Primaris
Healthcare Business Solutions

2020 External Quality Review

Care Management

home state health

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MoHealthNet

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Topics **Pages**

1.0 Purpose and Overview

1.1 Background

The Department of Social Services, Missouri HealthNet Division (MHD), operates a Health Maintenance Organization (HMO) style Managed Care Program called MO HealthNet Managed Care (hereinafter stated "Managed Care"). To ensure all Missourians receive quality care, Managed Care is extended statewide in four regions: Central, Eastern, Western, and Southwestern. The goal is to improve access to needed services and quality of healthcare services in the Managed Care and state aid eligible populations, while controlling the program's cost. Participation in Managed Care is mandatory for certain eligibility groups within the regions in operation. Total number of Managed Care (Medicaid and CHIP combined) enrollees by end of State Fiscal Year 2020 was 657,492 representing an increase of 10.20% as compared to end of SFY 2019.

MHD contracts with Managed Care Organizations (MCOs), also referred to as Managed Care Plans, to provide health care services to its Managed Care enrollees. Home State Health is one of the three MCOs operating in Missouri (MO). MHD works closely with Home State Health to monitor services 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 (EQR).

MHD contracts with Primaris Holdings, Inc. (Primaris), an External Quality Review Organization (EQRO), to perform an EQR. An EQR is the analysis and evaluation of aggregated information on quality, timeliness, and access to the health care services that a Managed Care Plan, or its contractors, furnish to Medicaid beneficiaries. EQR 2020 evaluates activities of Home State Health during calendar year (CY) 2019.

1.2 Care Management

Review of Home State Health's care management (CM) program is one of the activities mandated in MHD-EQRO contract. MHD Managed Care contract, section 2.11, provides guidelines for evaluation of CM Program. The aim of CM review is to identify contributing issues and key drivers. For EQR 2020, MHD requires Primaris to evaluate three focus areas:

- Asthma (members in age group of 5-18 years only).
- Opioid /substance use disorder (SUD).

- Behavioral health (BH) diagnosis leading to hospitalization (including residential treatment program for substance use disorder).

Care management is a promising team-based, patient-centered approach "designed to assist patients and their support systems in managing medical conditions more effectively."[1] It also encompasses those care coordination activities needed to help manage chronic illness. Three key strategies to enhance existing or emerging CM programs: (1) identify population(s) with modifiable risks; (2) align CM services to the needs of the population(s); and (3) identify, prepare, and integrate appropriate personnel to deliver the needed services. CM is organized around the precept that appropriate interventions for individuals within a given population will reduce health risks and decrease the cost of care[2].

