Primaris
Healthcare Business Solutions

2019 External Quality Review
Care Management

UnitedHealthcare®

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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.

UnitedHealthcare 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.

UnitedHealthcare'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.

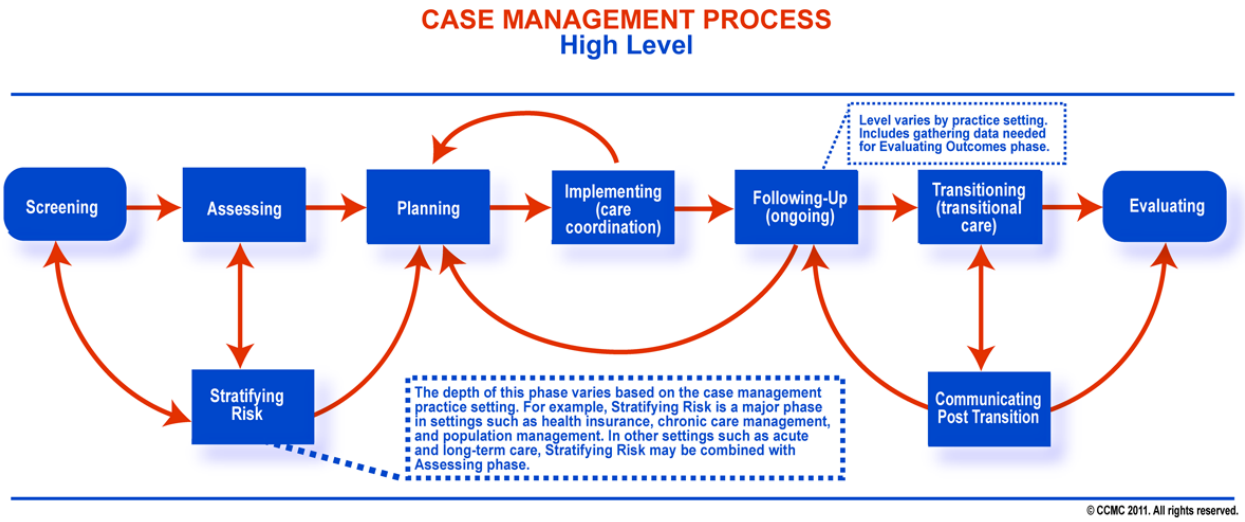

Figure 1: Care Management Process
(https://www.cmbodyofknowledge.com/content/introduction-case-management-body-knowledge)

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 UnitedHealthcare.
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 UnitedHealthcare:

- 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 UnitedHealthcare'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 UnitedHealthcare 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

UnitedHealthcare 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 UnitedHealthcare's office in St. Louis, MO, on June 26-27, 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).

- Heidi Strickler, Manager, Medical Clinical Operations
- Melanie Rains Davie, Associate Director, Case Management
- Michael Leftwich, Manager, Medical Clinical Operations
- Sarah K Stinnett, RN, Senior Case Manager
- Gerald Snell, Associate Director Medical Clinical Operations
- Aline Hanrahan, Associate Director, Behavioral Affordability
- Jennifer B Stevens, Manager, Care Advocate
- Katherine Whitaker, Associate Director, Compliance
- Dr. Ravi Johar, MD, Chief Medical Officer
- Jamie Bruce, Chief Executive Officer

Medical Record Review (MRR)

Primaris assessed UnitedHealthcare'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 UnitedHealthcare. 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). UnitedHealthcare 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 26-27, 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: UnitedHealthcare 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: 160,854.
Members identified for CM programs: 51,057
Members enrolled in all CM programs: 21,165
CM staff available: 50 care managers
Average case load: 285
Maximum number of members that can receive CM: 14,250

Figure 2 demonstrates the volume of identified members (293) for OB CM, the number managed (109 members with an assessment and a care plan) and the volume that declined/lost contact (184)

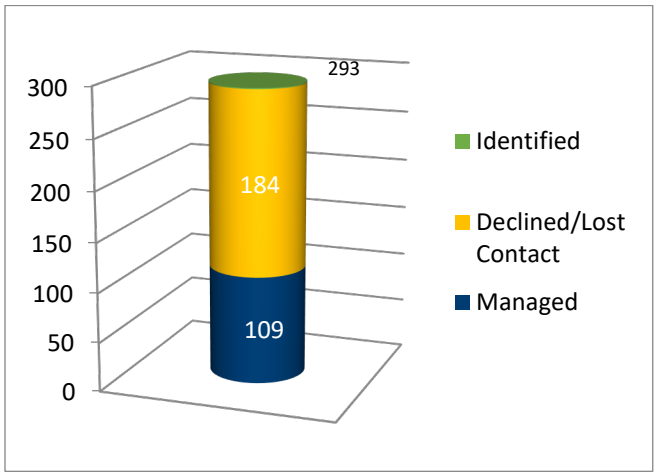

Figure 2: CY 2018 OB CM Members

Figure 3 demonstrates the volume of identified members for Lead (74), the number managed (57) and the volume that declined/lost contact (17).

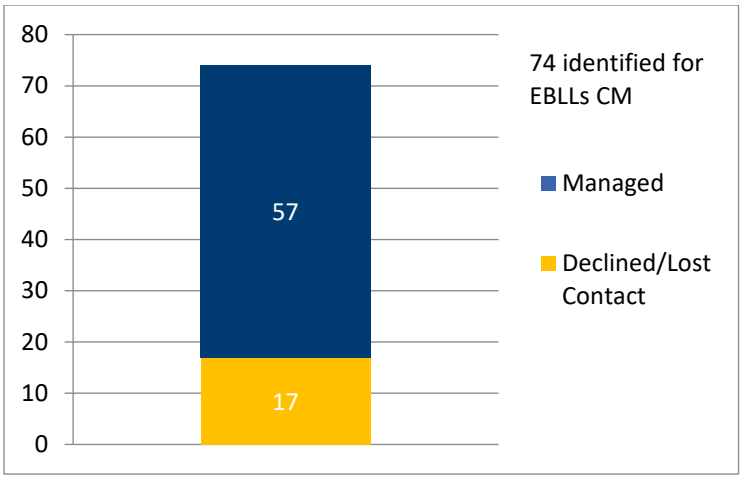

Figure 3: CY 2018 EBLLs CM Members

Figure 4 demonstrates the total number of eligible members (1,304) for BH CM in CY 2018. Only 377 could be successfully enrolled.

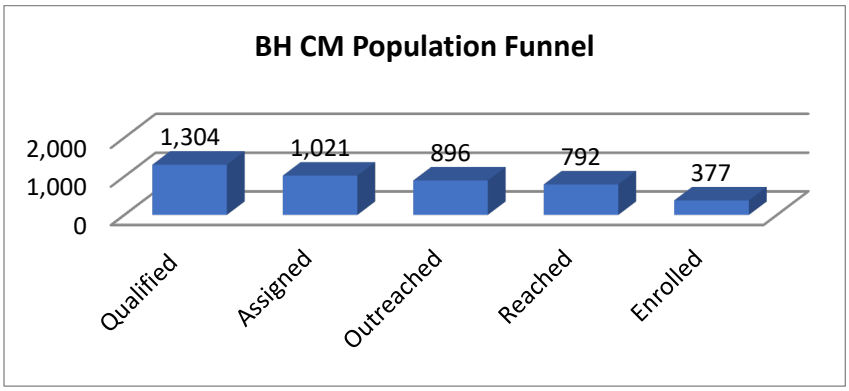

Figure 4: BH CM Members

3.2 Review of Policies and Procedures

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

Table 1: UnitedHealthcare-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.	●		NCM 001 Identification of High Risk Members for CM, NCM 012 Risk Stratification Process,

			NCM 020 Delegated CM/Care Coordination, Whole Person Centered Care Model (WPC) 2019.
2. Provider and member profiling activities.	●		NCM 012 Risk Stratification Process.
3. Procedures for conducting provider education on CM.	●		WPC 2019, NCM 007 Informing and Educating Providers, MO CM 01 Missouri Case Rounds.
4. A description of how claims analysis will be used.	●		WPC 2019, NCM 012 Risk Stratification Process, MO MCH-01 Missouri Maternity Program, NCM 001 Identification of High Risk Members for CM.
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.	●		WPC 2019, NCM 020 Delegated CM/Care Coordination.
6. A process to ensure integration and communication between physical and behavioral health.	●		WPC 2019, NCM 020 Delegated CM/Care Coordination.
7. A description of the protocols for communication and responsibility sharing in cases where more than one care manager is assigned.	●		WPC 2019, NCM 020 Delegated CM/Care Coordination.
8. A process to ensure that care plans are maintained and updated as necessary.	●		WPC 2019, NCM 001 Identification of High Risk Members for CM, NCM 002 High Risk CM Process, NCM 020 Delegated CM/Care Coordination.

9. A description of the methodology for assigning and monitoring Care Management caseloads that ensures adequate staffing to meet CM requirements.	●		WPC 2019.
10. Timeframes for reevaluation and criteria for CM closure.	●		WPC 2019, NCM 001 Identification of High Risk Members for CM, NCM 002 High risk CM Process, NCM 020 Delegated CM/Care Coordination, MO 01 Elevated Lead Level Program.
11. Adherence to any applicable State quality assurance, certification review standards, and practice guidelines as described in the contract.	●		WPC 2019, NCM 020 Delegated CM/Care Coordination.

