P.T.M.
Healthcare Business Solutions

2022 External Quality Review

Care Management

Home State Health

Measurement Period: Calendar Year 2021
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MoHealth Net

THE GREAT SEAL OF THE STATE OF MISSOURI

TABLE OF CONTENTS

1.0 OVERVIEW

The Department of Social Services, Missouri HealthNet Division (MHD) is officially designated with administration, provision, and payment for medical assistance under the Federal Medicaid (Title XIX) and the State Children's Health Insurance (CHIP)(Title XXI) programs. Missouri has an approved combination CHIP under Title XXI of the Social Security Act. Missouri's CHIP uses funds provided under Title XXI to expand eligibility under Missouri's State Medicaid Plan and obtain coverage that meets the requirements for a separate child health program. The MHD operates a Health Maintenance Organization (HMO) style Managed Care program called Missouri (MO) HealthNet Managed Care (hereinafter stated "Managed Care"). Managed Care is extended statewide in four regions: Central, Eastern, Western, and Southwestern, to improve accessibility and quality of the healthcare services to all the eligible populations while reducing the cost of providing that care. Participation in Managed Care is mandatory for the eligible groups within the regions in operation. Coverage under CHIP is provided statewide through the Managed Care delivery system.

An amendment to the Missouri constitution passed in August 2020 required the MHD to modify its Medicaid and CHIP programs to include low-income adults ages nineteen to sixty-four. The new population is called Adult Expansion Group (AEG). The MHD began enrolling AEG in the Managed Care effective Oct 1, 2021, under section 1932(a). The total number of Managed Care (Medicaid, CHIP, and AEG) enrollees in June 2022 was 1,006,657, representing an increase of 24.47% compared to the end of SFY 2021.

The MHD contracts with Managed Care Organizations (MCOs) to provide health care services to its Managed Care enrollees. Home State Health is one of the three MCOs operating in MO.

The MHD contracted with PRO Team Management Healthcare Business Solutions, LLC (hereinafter stated PTM), an External Quality Review Organization (EQRO), to conduct an External Quality Review (EQR).[1] The review period for EQR 2022 is the calendar year (CY) 2021.

2.0 OBJECTIVE

PTM reviewed Home State Health's care management (CM) program to determine the key

[1] An EQR is the analysis and evaluation of aggregated information on quality, timeliness, and access to the health care services that an MCO, or its contractors, furnish to Medicaid beneficiaries (42 Code of Federal Regulations-CFR-430.320).

drivers and issues per the EQRO contract.

Figure 1. Case Management Knowledge Framework[2]

"Case management" is a professional and collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet an individual's health needs (Figure 1). It uses communication and available resources to promote health, quality, and cost-effective outcomes in support of the 'Triple Aim,' of improving the experience of care, improving the health of populations, and reducing per capita costs of health care" (reference: Commission for Case Manager

[2] https://cmbodyofknowledge.com/content/introduction-case-management-body-knowledge

Certification).

The term "case management" is replaced by "care management" in the MHD contract and hereinafter, stated as care management (CM). The MHD required PTM to evaluate three CM focus areas in the EQR 2022:

- Individuals in foster care, receiving foster care or an adoption subsidy, or other out-of-home placement (hereinafter referred to as Foster Care CM).
- Individuals with Autism Spectrum Disorder (Autism CM).
- Children with Elevated Blood Lead Levels (EBLLs CM).

3.0 TECHNICAL METHODS

The guidelines provided in the MHD contract (version: Oct 1, 2021), section 2.11.1, Member Care Management; and section 4.7.4, Care Management, were utilized for creating evaluation tools for the CM review. Home State Health's CM program was evaluated under the following heads:

1. Policies and Procedures Review: Per the MHD contract, section 2.11.1(c)(5), Home State Health must have policies and procedures for the CM program. PTM reviewed all the documents submitted by Home State Health and reported the results in Table 1 under section 4.1 of this report.

2. Medical Record Review (MRR): PTM assessed Home State Health's ability to make all pertinent medical records available for review. Home State Health submitted a list of members care managed in CY 2021 for the three focus areas. PTM selected a sample of 30 medical records (sample size-20 and 50% oversample for exclusions and exceptions) from each focus area. A simple random sampling methodology was utilized for drawing samples (reference: CMS EQR protocols, Appendix B). PTM requested Home State Health to upload all 30 medical records electronically at PTM's secure file upload site.

An evaluation tool (Excel sheet) 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/stressors; legal issues; care planning; lab testing; progress notes/follow-up; monitoring of services and care; coordination and linking of services; the transition of care after hospitalization; transfers; and discharge plans; and case closure.

Inter-Rater Reliability (IRR): The PTM team met weekly throughout the CM review to assess the degree of agreement in assigning a score for compliance with the evaluation tools. Findings from all cases of Autism CM and EBLLs CM were reviewed, and the

discrepancies were reconciled to achieve 100% IRR. A different auditor reviewed ten percent of cases from Foster Care CM. PTM scored 100% exceeding its target of 95% IRR.