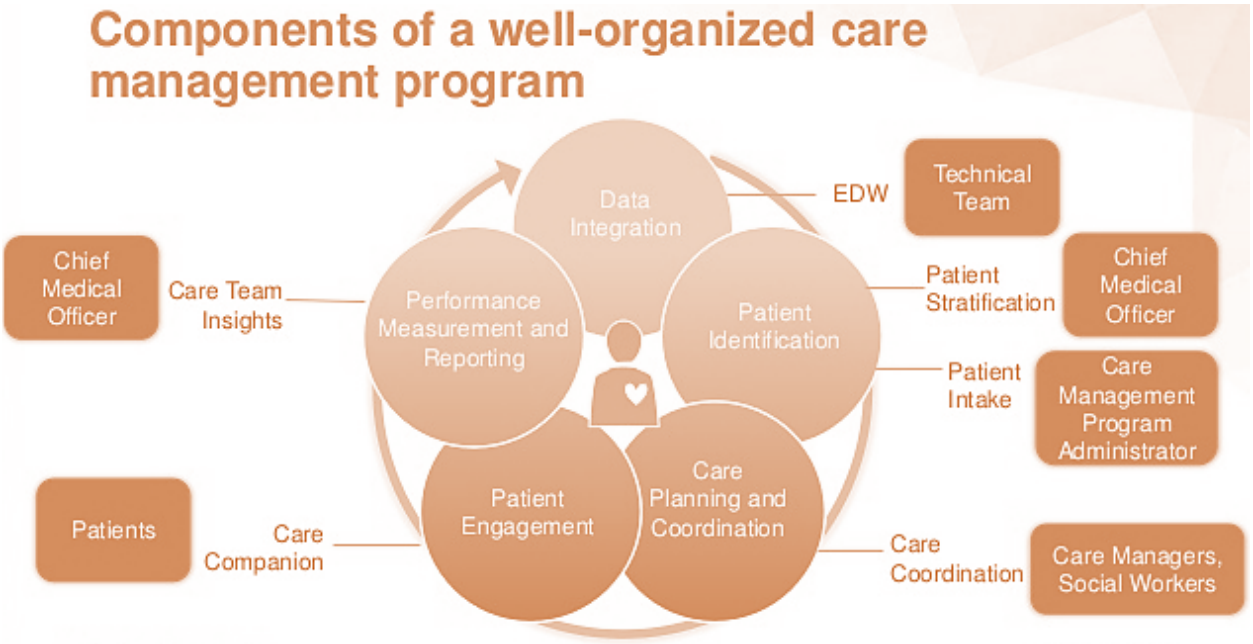

Figure 1. Care Management Components (Source: Healthcatalyst.com, Acronym EDW-Enterprise Data Warehouse)

2.0 Methodology

Evaluation of Home State Health's CM program was conducted under the following heads (Figure 2):

[1] http://www.chcs.org/resource/care-management-definition-and-framework/
[2] https://www.ahrq.gov/ncepcr/care/coordination/mgmt.html#ref3

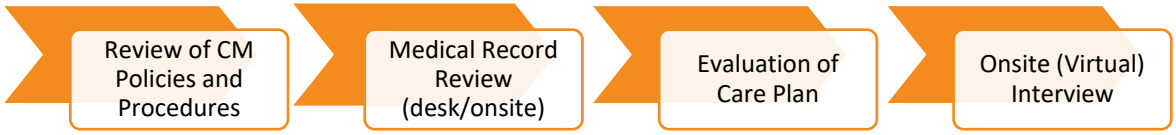

Figure 2. CM Evaluation Process

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

2. 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 focus areas.
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 include 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.

3. Onsite Interview.
Home State Health 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 on 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 Home State Health officials were interviewed on Oct 29, 2020 (via virtual meeting due to Covid-19 Pandemic) to evaluate the CM program:

Bob Lampe, Vice President, Compliance
Kelley Peters, Senior Director, Case Management
Lucian Nevatt, Director, Quality Improvement
Angela Cusanelli, Process Improvement Specialist
Chris Hoover, Senior Manager, Case Management
Jennifer West, Manager, Case Management
Crystal McNail, Supervisor, Case Management
Stacey Schulte, Supervisor, Case Management
Jessica Stevens, Supervisor, Case Management
Julie Mertzlufft, Supervisor, Case Management
Karin Byrne, Supervisor, Case Management
Shannon McDermott Crandall, Supervisor
Susan Nay, Senior Quality Management Specialist
Lupe Ponce, Senior Quality Management Specialist

4. Medical Record Review (MRR).

Primaris assessed Home State Health's ability to make available any and all pertinent medical records for review. A list of members care managed in CY 2019 for the three focus areas was submitted by Home State Health. Primaris selected a sample of 30 medical records (required sample size of 20 plus 50% oversample for exclusions and exceptions) for each focus area by using systemic random sampling methodology based on Appendix B of CMS protocols for EQR, Oct 2019 version. Home State Health was requested to upload all 30 medical records for each focus area, at Primaris' secure web-based file upload site. Desk review of policies, procedures, and medical records was conducted in Feb-Apr 2020. Clarifications/additional information (if any) were requested during onsite session. (Note:

Due to Covid-19 Pandemic, the onsite visit scheduled for Mar 2020 was cancelled per MHD's instructions and rescheduled in Oct 2020 virtually.)

An evaluation tool (Excel workbook) was created to capture information from medical records which included, at a minimum: referrals; assessment; medical history; psychiatric history; developmental history; medical conditions; psychosocial issues; legal issues; care planning; lab testing; progress/contact notes; discharge plans; aftercare; transfers; coordination/linking of services; monitoring of services and care; and follow-up. (Note: Home State Health submits CM Logs to MHD each quarter. Review of these logs is outside the scope of this report.)

Inter Rater Reliability: 10% of the MR from each focus area are reviewed by a different auditor to assess the degree of agreement in assigning a score for compliance in the evaluation tool. Primaris' aim is to achieve 95% score for IRR. We scored 100%.