3.3 Evaluation of Care Plan

Upon interviewing UnitedHealthcare officials and reviewing the medical records for all three CM programs, Primaris concludes that UnitedHealthcare 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

Healthy First Steps® (HFS) is a special voluntary program for UnitedHealthcare pregnant members and their babies. It is designed specifically to address the needs of this vulnerable population through an integrated, holistic approach across the continuum of care. HFS program aims to identify pregnant members early on by leveraging sophisticated

identification and stratification algorithms; and engaging them as early as possible to ensure that members receive the care and services necessary to promote a healthy pregnancy and achieve better health outcomes for infants and children. The HFS program focuses on the importance of prenatal and postpartum care in addition to the social determinants of health. UnitedHealthcare's locally-based nurse coordinators not only serve as the single point of contact for their highest risk, complex needs members, but they are also integral in providing education, coordination, and consultation with obstetric and pediatric practitioners to optimize the health of their members.

Population Identification

The Business Intelligence team compiles a weekly data file of members who may be pregnant as identified by indicators from multiple data sources. This data file includes member demographics and an indicator to allow for member risk stratification. There is an additional indicator to suggest whether a member is currently affiliated with an obstetric practitioner or a contracted accountable care organization. This comprehensive data file is loaded into United Healthcare's care management software where additional algorithms result in risk stratification. Sources of data for the identification of members who are pregnant may include, but are not limited to:

- Member eligibility files (State 834 file indicators)
- Presumptive eligibility information (where applicable)
- Notification by state partners, such as Medicaid case workers
- Claims data, including:
  - Obstetric laboratory claims
  - Pharmacy data
  - Inpatient admission data
  - Emergency department data
  - Outpatient medical and behavioral health data
  - Claims data using specifications from the Healthcare Effectiveness Data and Information Set® (HEDIS) , including current procedural technology and diagnosis codes (excluding intrauterine death and abortions)
- Blended Census Reporting Tool (BCRT), which includes current authorizations, referrals, and case management flags
- Admission, Discharges and Transfers (ADT) files, which include real time inpatient admissions and emergency room data
- Provider Referrals, Notifications of Pregnancy, and Obstetrical Risk Assessment Forms (OBRAF)
- Member self-identification or caregiver referrals

- Internal staff referrals, including from:
  - Case managers
  - Nurse Line staff
  - Hospitality, Assessment & Reminder Center (HARC) staff conducting welcome calls and/or health risk assessment calls
  - Advocate4Me member services staff who receive inbound customer service calls and coordinate services to close gaps in care
  - Staff from other health management, wellness, or coaching programs
- Health Risk Assessment data
- Data from Electronic Medical Record feeds when available

Members are encouraged to self-refer into the program. Members are made aware of the availability of the HFS program through several avenues, including the member handbook, member websites, general health education campaigns, and the welcome kit distributed to all members upon enrollment. All members are eligible for HFS and are offered program enrollment unless the member specifically requests to be excluded.

Data Integration

Through United Healthcare's information technology platforms and clinical management systems, member data including demographic, eligibility, program enrollment, claims, and utilization information are combined and presented in a way that enables staff to facilitate coordination of care for members directly as well as through their health care provider.

Risk Stratification

UnitedHealthcare utilizes an automated risk stratification process. In the clinical management system, the members are stratified into high risk and low risk. In the event that UHC does not have adequate data to stratify the member, the member is routed to a queue within the clinical management system which results in a series of outreach calls by a dedicated maternity member services outbound call team. This team attempts to reach the member telephonically and upon success, administers a pregnancy risk assessment. The call team assists and enrolls the member in various health incentive programs such as Baby Blocks and identifies any barriers the member may have such as transportation, childcare, financial assistance, and housing. The call team uses United Healthcare's digital community resource database, Healthify, to find the needed resources and link or refer the member to these services. The team follows up with the member to confirm the first prenatal visit occurred if not already completed at time of initial contact and will offer additional assistance should the member need it.

In circumstances when the member cannot be located telephonically, the member's case is routed to the field-based community health worker (CHW) team for additional outreach. The field-based CHW attempts contact with a member through an unannounced home visit as well as through various practitioner, provider, pharmacy, and community-based program outreaches to obtain additional member contact information. Once the member is reached, the CHW provides the same information and support as provided by the Member services call team. Figure 5 demonstrates the work flow of OB CM program.

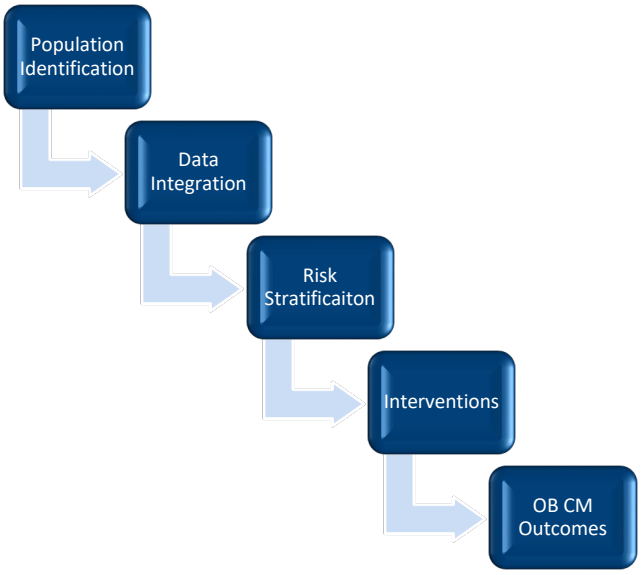

Figure 5: Work Flow of Obstetrics CM Program

Member Interventions

The following interventions were implemented in CY 2018 to improve OB member outcomes:

- Health Education is provided to all pregnant women through welcome package that includes information on:
  - HFS program
  - Baby Blocks**:** Baby Blocks is an online member incentive program that offers incentives for obtaining recommended prenatal and postpartum care.
  - KidsHealth**:** KidsHealth is a content-rich website with a wealth of health promotion information on pregnancy, healthy behaviors, delivery, and early childhood care. Content is available to read or to hear via audio play back.
  - Prenatal care, periodicity schedule, lab or other tests needed.
  - Routinely accessing prenatal care, adhering to the care plan established by her treating practitioner.

  - Common medical and behavioral and comorbidities that may affect her pregnancy.
  - Good nutrition, appropriate exercise, stopping the use of alcohol, tobacco and other substances.
  - Signs of possible depression during pregnancy and after delivery, and how the mother can receive additional assistance and help.
  - Pregnancy and infant topics including the importance of carrying a pregnancy to term when no medical complications exist, breastfeeding benefits, the importance of contraception and child spacing as well as infant care and safety such as car seat safety and SIDS prevention.
  - Information about care plan, self-management tools, disease management programs, and community resources.
  - Additional resources external to the organization, including community-based organizations providing services to pregnant women and their children and support services for addiction recovery and domestic violence.
- Expansion of Scope of Care and Community Partnerships.
  - UnitedHealthcare awarded Jordan Valley Health Center in Springfield, MO, a $1M grant to expand their community health worker program. This program allows Jordan Valley to expand their reach to members. The CHW connect members with resources such as food, housing and transportation, and provide one-on-one health screenings and preventive-care services. They also help individuals and families apply for and use health benefits, schedule doctor appointments, manage medications, and provide personal support to set and reach goals that can improve their long-term health.
  - Developed relationship with Helping Hand Me Downs in the St. Louis area to connect mothers with necessary resources.
  - Connected with Operation Food Search to discuss the “Fresh RX” program being implemented at SSM (St. Louis health system) for pregnant mothers.
- Initiation of a Partnership with Optum in the development of a home based 17 alpha-hydroxyprogesterone caproate (17P) and antiemetic program for the qualifying members to provide physician directed treatment and support.
- Development of a Substance Use Disorder Program
  - Use of specified assessment to identify and stratify needs based on member input.
  - Connection to state based CSTAR program.
  - Introduction to SSM Wish Clinic.

- Optimized Touch-Points for a Better Member Experience: Assisting members through a streamlined experience—triaging, educating, and linking—via a single touch point, leveraging existing information and utilizing digital media and interactive tools to quickly assess and link members to care and resources.
  - Increased High Risk Maternity Team by 50%.
  - Provider portal available to access member care plans.

3.4.1 Findings of OB Medical Record Review

An oversample of 30 medical records is reviewed. Only 17 are included for evaluation of OB CM and 13 medical records are excluded (3 cases-enrolled in last quarter for CM; 4 cases-unable to contact (UTC); 3 cases-incorrect diagnosis; 2 cases-declined CM; and 1 case-ineligibility).