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

Inclusion Criteria:

- Foster Care CM

Anchor date: Member should be enrolled in the CM in CY 2021 for a minimum of one quarter.
Age: Based on eligibility criteria in the MHD contract (Category of Aid-COA 4).
Continuous enrollment: No break in enrollment for more than 45 days[3] with the MCO.
Event/Dx: ICD-10-CM-Z62.21/Z02.82 (must not be in CM in CY 2020).

- Autism CM

Anchor date: Member should be enrolled in the CM in CY 2021 for a minimum of one quarter.
Age: Children at least 18 months of age.
Continuous enrollment: No break in enrollment for more than 45 days with the MCO.
Event/Dx: ICD-10-CM-F84.0 (must not be in CM in CY 2020).

- EBLLs CM

Anchor date: Member should be enrolled in the CM in CY 2021 for a minimum of one quarter.
Age: Children at least one-year-old during the measurement year.
Continuously enrolled: No break in enrollment for more than 45 days with the MCO.
Event/Dx: A venous blood lead level of 10 ug/dL.

Exclusion Criteria: Failure of initial contact with the member despite exhausting all means to contact a member per the MHD contract 2.11.1(f).

Exceptions: The member does not require care management on medical grounds/criteria.

3. Evaluation of Care Plan: The MHD contract 2.11.1(e) provides guidelines for the "care plan." PTM verified all the components of the care plans Home State Health created for each member included in the sample study for the medical record review.
All care plans must address the following: use of clinical practice guidelines (including the use of CyberAccess to monitor and improve medication adherence and prescribing

[3] Days refer to "calendar days" unless specified as "business days" throughout this report.

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 care decisions; 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; and reviews to promote the achievement of CM goals and use of the information for quality management.

4. Onsite Interview: PTM conducted virtual site meetings with Home State Health officials on July 27, 2022, to assess the following:

- The knowledge of the 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.
- Clarifications from the preliminary findings during the desk review of policies and procedures and medical records carried out from Jun-Aug 2022.

Home State Health officials who attended the sessions for each CM focus area were as follows:

Foster Care CM: Vice President, Foster Care Operations; Manager, Care Management; Director, Case Management; Director, Foster Care Operations Medical Management; Senior Auditor-Clinical, Case Management; Supervisor Care Management; and Manager, External Community Stakeholder.

Autism CM: Supervisors (clinical and non-clinical), Care Management; Senior Manager, Care Management; Manager, Care Management; and Manager, Utilization Management.

EBLLs CM: Supervisors (clinical and non-clinical), Care Management; Senior Manager, Care Management; Manager, Care Management; Manager, Utilization Management; Senior Trainer-Auditor (clinical); Analyst, Compliance; Trainer, Medical Management; and Manager; and Stakeholder Engagement.

4.0 CARE MANAGEMENT PROGRAM

This section presents CM highlights based on the information submitted by Home State Health.

CM Data for CY 2021

Medicaid Managed Care members enrolled (year-end) = 299,237
Eligible population identified for CM = 23,113
Number of members identified for CM in the focus areas/enrolled =
- Foster Care: 856/75
- Autism: 212/131
- EBLLs: 495/98

CM staff available (Total) = 62
- Foster Care: 3
- Autism/Behavioral Health: 14
- EBLLs: 2

Average case load = 77 (maximum 107)