The following criteria were used for inclusions/exceptions/exclusions of medical records in the study sample:

Inclusion Criteria

- Asthma CM

Continuous enrollment: No break in enrollment for more than 45 days with the MCO.
Event/Dx: Asthma (ICD-10-CM code J45.xxx)
Anchor date: Members should be enrolled in CM in CY 2019
Age: Members in age group 5-18 years during the measurement year (CY2019).

- Opioid/SUD CM

Continuous enrollment: No break in enrollment for more than 45 days with the MCO.
Event/Dx: Opioid Dependence (ICD-10-CM code F11.xxx).
Anchor date: Members must be enrolled in CM in CY 2019.
Age: N/A

- BH CM

Continuous enrollment: No break in enrollment for more than 45 days with the MCO.
Event/Dx: Must not have been in care management in CY 2018 (unless a new diagnosis made in CY 2019). Members should be hospitalized in a psychiatric hospital or be receiving residential treatment for substance use disorder in CY 2019.
Anchor date: Members should be enrolled in CM in CY 2019.
Age: 6 years or older during the measurement year (CY 2019).

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

CM Data

Medicaid Managed Care members enrolled in CY 2019 = 205,395
Members enrolled in CM (each focus area) = Asthma:122, SUD: 136; BH: 235
CM staff available = 83 (clinical/nonclinical), Care Managers: 28
Average case load = 62 active cases
Maximum members who can receive CM = Home State Health will ensure sufficient staffing is available to meet the contractual obligations for providing CM to all members who need these services.

3.1 Review of Policies and Procedures

The following policies and procedures were submitted by Home State Health (Table 1). Upon review, Primaris assigned a score of "Met" with all the requirements mandated by MHD contract. (Note: Definitions of Met/Not Met are adopted from CMS EQRO Protocol 3.)

Table 1: Home State Health-Care Management Policy Review

Policies and Procedures shall include (MHD 2.11.1c5):	Met	Not Met	Document(s) Name
1. A description of the system for identifying, screening, and selecting members for CM services.	●		MO.CM.01 Case Management Program Description
2. Provider and member profiling activities.	●		MO.CM.01 Case Management Program Description, Annual Quality Assessment and performance Improvement Program Evaluation, Monitoring utilization MO.UM.01.03
3. Procedures for conducting provider education on CM.	●		Home State Provider Orientation (5.7.19)

4. A description of how claims analysis will be used.	●		MO.CM.01 Case Management Program Description
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.	●		MO.CM.01 Case Management Program Description
6. A process to ensure integration and communication between physical and behavioral health.	●		MO.CM.01 Case Management Program Description
7. A description of the protocols for communication and responsibility sharing in cases where more than one care manager is assigned.	●		MO.CM.01 Case Management Program Description
8. A process to ensure that care plans are maintained and updated as necessary.	●		MO.CM.01 Case Management Program Description
9. A description of the methodology for assigning and monitoring Care Management caseloads that ensures adequate staffing to meet CM requirements.	●		Case Guide Visual
10. Timeframes for reevaluation and criteria for CM closure.	●		MO.CM.01 Case Management Program Description
11. Adherence to any applicable State quality assurance, certification review standards, and practice guidelines as described in the contract.	●		Home State Provider Orientation (5.7.19)
12. Additional information.	●		Care Management User Guide (123-127), CM Audit Tool, Provider Quick Reference Guide, Training Transcript, MM Training Plan.

3.2 Evaluation of Care Plan

Upon interviewing Home State Health officials and conducting MRR for all three CM focus areas, Primaris concluded that Home State Health utilizes policies and procedures based on contractual guidelines for care plan. However, the care plan per se, is member driven and may not include all the components as listed under section 2.0 (2) of this report. The care managers work with the members and create goals based on the care gaps or requirements projected by the members. Interventions are planned to address those requirements before a case is closed. If a member is not willing to address a care gap/issue, it is not included in care plan.

Recommendation

MHD mandate Home State Health to create a checklist with all the requirements listed under MHD contract section 2.11.1e while developing a care plan for each member.

3.3 Care Management Process

The following information is provided by Home State Health:
Home State Health assesses the entire member population and any relevant subpopulations at least annually to determine if the CM Program meets the needs of all members eligible for CM. Results of the population assessment are analyzed and subsequent enhancements are made to the CM Program if opportunities for improvement or gaps in CM services are identified such as: staffing ratio/caseloads; types of CM activities assigned to specific members; implementation of targeted training related to cultural competency, specific medical or behavioral health conditions, cross-training for medical and behavioral health staff; and identification of appropriate community or other resources for members and staff.