The MRR compliance (%) is reported under the following headings (Figure 6):

a. Diagnosis: 100% compliance.
   Medical records have a diagnosis of pregnancy (high risk/low risk) in all the 17 medical records.
b. First enrollment: 100% compliance.
   All cases are enrolled within 24 hours of notification of a member's pregnancy and outreach to a member is initiated.
c. Last enrollment: 100% compliance.
   A case is closed at 60 days post-partum. When a case manager is unable to reach a member, the case is closed after third outreach attempt.
d. Offer CM within 15 business days of notification of pregnancy: 100% compliance.
   UnitedHealthcare has contacted their OB members within the time frame to assess their needs.
e. Referrals: 100% compliance.
   The referrals are received through claims, eligibility, or enrollment data.
f. Assessment: 100% compliance.
   All cases have an assessment. However, there are three different types of assessment questionnaires followed by the care managers. All the required components per MHD contract are not included in these different questionnaires. Thus, medical history is assessed in 100% cases; psychiatric history, developmental history, and psychosocial issues are assessed in 88% cases; and legal issues are addressed in 24% cases.
g. Updated care plans: 76% compliance.
   Updated care plans are present in 13 of 17 cases. Out of 4 cases that did not have a care plan-2 declined CM, 1 case is UTC and 1 case-notes suggest that the goals are met, but care plan is missing from the medical record.

h. Risk appraisal: 94% compliance.
   This is present in 16 of 17 cases. One case is closed as UTC.
i. Provider treatment plans: Zero compliance.
   Providers have access to the care plan via UnitedHealthcare's website. However, they are not involved with 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.

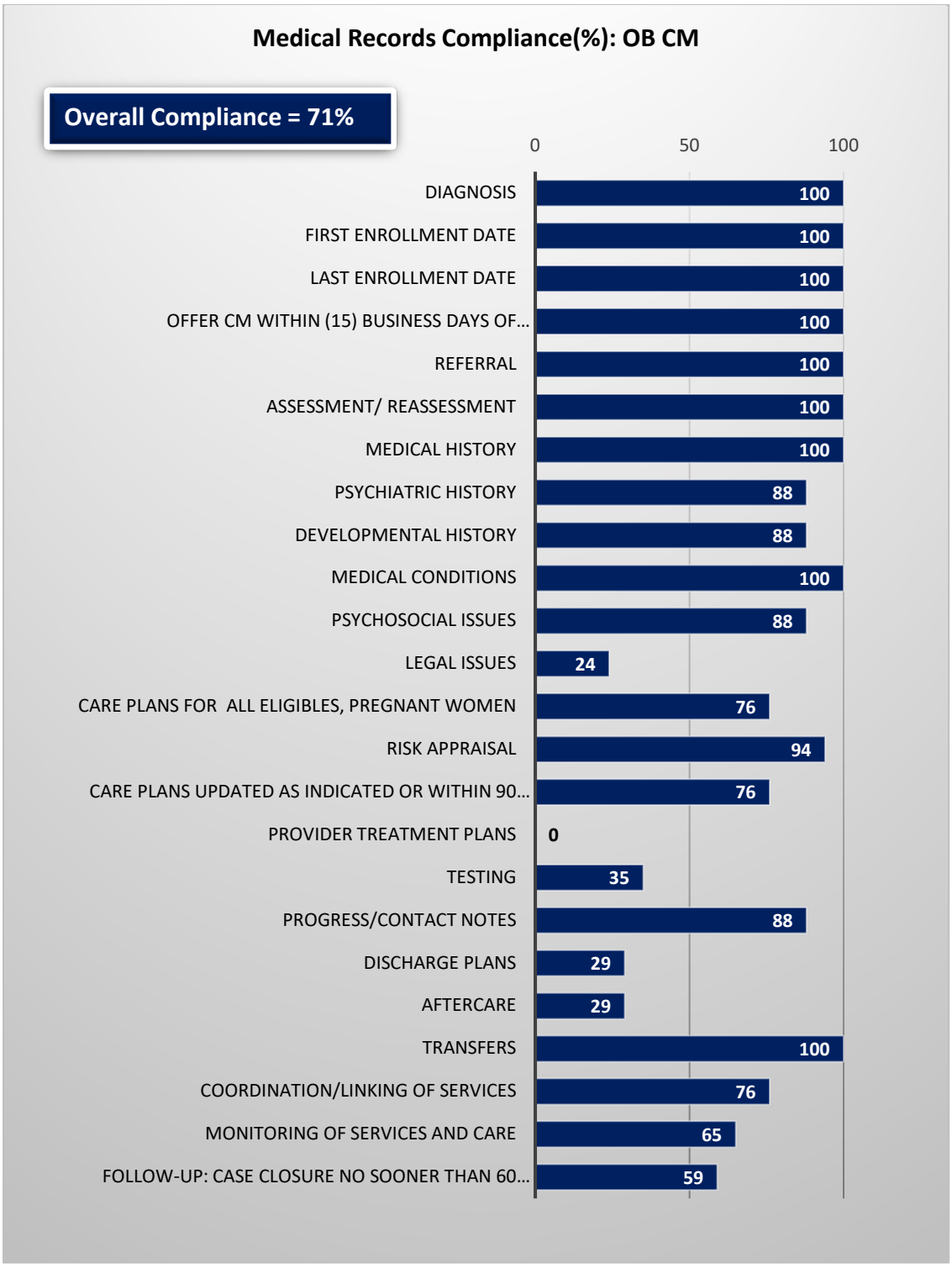

Figure 6: Medical Record Review for OB CM Program

j. Lab tests: 35% compliance.

These are documented in 6 of 17 cases.

k. Progress notes: 88% compliance.
These are found in 15 of 17 cases. One case declined CM, and one case-UTC.

l. Discharge plan, Aftercare: 29% compliance.
Discharge plan and aftercare notes are present in 5 of 17 cases. For the remaining 12 cases: 3 cases declined CM; 7 cases are UTC; and in 2 cases there is no documentation about an outreach effort by the care managers.

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

n. Coordination and linking of services: 76% compliance.
Medical records show that 13 of 17 cases are linked to community resources. In the remaining 4 cases: 3 cases declined CM, and one is UTC.

o. Monitoring of services: 65% compliance.
Services are monitored in 11 of 17 cases. The reason for noncompliance in 6 cases is due to decline for CM (3 cases), UTC (2 cases), no efforts made by care manager per medical records (1 case).

p. Follow up (case closure no sooner than 60 days post-partum): 59% compliance.
A post-partum follow up care is seen in 10 of 17 cases. 7 cases do not have a follow up as 3 declined CM and 4 are reported as UTC.

3.4.2 Conclusions

Oversample of medical records: 30

Exclusions: 13

MRR sample: 17 cases. These cases are closed for the following reasons (Table 2):

Table 2: Case Closure	17
Goals met	6
Incomplete CM	1
Unable to contact (UTC)	7
Declined CM	3

Issues & Key Drivers

Issues

- Only 35% pregnant members (6 of 17) are managed successfully with all the "goals met." The MCO is not able to contact 41% (7 of 17) members, and 18% (3 of 17) decline CM at the time of being active in OB CM program. It appears that there is a lack of member engagement in the CM. This explains the low compliance for

discharge planning (29%), after-care (29%), and post-partum case closure (59%). In 6% of cases (1 of 17), the there is a lack of documentation about the outreach attempts for post-partum care.

- The care workers use 3 different assessment questionnaires for members. All the required information, namely, medical history, psychiatric history, developmental history, psychosocial issues, and legal issues for each pregnant member are not captured in every assessment. The compliance rate ranges from 24%-100% for various requirements listed above.
- An updated care plan is available in 76% cases. The common reasons for non-compliance are: member declines CM, or UTC. Incomplete documentation also appears to be an issue (1 case).
- The engagement of providers with the care plan is nil (0%). The care plan is posted on the website and the providers have access to it. No feedback/acknowledgement is received from the provider.
- Lab tests are documented in 35% cases. All the pregnant women require blood/urine tests/Ultrasonography at regular intervals. These are not documented in the medical records or linked to claims system which could serve as an evidence.

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 71%. UnitedHealthcare 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% either through enrollment, claims, or eligibility system. High risk assessment (risk appraisal) is available in 94% cases. Coordination and linking to services are evident in 76% cases.

- UnitedHealthcare has implemented multifaceted identification and stratification methodologies that address the comprehensive and holistic needs of pregnant members to include medical, social, and behavioral risk factors and conditions.
- UnitedHealthcare stated they provide support through clinical and nonclinical staff as well as network providers and practitioners for women at risk for complications during or throughout their pregnancies and deliveries, including but not limited to: behavioral health support; outreach and coordination for babies in the neonatal intensive care unit; 17P treatment programs, and coordination with community resources and programs.

Improvement by UnitedHealthcare

UnitedHealthcare's contract with MHD went in effect on May 01, 2017. Since data for the entire CY 2017 was not available, UnitedHealthcare was not included in EQR 2018. Thus, there are no recommendations from last year's EQR which could serve as basis for assessing improvement in EQR 2019.

3.4.3 Recommendations

- UnitedHealthcare should include all the information pertaining to medical, psychiatric, developmental, psychosocial, and legal history in a single questionnaire which should be used for assessing a member's needs.
- Documentation about outreach and its outcomes should be completed in progress notes and care plan should be updated.
- 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: UnitedHealthcare posts the member's care plan on their website which can be accessed by a provider as required.
  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 any unique barriers to enrollment for each. Messaging should account for the health care experience of the members and any potential privacy concerns[2].

