by the care managers.
- Follow-Up After Hospitalization for Mental Illness (HEDIS Measure): 7-Day Follow-Up rate in CY 2018 is 29.28% versus 31.45% in CY 2017 (a decrease of 2.17% points). Similarly, 30-Day Follow-Up in CY 2018 is 54.14% versus 56.81% in CY 2017 (a decrease of 2.67% points).
- Antidepressant Medication Management (HEDIS Measure): Though there is an increase of 3.02% points in effective acute phase treatment in CY 2018 (48.03%) as opposed to CY 2017(45.01%), there is a decrease of 2.01% points in effective continuation phase treatment in CY 2018 (30.11%) as opposed to CY 2017 (32.12%).

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 88%. Missouri Care has scored 100% in documenting their medical records with diagnosis, enrollment and case closure dates, referrals, assessments, updated care plans, progress notes, coordination, linking, and monitoring of community care services.
- Missouri Care has the following BH Inpatient CM outcomes (Table 11)

Table 11: BH Inpatient Outcomes

	Count	Billed ($)	Paid ($)
Pre Program	646	8,852,380	2,348,576
Post Program	128	1,859,709	487,025
Improvement	80.2%	79.0%	79.3%

Improvement by Missouri Care

A comparison with previous year (CY 2017) is made to determine the extent to which Missouri Care has effectively addressed the recommendations for quality improvement made by the EQRO (Table 12). (Note: For 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 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 (75% points); provider treatment plans (95% points); discharge plans (35%); and follow up (39%).

Table 12: Comparison of BH CM MRR (%) for CY 2017-2018

Criteria	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	25
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	100
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	85	50
Transfers	84	100
Coordination/Linking of Services	100	100
Monitoring of Services and Care	100	100
Follow-Up	89	50

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. Missouri Care 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.

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[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/

- 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 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. Missouri Care 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 Missouri Care 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 Missouri Care within 30 days to express concerns or offer changes. By including this statement on every treatment plan, Missouri Care 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/