Population Identification
Sources utilized for assessment of the entire member population include:

- Data provided by the state agency (includes information such as age, especially for children/adolescents and elderly, sex, ethnicity, race, primary language, and benefit category).
- Diagnostic and utilization data (e.g., overall claims received, inpatient admissions and ED visits, and pharmacy data, authorizations).

The population assessment specifically addresses the needs of children and adolescents, individuals with disabilities, and members with serious and persistent mental illness (SPMI).

Care Management Functions at Home State Health:

- Early identification of members who have special needs.
- Assessing member's risk factors.
- Developing an individualized plan of care in concert with the member and/or member's family, Primary Care Provider (PCP), and managing providers.
- Identifying barriers to meeting goals included in the care plan.
- Applying appropriate interventions to remove barriers to meeting goals included in the care plan.
- Referring and assisting to ensure timely access to providers.
- Coordinating of care linking members to providers, medical services, residential, social, and other support services where needed.
- Ongoing monitoring and revision of care plan as required by the member's changing condition and the rationale for implementing CM services.
- Supporting continuity and coordination of care.
- Ongoing monitoring, follow up, and documentation of all care coordination/CM activities.
- Addressing the member's right to decline participation in the CM program or dis-enroll at any time.
- Accommodating the specific cultural and linguistic needs of all members.
- Conducting all CM procedures in compliance with HIPAA and state law.
- Planning and conducting provider education on CM.
- Improving member care and health outcomes.
- Investigating members' complaints about care delivery.
- Identifying the rationale for implementing CM services.
- Determining circumstances under which information will be disclosed to third parties.
- Reducing of inappropriate inpatient hospitalizations or utilization of emergent services and lowering total costs through better-educated providers and members.

- Ensuring the member handbook informs members that they may request case management services at any time.

Members with asthma are stratified based on criteria listed in Table 2. Asthma CM provides telephonic outreach, education, and support services to promote adherence to asthma treatment guidelines, prevent exacerbations and optimize functional status. Enhanced Asthma Care Management Program (Waves Program) was designed in early CY 2019 and launched in mid-CY 2019 with a goal to reduce the medical costs through prevention of inappropriate emergency room (ER) admissions and inpatient hospitalizations (IP) due to medication issues.

Table 2. Member Stratification for Asthma CM

>3 Inpatient admissions within the last 12 months	1-2 Inpatient admissions within last 12 months
Medication noncompliance or overuse on rescue medications	Medication noncompliance or overuse of rescue medications

3.4. Findings of Medical Records Review

Table 3 shows number of medical records included in the study for each CM focus area.

Table 3. Number of Medical Records

	Asthma CM	Opioid/SUD CM	Behavioral Health CM
Sample size/oversample			27
Number of medical records excluded from review	None	1	7
Number of medical records included in study	20	20*	20
Cases closed goals met	4	5	4
Cases open in progress	4	8	3

*Obstetrics cases mostly.

Table 4 identifies compliance (%) of medical records with various criteria per MHD contract, applicable to all three CM focus areas.

Table 4. Compliance (%) with CM Criteria

Evaluation Criteria	Asthma CM	Opioid/SUD CM	BH CM
Diagnosis			100
Risk stratification	100	Not applicable (N/A)	N/A
Enrollment date CM	100	100	100
Case closure date	100	100	100
Referral date	100	100	100
Offer CM (Assessment) within 30 days (new patient or new diagnosis). For OB cases within 15 days.	100	85	N/A
Offer CM (Assessment) within 5 business days of admission to psychiatric hospital or substance use treatment program	N/A	N/A	45
Assessment	100	100	100
Medical history	100	100	100
Psychiatric history	100	100	100
Developmental history	100	100	100
Psychosocial issues	100	100	100
Legal issues	100	90	80
Care plan	100	100	100
Participation by member in care plan/reasons for non participation	100	N/A	N/A
Care plan updated	100	100	100
Progress notes	100	100	100
Lab tests	100	100	100
Transfer	100	100	100
Monitoring medication adherence	95	N/A	N/A
Monitoring services and care	95	100	100
Coordination and linking of services	100	100	100
Discharge plan	19	33	24
Follow up	19	33	24
PCP notification of case closure*	88	100	20
Aggregate Score	92	93	85

*Applicable for children only (age through 18 years)

Red highlighted figures indicate areas for improvement.