[1]https://whb.ncpublichealth.com/provpart/docs/pregCareManual/PregnancyCareManagementStandardizedPlan-Revised2012-11-13.pdf
[2] https://www.advisory.com/research/care-transformation-center/care-transformation-center-blog/2015/02/enroll-patients-in-care-management

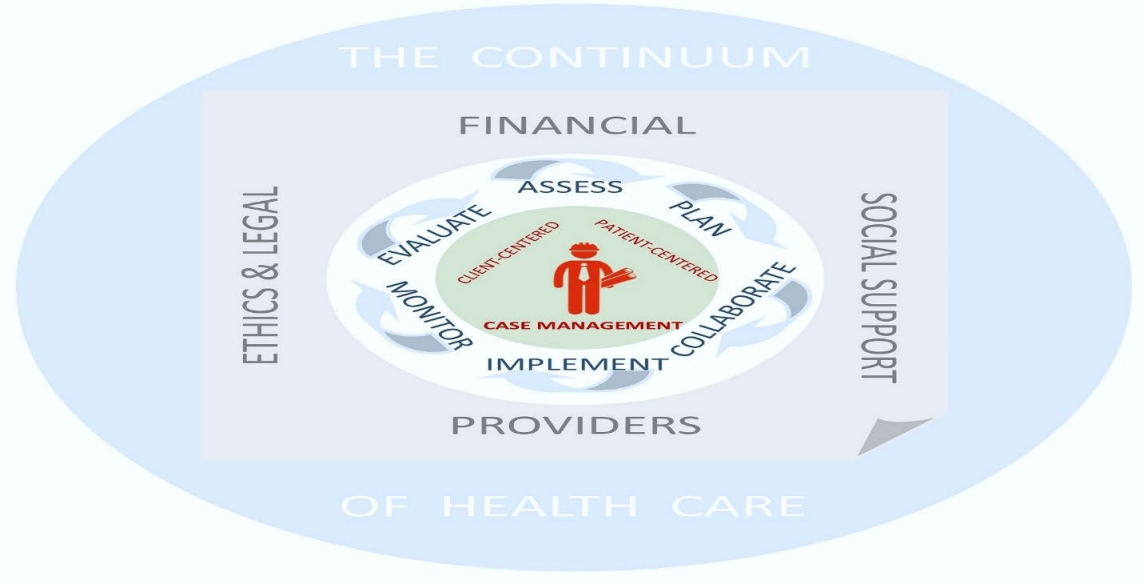

Figure 7: Care Management Continuum of Care

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

3.5 Children with Elevated Blood Levels (EBLLs) Care Management

Lead Case Management Program Overview

CM services are offered to all eligible members with a blood lead level (BLL) of 10 ug/dL or greater in accordance with MHD guidelines. BLL testing is mandatory at 12 and 24 months of age for all MO HealthNet children or annually for all children 6 months to 72 months of age, if the children are residing in an area designated as "high risk" for lead poisoning in Missouri, as defined by Department of Health and Senior Services (DHSS).

The purpose of the program is to:

- Ensure compliance with MHD testing guidelines.
- Work with local health departments to verify that children with elevated blood levels receive an environmental lead assessment.
- Engage families to promote preventive health on elevated blood lead levels.
- Collaborate with the state agency to promote and circulate State website materials aimed at educating children on lead poisoning.

Referral sources for the EBLLs CM program include:

- Monthly state Lead report
- DHSS
- Community Agencies
- Member/Caregiver

- Primary Care Provider (PCP)

UnitedHealthcare offers CM within the following timeframes to all children when a referral is made, and EBLL is present (venous or capillary):

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

The clinical administrative coordinators (CAC) at UnitedHealthcare ensure confirmation of capillary tests using venous blood according to the timeframe listed below:

- 10-19 ug/dL–Within 2 months
- 20-44 ug/dL–Within 2 weeks
- 45-69 ug/dL–Within 2 days
- 70 ug/dL–Immediately

The follow up guidelines for EBLLs are:

- 10-19 ug/dL in 2-3 months intervals.
- 20-70+ ug/dL in 1-2 months 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 15 ug/dL for at least 6 months;
    - Lead hazards have been removed; and
    - There are no new exposures.

When the above conditions have been met, the CACs proceed with retest intervals and follow-up for BLLs 10-19 ug/dL. UnitedHealthcare states that they document all aspects of CM for EBLLs in the Missouri Health Strategic Architectures and Information Cooperative (MOHSAIC). This is a lead application database at the State. (Note: Verification of documentation in this database by Primaris is outside the scope of this report.)

Work Flow

Initially, all members with an EBLLs are stratified as “high risk.” After an assessment is complete and a care plan is developed, their risk stratification level is moved down to a “moderate” or “low risk” depending on needs and level of repeat blood lead levels. UnitedHealthcare uses the DHSS childhood lead poisoning prevention program nurse’s lead CM questionnaire and the nutritional assessment forms to capture all the required CM elements for documentation. An internal lead assessment is also completed in the community care (CC) clinical documentation system.

Individualized care plan (called as plan of care-POC at UnitedHealthcare) include the members’/caregivers’ self-management goals and any identified opportunities to increase

their knowledge of preventive measures, the importance of timely blood level retesting, and any remediation efforts. Care plans are accessible to the PCP via the Provider Portal. The CC automatically documents the case managers' name, date and time for each entry noted in the member's record.

An exit evaluation/case closure is performed prior to discharge. This is done once the lab tests have normalized. The family is informed of normalization of the lead level. The discharge counseling includes the current blood lead level status, review of ongoing techniques for prevention of re-exposure to lead hazards, as well as nutrition, hygiene, and environmental maintenance. This contact occurs via telephone or in person by the care managers. Providers are sent an enrollment letter when a member is enrolled in CM. Follow up with the physician's office is made to confirm appointments for repeat blood lead levels as well as for any urgent member need. Providers are sent a case closure letter when a member is discharged from the CM program. A Lead education package is mailed to all the members upon receiving a notification of EBLLs. Figure 8 demonstrates the work flow of EBLLs CM program.

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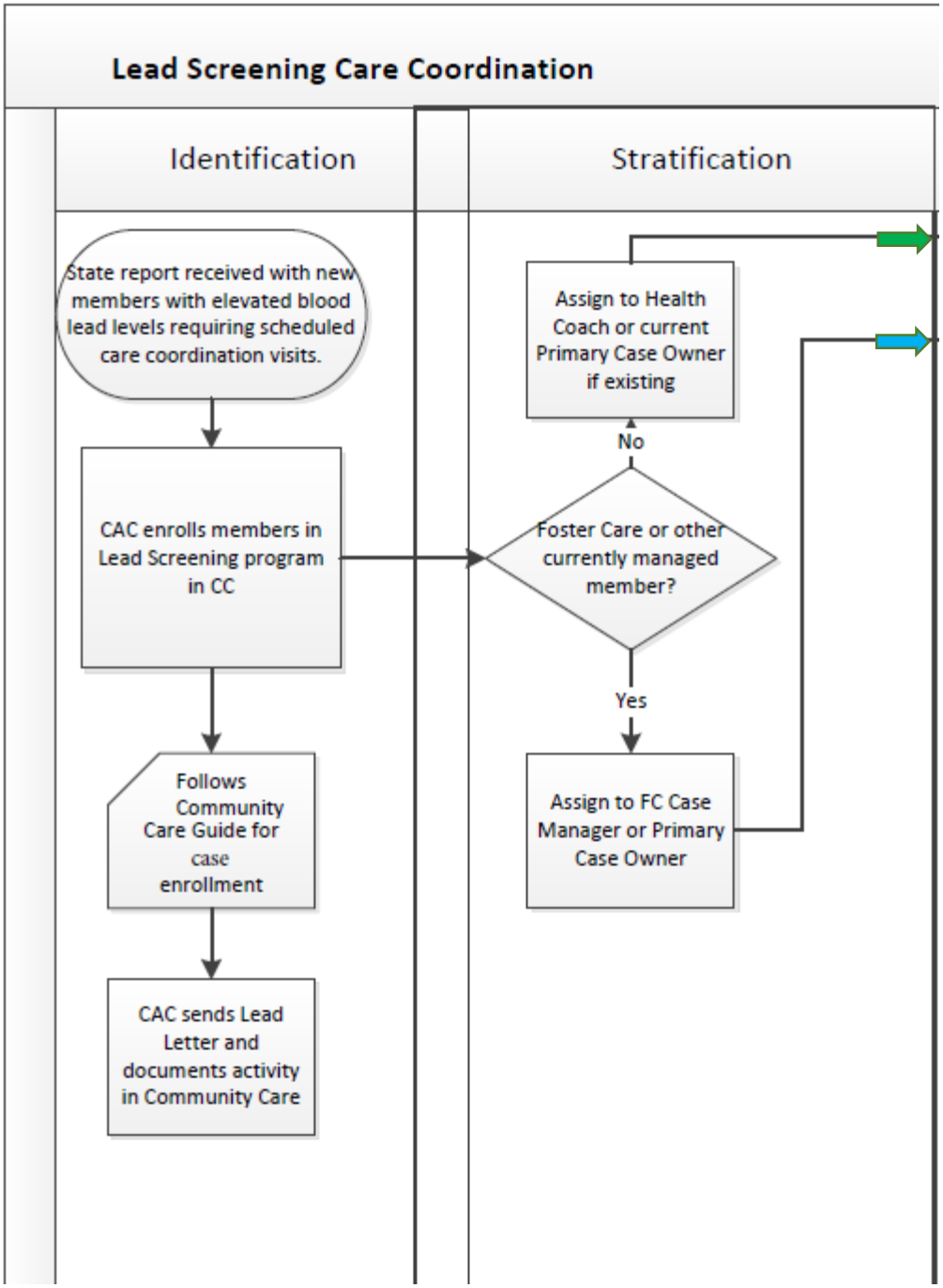