Note: Criterion-Provider Treatment Plan-is not evaluated in EQR 2020 per MHD's instructions.

4.0 Conclusions

4.1 Issues and Key Drivers

Issues:

1. **CM Criterion**: Offer CM (need assessment) within 5 business days of admission to psychiatric hospital or substance use treatment program.
Home State Health scored 45% for this criterion in EQR 2020. Even though this is an improvement from EQR 2019 (13%); low score remains an issue.

2. Repeat CM Assessment: A need assessment for CM is not done each time a member is enrolled in BH CM.
Members may be hospitalized several times while remaining enrolled in CM or a member may be reenrolled in CM after a previous case closure. Home State Health stated that they reassess a member as appropriate-on a six month or annual basis and review previous assessments after each hospital discharge.
Primaris noticed ambiguity in this regard during MRR. There are no guidelines in MHD contract on this issue.

3. CM Criterion: Offer CM (date of need assessment) within 30 calendar days of enrollment with MCO for new member with diagnosis/new diagnosis of existing member (for Asthma CM and Opioid/SUD CM).
Home State Health lacks clarity on what constitutes a "new diagnosis" or a "new member." A member may have multiple enrollment dates in a given year.
Since these terms are not specifically defined in MHD contract, Primaris evaluated this criterion as: Offer CM (date of need assessment) within 30 calendar days of notification/referral (by any source: member services/case managers/utilization management alerts/internal reports generated by using claims data and authorizations).

4. Care Plan: As stated earlier in section 3.2 of this report, the care plan addresses areas based on members' projected needs and does not include all points listed in MHD contract. A member in Asthma CM refused to address Asthma in care plan and wanted help in management for obesity only. Five members in Opioid/SUD CM did not want to address SUD issues in the care plan.

5. Discharge plan and follow up: Low compliance scores for these criteria are noted across all CM focus areas.
Asthma CM: Cases were lost due to unable to contact (UTC-9 cases); declined CM (1 case); loss of eligibility (1 case).
Opioid/SUD CM: UTC (5 cases); loss of eligibility (2 cases).
BH CM: UTC (5 cases); loss of eligibility (7 cases); declined CM (1 case).

6. Pharmacy: Home State Health reported difficulties they had faced on some occasions in gathering member information from MHD's Pharmacy unit. On further enquiry by Primaris, Home State Health agreed that they do not maintain a log or a tracking mechanism related to issues faced and actions taken to resolve those issues.

7. Notification of case closure to PCPs in case of BH members was an issue. Home State Health attributed it to inaction on part of one BH care manager.

Key Drivers:
The following information was obtained from medical records and Home State Health CM staff during interview (Table 5).

Table 5. Key Drivers

Asthma CM
• Education to providers on using asthma action plan. • Education to members on cessation of smoking, identification, and avoidance of environmental triggers. • Environmental evaluation of risk factors-partner with Asthma Bridge Program for home assessment. • Checking for immunization status for influenza vaccine. • Monitoring for medication adherence (CyberAccess[sm]).* • Providing nutritional and physical activity counselling resources. • Nursewise (nursing advice services round the clock, 24 x 7). • Transportation services-Utilizing LYFT for transportation to decrease member complaints and missed appointments (for all CM focus areas). • Providing information about PCPs/Urgent Care/ED utilization.
Opioid/SUD CM
• Skilled clinical staff (licensed) is assigned to all aspects of the screening and assessment process, including initial telephone contacts. • Education to pregnant members on risks with smoking marijuana, quitting strategies. Offering Smoking Cessation Program. • 24 hours Nurse Advice Line.

• Providing information about psychiatrists and counsellors. • Substance Awareness Traffic Offender Program (SATOP). Members are referred for legal issues regarding DUI (driving under the influence). • Provision of Aunt Bertha community resource platform. • Referral to Bridgeway (offers options for detoxification from drug or alcohol dependence with an individualized treatment plan tailored to members' needs).
BH CM
• Engagement of care managers with the members during hospitalization. • Accurate contact information of members/secondary contacts/guardians when the patient is in the hospital. • Training of care managers regarding linguistic and cultural competency. • Provider engagement. • Linking to community resources. • Medication adherence monitoring. • Intensive Outpatient Program (IOP).

* CyberAccess[sm] is a web-based, HIPAA-compliant tool that allows the MCO to view drug utilization information in near real time.

4.2 Quality, Timeliness, and Access to Care

Home State Health scored 80% to 100% in: 22 of 24 criteria evaluated for Asthma CM; 19 of 21 criteria for Opioid/SUD CM; and 17 of 21 criteria for BH CM (Table 4).
Table 6 reports some of the HEDIS® measures related to the three focus areas.
Improvement in some of the rates can be attributed to Home State Health's CM Program.

Table 6. HEDIS® Measures Related to CM Focus Areas

CM	HEDIS® Measures	CY 2018	CY 2019	National Average (Medicaid)
Asthma	Medication Management for People with Asthma (age 5-64 years)-50% covered	61.66%	65.95%*	61.52%
	Medication Management for People with Asthma (age 5-64 years)-75% covered	40.45%	40.28%*	37.76%
	Asthma Medication Ratio (age 5-64 years)	62.82%	63.65%*	62.99%
Opioid	Use of Opioids from Multiple Providers (Prescribers)	20.66%	16.43%*	23.20%

	Use of Opioids from Multiple Providers (Pharmacies)	14.29%	10.36%	8.29%
	Use of Opioids from Multiple Providers (Prescribers and Pharmacies)	7.72%	4.95%	4.83%
BH	Follow Up After Hospitalization for Mental Illness-within 7 days	31.54%	29.47%	35.80%
	Follow Up After Hospitalization for Mental Illness-within 30 days	52.74%	53.87%	56.78%

*Exceeds the national average for Medicaid-HMO

4.3 Improvement by Home State Health

Table 7 shows results of medical records' compliance with CM criteria listed under MHD contract, for three years (EQR 2018-EQR 2020). (Note: The overall score for these years are not comparable due to exclusion of one of the low scoring areas from previous years, "Provider Treatment Plan" in EQR 2020.

Table 7. MRR-Compliance with CM Criteria (EQR 2018-EQR 2020)

Home State Health	OB*	EBLLs*	BH	Asthma	Opioid/SUD	Average Score**
EQR 2020	N/A	N/A	85%	92%	93%	90%
EQR 2019	92%	82%	83%	N/A	N/A	86%
EQR 2018	86%	75%	98%	N/A	N/A	86%

*Acronyms: OB-Obstetric, EBLLs-Elevated blood lead levels / **Not comparable

Response to Previous Year's Recommendations

Table 8 shows previous year's recommendations applicable to overall CM program and Home State Health's response to them. (Note: The Table does not address previous recommendations specific to focus areas which were not reviewed in EQR 2020).

Table 8. Response to Previous EQR's Recommendations

Recommendation	Action by Home State Health	Comment by EQRO
1. Enrollment date should be clearly stated in medical records. It is recommended that a member should be considered as "enrolled" when a care manager makes an assessment of the need of the member denoting "case start date."	Same observation during EQR 2020: case start date is not the same as enrollment date. However, Home State Health explained their new definition of enrollment.	Met Home State Health should consistently apply their definition of

	They consider a member to be enrolled in CM on the day a care plan is created.	enrollment to all focus areas in CM.
2. 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).	Home State Health does make calls/sends letters before closing a case in most instances.	Partially Met Home State Health should also consider visiting a family's home and checking with the PCP, other providers and programs before closing a case as UTC.
3. CM Assessment within 5 days of admission in psychiatric hospital/residential treatment program:	Home State Health has improved score from 13% to 45%.	Partially Met Most of the referrals for BH CM occur during concurrent review. Home State Health should work with the hospital authorities to secure permission for the care managers to visit patients during hospital stay so that they can engage with the member for a CM

		assessment during hospitalization.
4. Care managers should obtain written consent from the members in BH CM so that their care plan can be shared with PCPs. This is important for integration of BH and physical health. (Care managers must also recognize 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.)	Home State Health shared care plans with PCPs for less than 50% cases reviewed during MRR. They stated during an interview that BH-sensitive information was removed before sharing the care plan with PCP.	Partially Met BH care plan should be shared with PCPs after obtaining written consent from members according to instructions in 42 CFR Part 2,* as applicable.
5. The care plan submitted to the providers should receive an acknowledgement/approval from providers.	This criterion was not evaluated in EQR 2020 per MHD's instructions.	Partially Met MHD and Home State Health are working on a process to address this issue.
6. Engaging members in CM program. Deploying the right team member at the right time has a significant impact on a patient's interest in participation. Tailor messaging to different patient populations to address any unique barriers to enrollment for each.	Home State Health has made some progress in this regard. The number of BH cases closed due to "goals met" have increased from 3 to 4 in comparison to previous EQR. The number of cases closed due to "UTC" (5) and "declined CM" (1) remains the same in EQR 2020 as compared to previous year.	Partially Met