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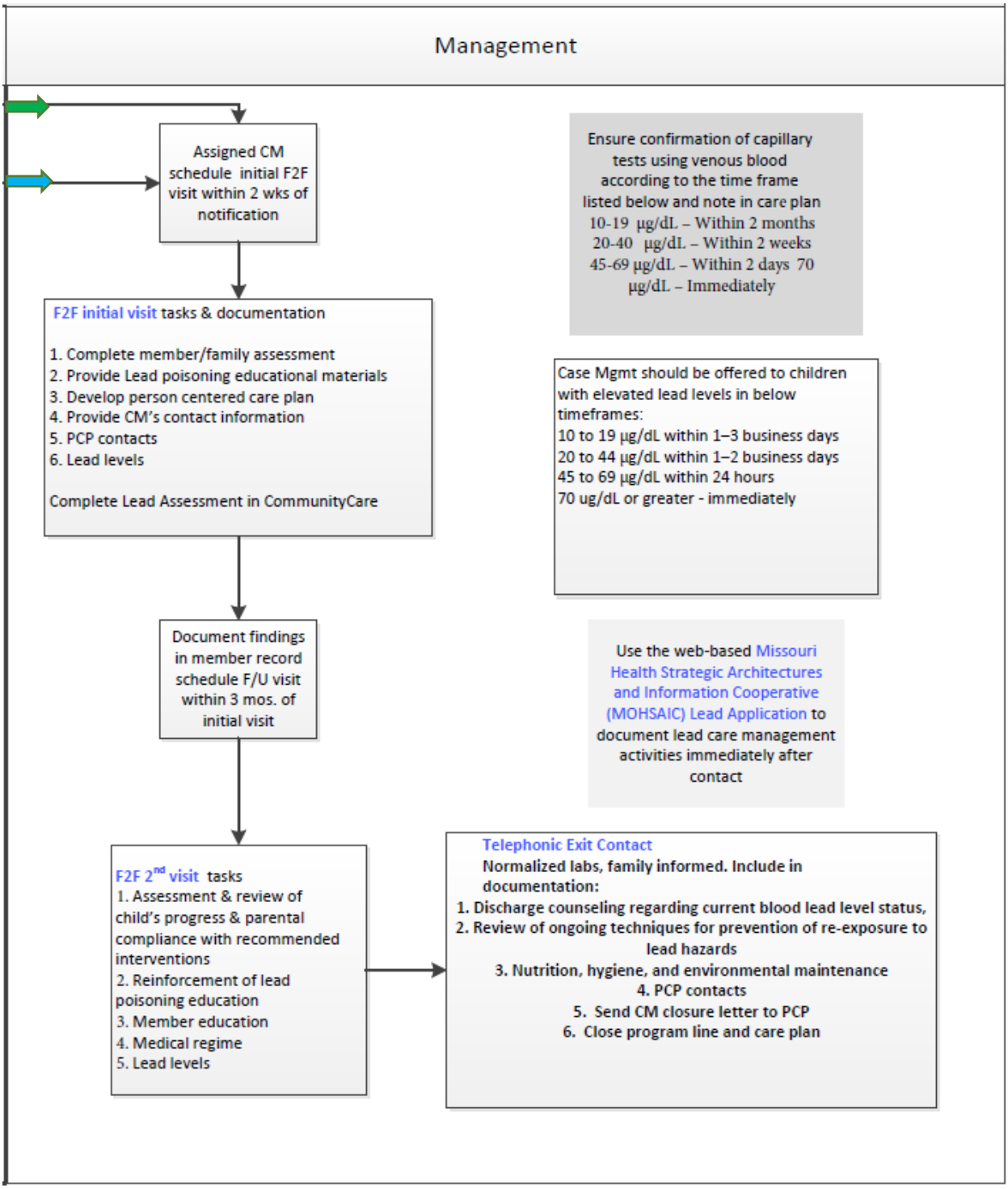

Figure 8 : Workflow of Elevated Blood Lead Levels CM Program

3.5.1 Findings of EBLLs Medical Record Review

An oversample of 27 medical records is reviewed in order to obtain the required sample size of 20 medical records. Exclusions are 7 (5 cases: No CM in CY 2018 and 2 cases: UTC). The MRR compliance (%) is reported under the following headings (Figure 9):

a. Diagnosis: 100% compliance.
   There is a documented evidence of diagnosis in all cases. However, cases managed by Pediatric Care Network (PCN-subcontractor of UnitedHealthcare offering CM in Western region of Missouri) mentioned "high lead" in their notes/assessment as opposed to clearly stating in the medical record.
b. First enrollment date: 100% compliance.
   Most of the cases (18 of 20) are enrolled for CM on the same day of notification from the state. 2 cases have a different enrollment date (managed by PCN).
c. Last enrollment date: 100% compliance.
   Cases are closed due to goals met (6), loss of eligibility (2), unable of contact (UTC-1), refusal for CM (6). One of the 6 members who refused CM, was in contact with local public health agency and did not want to be engaged with UnitedHealthcare. 5 cases are still open for CM in CY 2019.
d. Offer CM within time frames for EBLLs: 30% compliance.
   The attempt to outreach a member begins within 24 hours of notification from the state. The members are not available for an assessment or do not answer the phone or refuse CM.
e. Referrals: 100% compliance.
   UnitedHealthcare receives referrals from state (100%), PCPs, or the members.
f. Assessment: 75% compliance.
   The lead assessment is complete in 15 of 20 cases. However, an assessment does not include medical history, psychiatric history, developmental history, psychosocial and legal issues. The compliance of these elements is 20% only. The CM done by PCN includes all the components of assessment per MHD contract.
g. Confirmation of capillary blood test by venous test within the time frame per MHD guidelines: 95% compliance.
   In 19 of 20 cases, confirmation of venous blood lead levels are available within the timeframe. Most of these cases (15 of 19) are reported with venous blood lead levels at the time of notification to the MCO by the state. One case did not have a confirmation by venous blood as mother refused CM.
h. Follow up on EBLLs within the time frame per MHD guidelines: 68.4% compliance.
   A follow up BLL within the time frame is done in 13 of 19 cases. This requirement is marked as not applicable (N/A) for 1 case as venous level is low (l.0 µgm/dl).

i. Home visits: 68.4% compliance for first visit, 10.5% compliance for second visit.
   If a home visit is done by LPHA for an environmental risk assessment, UnitedHealthcare does not make a home visit (first follow up) at member's residence.
j. Care plan with updates: 75% compliance.
   An updated care plan is found in 15 of 20 cases.
k. Progress notes: 85% compliance.
   Detailed notes on every contact with the member are present in 17 of 20 cases.
l. Provider treatment plan: 26.3% compliance.
   The engagement of providers with the care managers in developing a care plan is low (5 of 19 cases, N/A in one case).The care plan is posted on the website which is accessible to the providers. 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.
n. Coordination and linking of services: 90% compliance.
   In 18 of 20 cases, the members are linked to dental services, vision services, PCPs, local public health department, DHSS, home remediation services.
o. Monitoring of services: 75% compliance.
   Services are monitored in 15 of 20 cases.
p. Discharge plan: 100% 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. There are 5 cases marked as N/A (still open for CM).
q. Exit evaluation/case closure contact: 60% compliance.
   Only 9 of 15 cases have exit evaluation. This is not applicable for 5 cases as they are still open for CM.
r. Notification to providers/members: 93.3% compliance for provider notification/13.3% compliance for member notification.
   In 14 of 15 cases, the providers have been sent a written notification about child's condition and case closure. Only 2 of 15 members are notified in writing about case closure. The case managed by PCN has a member-closure letter. UnitedHealthcare does not send a member closure letter. The members are verbally notified. (N/A for 5 open cases).