*42 Code of Federal Regulations Part 2: Confidentiality of SUD Patient Records

5.0 Recommendations

Home State Health

1. Home State Health should continue to work on the recommendations scored as "Partially Met" in Table 8.

2. Members in BH CM are neither assessed each time a case is reopened nor when a member is discharged from hospital multiple times, while being enrolled in CM.
Primaris recommends Home State Health refer to MHD contact, section 2.11.1d5 as applicable for BH CM and contact MHD for additional clarifications on the frequency of CM assessment for existing patients who have recurring episodes of behavioral issues.

3. Home State Health informed Primaris about educating their providers regarding use of asthma action plan [3] for their members in asthma CM.
Primaris recommends Home State Health audit providers' medical records at planned intervals to determine whether providers are using asthma action plan (recommended by Centers of Disease Control and Prevention (CDC)/or tailored) in managing asthma. Also, to check whether providers have adopted prescribing practices consistent with clinical practice guidelines.

4. Home State Health should address all points listed under MHD contract, section 2.11.1.e while developing a care plan for each member.

5. Primaris recommends Home State Health initiate a process that tracks all the issues related to MHD's Pharmacy unit, from start to finish, including but not limited to: date/time of encounter; who spoke to whom (with titles/roles); name and Medicaid ID of the member for whom the communication/contact was made; issue discussed; and the specific outcome. Home State Health must use supporting documentation (e.g., fax, letters); collaborate with provider services to support improving communication with the MHD Pharmacy unit; and utilize the demographic reports sent by the MHD, the providers (of record) to locate the member for CM services.

MHD

1. Care Plan: Intervention by MHD is needed to improve care plan per section 3.2 of this report.

2. Criterion: Offer CM (date of need assessment) within 30 calendar days of enrollment with MCO for new member with diagnosis/new diagnosis of existing member.
Criterion needs to be modified so that the requirement of contract wherein, "an MCO is required to conduct a risk assessment/need assessment within 30 days of notification of

[3] https://www.nhlbi.nih.gov/health-topics/all-publications-and-resources/asthma-action-plan

enrollment by the MHD" can be assessed accurately. Clear definitions of "new member" "new diagnosis" should be provided.

3. Criterion: CM Assessment within 5 days of admission in psychiatric hospital/residential treatment program.
Primaris recommends a change in the criteria by replacing "admission" with "discharge" and "business days" with "calendar days." Many members may not be in a proper mental state to engage with care managers within five days of admission. Home State Health may have several holidays/non-business days which may delay members' care.

4. Case Closure Notification: Home State Health did not send closure letters to PCPs of all adults, contrary to their practice during previous years. However, they are in compliance with the contract.
MHD contract section 2.11.1f states that a PCP must be notified in writing of all instances of children discharged from CM and the reason for discharge. MHD should provide clarification as to whether PCP notification requirement is limited to children (age limit) only and not applicable for adults.

5. The MHD should provide a minimum duration for which a CM outreach should be tried by Home State Health before case closure for "UTC" occurs.

6. The MHD should consider setting benchmarks and incentives for critical criteria in the CM program which can serve as a driving force for the MCOs to improve their efforts towards member outcomes.

Suggested Resources

1. Engaging Stakeholders in a Care Management Program. https://www.ahrq.gov/patient-safety/settings/long-term-care/resource/hcbs/medicaidmgmt/mm2.html

2. Patient Engagement. https://www.healthcatalyst.com/three-must-haves-of-an-effective-care-management-system

3. A guide for an overview of case management for substance use disorder treatment providers. https://store.samhsa.gov/product/TIP-27-Comprehensive-Case-Management-for-Substance-Abuse-Treatment/SMA15-4215. It discusses models, program evaluation, managed care issues, referral and service coordination requirements, and clients with special needs.