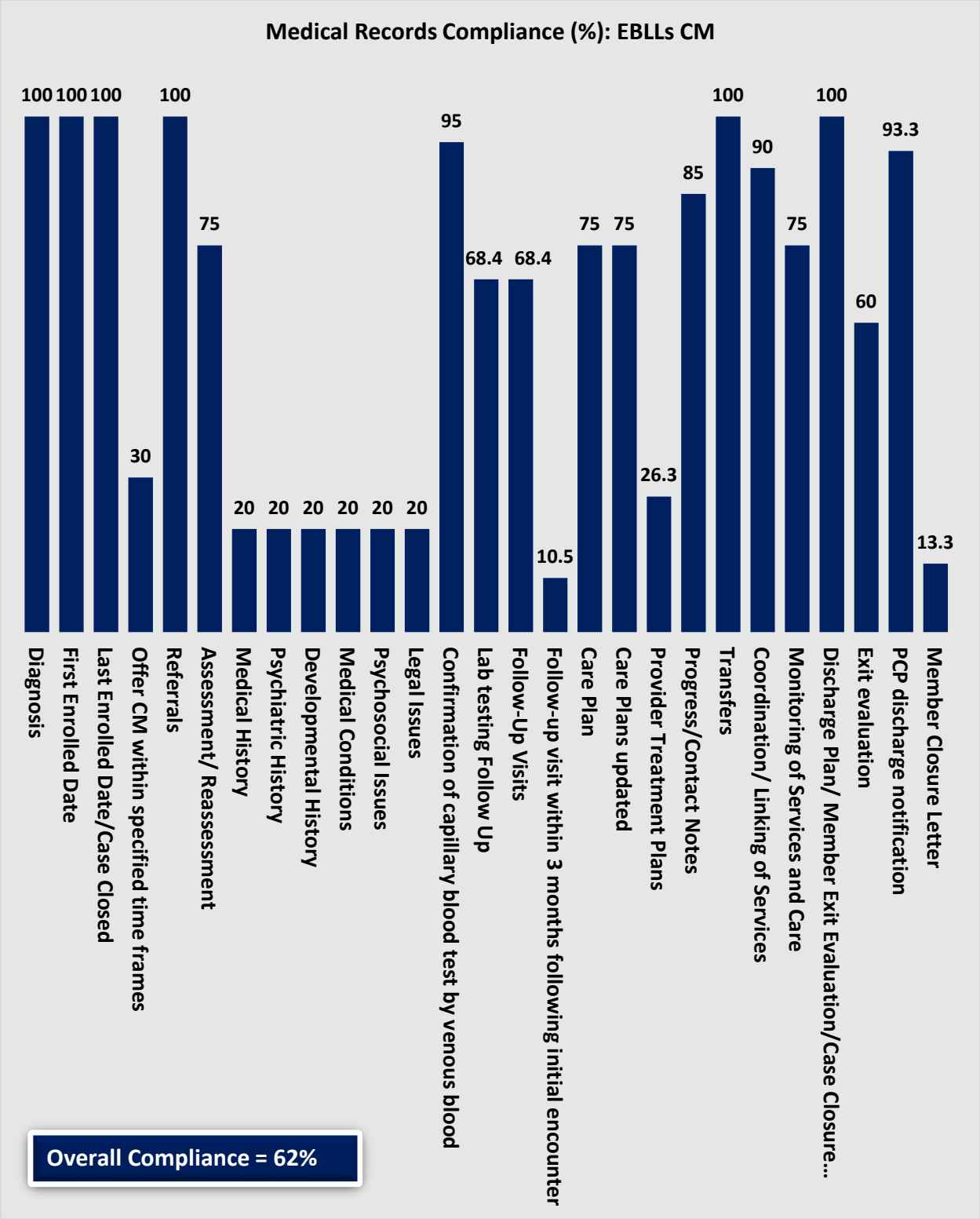

Figure 9: Medical Record Review for Elevated Blood Lead Levels CM Program

3.5.2 Conclusions

Oversample of medical records: 27

Exclusions: 7

MRR sample: 20 cases. 5 cases remain open for EBLLs CM in CY 2019. 15 of 20 cases are closed for EBLLs CM due to following reasons. (Table 3):

Table 3: Case Closure	15
Goals met/low blood lead levels	6
Lost eligibility	2
Unable to contact (UTC)	1
Declined CM	6

Issues and Key Drivers

Issues

- The CM is offered within the time frames based on the EBLLs in 30% cases (6 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 main cause of delay. Another 30% (6 of 20 cases) refused CM.
- UnitedHealthcare does not assess their members based on the criteria required by MHD. They follow a questionnaire with a focus on lead exposure. A detailed assessment of a member which should include medical, psychiatric, developmental, psychosocial and legal history is not present in most medical records. Only 20% of the cases had detailed assessment which were managed by PCN.
- Refusal to CM is the main issue for compliance. The timely follow up of repeat blood levels is done in 68.4% cases (13 of 19), initial home visit is done in 68.9% (13 of 19), and second visit is done in 10.5% cases (2 of 19).
- Provider engagement with the care plan is only in 26.3% cases.
- UnitedHealthcare does not notify their members in writing about the 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 Elevated BLL CM MRR is 62%. UnitedHealthcare has scored 100% in maintaining their medical records with diagnosis, enrollment and case closure dates, referrals, transfers, and discharge plan. An education package is mailed even if a member refuses CM or UTC. 95% cases have a confirmation of capillary BLL level with venous BLL within the time frame. Coordination and linking of community resources is seen in 90% cases. A written notification is sent to the providers at the time of case closure in 93.3% cases. Updated care plan is available in 75% cases.
- Initiative is taken by care managers to call the providers and notify about care plan, confirm appointments of their members. This has resulted in providers' engagement in 26.3% cases. The care managers also educate the providers about the CDC/MHD recommended timeframes for retesting EBLLs.
- UnitedHealthcare participates in Lead education via DHSS training (8/17/18 and 1/28/19). This is an ongoing review of DHSS "Missouri Child Lead Poisoning Prevention Program (CLPPP)" training materials for all incoming staff.

Improvement by UnitedHealthcare

UnitedHealthcare contract with MHD went in effect on May 01, 2017. Since data for the entire CY 2017 was not available, UnitedHealthcare was not included in EQR 2018. Thus, there are no recommendations from last year's EQR which could serve as basis for assessing improvement in EQR 2019.

3.5.3 Recommendations

For UnitedHealthcare

- 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 4).

Table 4: 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

- CM Assessment should include medical, psychiatric, developmental, psychosocial, and legal history in addition to lead specific questions. The diagnosis should be conspicuous.
- Member engagement: Follow up home visits (2) after receiving a confirmatory venous BLL should be made by UnitedHealthcare's care managers. A home visit by the county/local public health department for environmental assessment should not be considered in lieu of a follow up home visit. If the MCO wants to use local public health agencies to provide services, the MCO shall enter into written contracts with the local public health agencies (MHD Contract 2.11.1 e 4). 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 an "education package" the guardians 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.
- MHD contract section 2.11.1 e 5 requires a documentation of member/family notification of discharge from the care management. Primaris recommends

UnitedHealthcare to notify members in writing (a closure letter) as opposed to a verbal notification.

- Provider engagement: The MCO should have a point of contact at every provider's office to discuss and share the care plan. A notification letter should be sent to physician along with a copy of the member/guardian notification letter.
- 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

Whole Person Care (WPC) Program

Behavioral health care management is provided by UnitedHealthcare's WPC program. This program provides care coordination within an integrated, multi-disciplinary and geographically local team. The Whole Person Care (WPC) Management program is designed to address both the management of acute events as well as the reduction of future

risk for a member through integrated medical and behavioral care management/care coordination to Medicaid members. The WPC program focuses on the clinical and psychosocial needs to optimize the health status of individuals with complex and/or chronic health conditions. The program is accredited by National Committee for Quality Assurance (NCQA) case management.

The primary features of the WPC model:

- Primary point of contact for engaged member.
- Evidence-based proprietary identification and stratification.
- Comprehensive assessment and care plan.
- Telephonic and face-to-face member engagement.
- Locally based interdisciplinary team.

The outcomes of WPC Management focus on the following value domains:

- Decreased overall medical expenses/ increased overall medical cost savings.
- Improved health system utilization.
- Improved clinical outcomes.
- Improved functional health status.
- Improved member satisfaction.

Work flow

Each member enrolled in the WPC Management program is provided a locally based integrated care team (ICT) to assist the member in achieving improved health outcomes. Each member has a primary care manager to work with the ICT that is best suited to address the member's primary needs. All behavioral health referrals are assigned to a licensed behavioral health clinician (BHA). While there is a primary case owner, the team works collaboratively to consult and share expertise, and BHA's frequently consult with an RN on the team for assistance in managing a member's care when the member has co-occurring behavioral health and medical conditions. The BHA may also refer the member to a peer support specialist (PSS), who is a member of the ICT that has personal experience managing his/her own behavioral health condition. The case owner works with the member's primary care physician (PCP), behavioral health providers, specialist providers and internal UnitedHealthcare WPC ICT members who include, but are not limited to: pharmacist, medical director, legal liaison, housing specialist, PSS, RN and BHA. Program services are delivered through field visits, telephonically and through member education mailings. Opportunities to connect with individual members face-to-face are encouraged, particularly when the member experiences a hospitalization. Figure 10 explains the workflow of BH CM program.

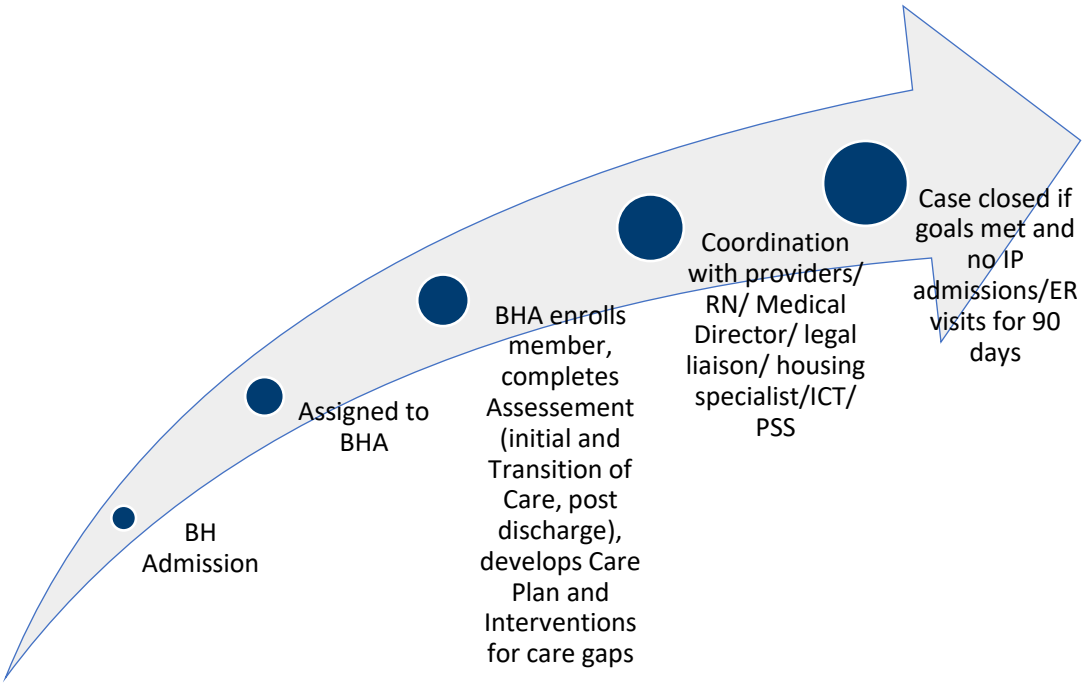

Figure 10: Workflow of Behavior Health CM Program

3.6.1 Findings for Behavioral Health Medical Record Review

(Excel Workbook Tab C)

Care management of members with behavioral health diagnosis leading to hospitalization (including residential treatment program for substance use disorder) is assessed. An oversample of 27 medical records is reviewed in order to obtain the required sample size of 20 medical records for evaluation. 7 medical records are excluded (5 cases: No CM in CY 2018 and 2 cases: UTC).

The MRR compliance (%) is reported under the following headings (Figure 12):

a. Diagnosis: 100% compliance.
   There is a documentation of diagnosis in all the 20 cases. Major depressive disorder is the admitting diagnosis in 12 of 20 cases. The second common reason for admission is disruptive mood disregulation disorder (3 cases). The remaining 5 cases are unspecified psychosis (1), bipolar disorder (1), adjustment disorder (1), mental disorder (1), and attention deficit hyperactivity disorder (1).
b. First enrollment date: 100% compliance.
   The cases are enrolled on the first day of successful outreach with the patient. However, all cases are enrolled after the discharge date from hospital/residential care.
c. Last enrollment date: 100% compliance.
   Cases are closed due to goals met (5), loss of eligibility (2), unable of contact (UTC-10), refusal of CM (3).

d. Assessment of the members for CM within 5 business days of admission to a psychiatric hospital or residential treatment program: MHD has mandated Primaris to focus on this section. Compliance is 20% (Figure 11).
   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.

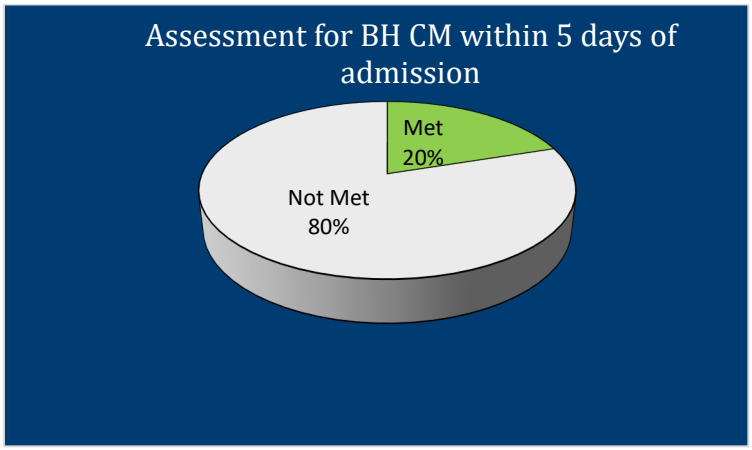

Figure 11: Assessment for CM within 5 business days of admission to a psychiatric hospital or residential substance use treatment program

e. Referrals: 100% compliance.
   Utilization Management system (UM) at UnitedHealthcare generates an auto-referral alert as a member is hospitalized or discharged from the hospital, and thus the care managers are notified.
f. Assessment: 45% compliance.
   There are two forms used for assessing a member's condition. One is "Access to Care" and other is "Transition of Care." Detailed assessment which should include medical, psychiatric, developmental, psychosocial history, is missing in 9 of 20 cases. However, legal issues are discussed in 19 of 20 cases and the compliance is 95%.
g. Care plan with updates/progress notes: 100% compliance.
   Care managers discuss the needs with the members and develop 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.

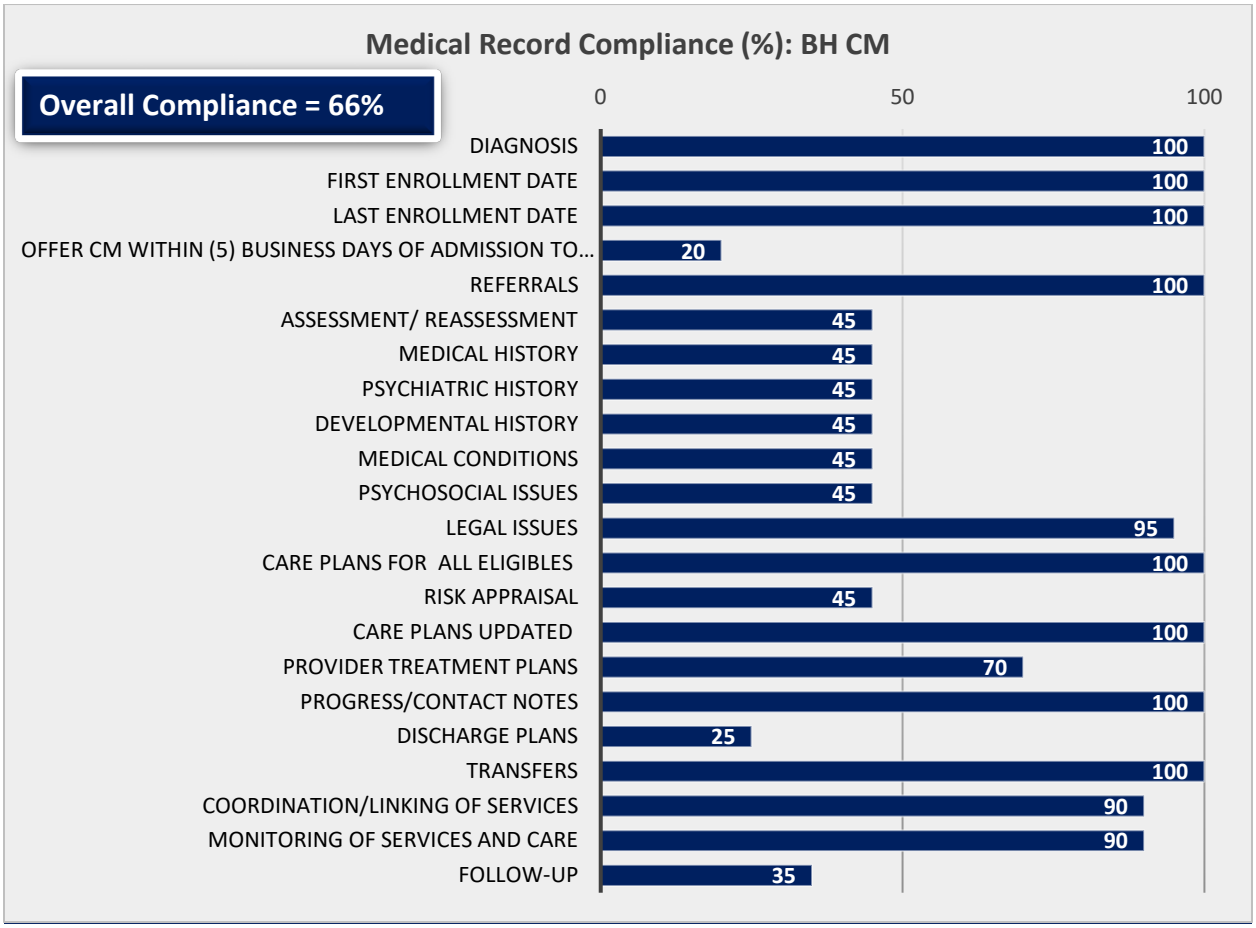

Figure 12: Medical Record Review for Behavioral Health CM Program

h. Risk appraisal: 45% compliance.
   High risk assessment is available for 9 of 20 cases only.
i. Provider treatment plan: 70% compliance.
   Care manager contacts a provider (psychiatrist, BH therapist, inpatient department, pharmacy) to verify the member's compliance with their scheduled appointments and also checks for medication refills. 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
   UnitedHealthcare 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. is recommended by a provider. Hence, this section is considered N/A.

k. Transfer: 100% compliance.
This section is addressed in all the medical records. One case is transferred to another state and thus loses eligibility with the MCO.

l. Coordination and linking of services/monitoring of services: 90% compliance.
Care managers coordinate with pharmacy, PCP, community resources, PSS, housing facilities, BH providers, transportation services, RNs, school counselling services, financial services to ensure full support and a complete recovery of their patients. 2 of 20 cases did not receive these benefits as the members could not be contacted, even after several attempts (more than 3).

m. Discharge plan: 25% compliance.
This is available for 5 of 20 cases. The remaining 15 cases did not have a discharge plan because of UTC (10 cases), loss of eligibility/transfer to another state (2 cases), refusal to CM (3 cases).

n. Follow up: 35% compliance.
This is done in 7 of 20 cases. The remaining cases do not have a follow-up because of UTC (9), refusal to CM (3), and loss of eligibility (1).

3.6.2 Conclusions

Oversample of medical records: 27

Exclusions: 7

MRR sample: 20 cases. All cases are closed under BH CM program due to the following reasons (Table 5):

Table 5: Case Closure	20
Goals met	5
Lost eligibility	2
Unable to contact (UTC)	10
Declined CM	3

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 20%. 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."

- The detailed CM assessment (called as Access to Care Assessment) is conducted only in 45% of the cases (9 of 20).
- Providers are not engaged in the care plan. However, when care managers call provider offices to confirm compliance of their members with their scheduled appointments, they get a feedback/response.
- UnitedHealthcare informed Primaris about a correspondence between them and their providers: A concern was expressed by providers that in the interest of confidentiality, patient information is not being released to UnitedHealthcare's clinical staff requesting it for care coordination and management. This concern is shared by care managers. Information about a BH patient is not shared with a provider as care managers do not have a written consent/permission by the patient. This leads to lack of coordination between providers and care managers to effectively implement a care plan.
- During the MRR, UnitedHealthcare official stated that a care manager is not able to verify the provider of a given member in 44.5% cases (Figure 13).

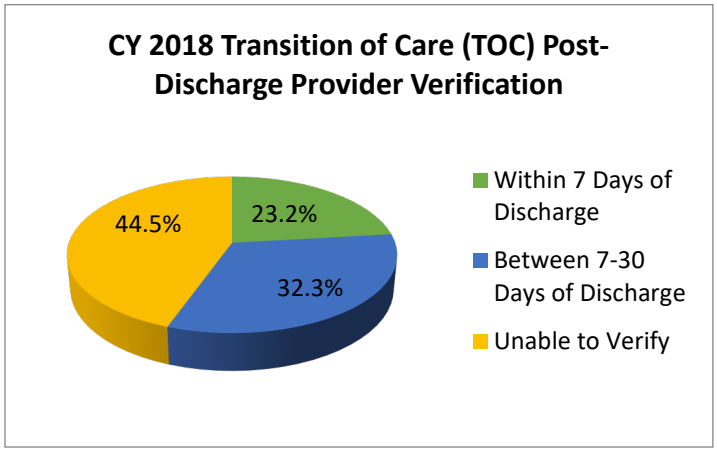

Figure 13: Post-Discharge Provider Verification

- 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. 15% of the cases (3 of 20) refused CM after being enrolled. 50% of the cases (10 of 20) did not get the entire benefit of care plan. The cases are closed because of UTC-members do not respond to the calls by the care managers.

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.
- Detailed "need assessment" for a care plan with member'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 66%. UnitedHealthcare has scored 100% in maintaining their medical records with diagnosis, enrollment and case closure dates, referrals, updated care plans, progress notes. Coordination, linking, and monitoring of community care services are seen in 90% cases.

UnitedHealthcare stated that in CY 2018 the program model for Whole Person Care was redesigned to create regionally based care management teams and to maximize opportunities for clinical oversight and direction of cases. As a result of the program redesign, the number of licensed behavioral health clinicians for MO WPC more than doubled.

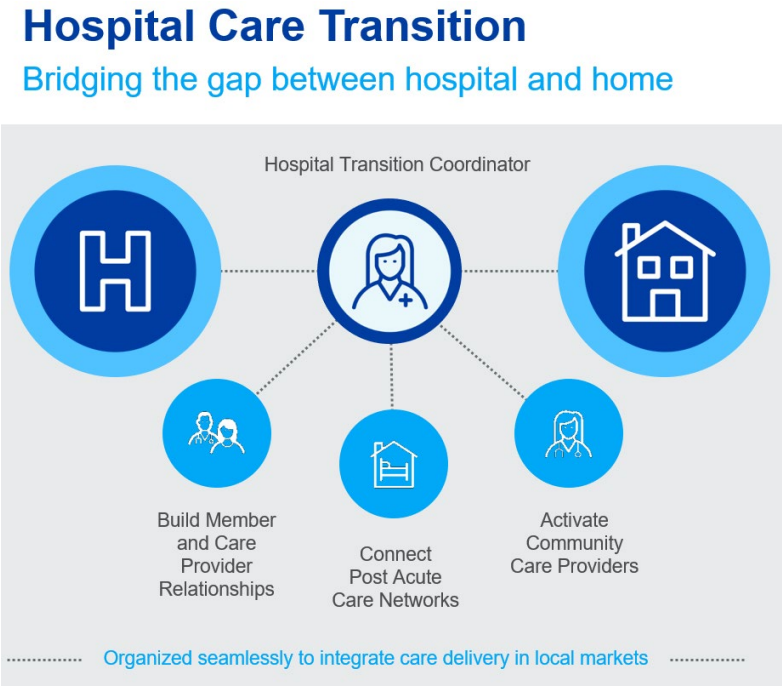

Figure 14: Hospital Care Transition Program of UnitedHealthcare

UnitedHealthcare engaged 20 behavioral health facilities to discuss policies and procedures related to behavioral health advocates (BHAs) gaining onsite access to members while they are still inpatient. The goal of this intervention is to engage more members at the hospital to facilitate follow up treatment post-discharge and prevent future readmissions. This intervention, along with the model redesign, helped contribute to an 82% increase in member visits by BHAs at inpatient facilities (Figure 14). This is an ongoing program at UnitedHealthcare (updated on 4/19/19).
UnitedHealthcare submitted that they have completed "Transition of Care-Assessment (TOC)," within 3 days of hospital discharge in 87.5% cases (Figure 15).

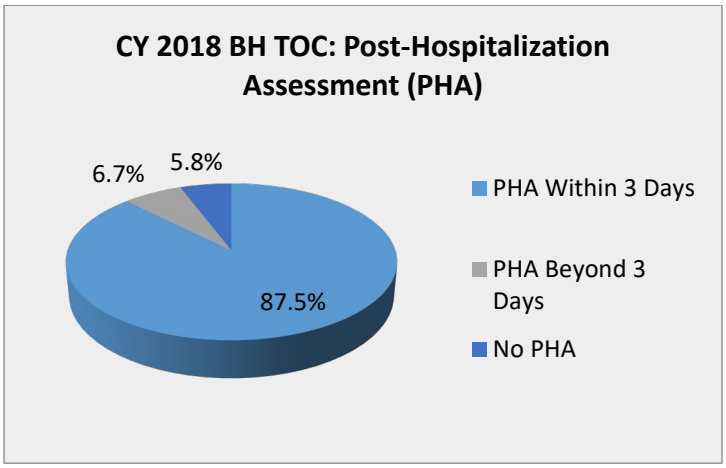

Figure 15: Transition of Care (TOC) Assessment-Post Discharge

Improvement by UnitedHealthcare

UnitedHealthcare's contract with MHD went in effect on May 01, 2017. Since data for the entire CY 2017 is not available, UnitedHealthcare was not included in EQR 2018. Thus, there are no recommendations from last year's EQR which could serve as basis for assessing improvement in EQR 2019.

3.6.3 Recommendations

- CM Assessment within 5 days of psychiatric hospital/residential treatment program: It is best to engage with the member for an assessment during Inpatient stay. UnitedHealthcare has already begun to channelize their efforts in this direction through Hospital Care Transition (HCT) program. Primaris recommends expanding it to all the behavioral health facilities since UnitedHealthcare has already witnessed an improvement as a result of their HCT program.

- UnitedHealthcare should consider enrolling a member in CM program and completing "Access to Care-assessment" when they have an opportunity to interact with a member post-discharge for completing their "TOC-assessment."
- Detailed Assessment: Primaris recommends UnitedHealthcare create an assessment which should include medical, psychiatric, developmental, psychosocial, and legal history. These requirements are listed in MHD contract.
- 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.
- MHD contract section 2.11.1 e 5 requires a documentation of member/family notification of discharge from the care management. Primaris recommends UnitedHealthcare to notify members by sending a member closure letter as opposed to a verbal notification.
- 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

[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

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 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. UnitedHealthcare can utilize this online tool to optimize their staff load for any CM program and improve member outcomes.

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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/

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

Recommendations for All CM

In regards to low compliance with Provider Treatment Plans, it is recommended that UnitedHealthcare 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 UnitedHealthcare within 30 days to express concerns or offer changes. By including this statement on every treatment plan, UnitedHealthcare 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.