CM Program

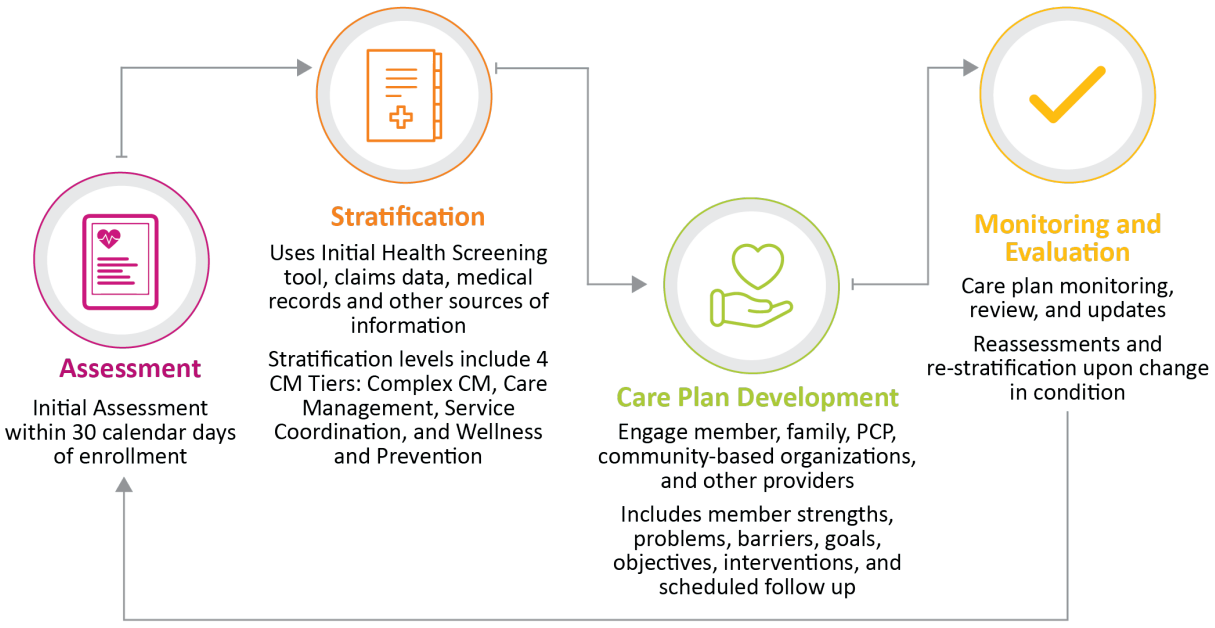

Figure 2. CM Process Flow Chart (Source: Home State Health)

Home State Health's person-centered, holistic care management approach focuses on member outreach and engagement, evidence-based care management programs, inclusive of disease management (DM), hospital care transitions (HCT) and transitions of care (TOC),

and innovative programs for improved health outcomes, and increased personal responsibility (Figure 2).

Population Identification for CM:
Members are assigned to the appropriate CM Tier based on a combination of screenings and assessments, including information from the 834 files (State enrollment files), enrollment broker's health risk assessment screening, current and historical claims, clinical and utilization data, and provider and self-referrals. Home State Health uses public and private data that includes over 140 data elements from sources such as the Centers for Disease Control and Prevention (CDC) Social Vulnerability Index, American Community Survey, Public Health Registries, CDC Chronic Disease Indicators, CDC National Environment Public Health Tracking, Public Safety Reports, USDA Food Atlas, and CDC Behavioral Risk Factor Surveillance System. These data sources create a geo-demographic and 360° risk profile for each member, indicative of the level and type of care management resources needed.

Care Gap Analytics:
Home State Health uses Interpreta Care Gap Analytics. The access is available to care managers through TruCare Cloud and to providers through Home State Health's secure Provider Portal and the Availity® Essential Plus multi-payer portal. Interpreta enables users to see care gaps and decide if the members are compliant, due, overdue, failed, or excluded.

Home State Health utilizes state-of-the-art predictive modeling software to identify members who may be at risk for high future utilization through risk score assignment. The Clinical Decision Support application is a multi-dimensional, episode-based predictive modeling and care management analytics tool that allows the Quality and care management teams to use clinical, risk, and administrative profile information obtained from medical, behavioral, and pharmacy claims data and lab value data to identify high-risk members. The Electronic Data Warehouse updates the Clinical Decision Support system bi-weekly with data, including eligibility, medical, behavioral, and pharmacy claims data, demographic data, and lab test results, to calculate and continuously update each member's risk score. The application supports the Quality team in identifying target populations for focused improvement interventions based on risk score and need.

Annually, Home State Health uses data from these systems to create a population assessment. The population assessment is used to segment the membership into appropriate Population Health Management Programs, activities, and services, e.g., CM program, disease management program, pregnancy/Start Smart for your Baby program,

and readmission reduction program.

5.0 FINDINGS

5.1 Policies and Procedures Review

Home State Health (Table 1) submitted the following policies and procedures. Upon review, PTM assigned a score of Met (), Partially Met (), or Not Met ()based on the requirements mandated by the MHD contract. (Note: Met/Not Met Definitions are adopted from CMS EQRO Protocol 3.)

Table 1. Findings: Policies and Procedures Review

Policies and Procedures must include (MHD contract, section 2.11.1(c)(5):	Met/ Not Met	Documents Submitted
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.UM.01.03 Medical Management, Quality Improvement Program Evaluation 2021.
3. Procedures for conducting provider education on CM.		MO.CM.01 Case Management Program Description.
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 developing 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.

Policies and Procedures must include (MHD contract, section 2.11.1(c)(5):	Met/ Not Met	Documents Submitted
9. A description of the methodology for assigning and monitoring Care Management caseloads that ensures adequate staffing to meet CM requirements.	●	MO.CM.01 Case Management Program Description.
10. Timeframes for reevaluation and criteria for CM closure.	●	MO.CM.01 Case Management Program Description.
11. Adherence to applicable State quality assurance, certification review standards, and practice guidelines as described in the contract.	●	MO.CM.01 Case Management Program Description.
12. A mechanism for feedback from youth in foster care or recently out of care and guardians/foster parents to inform processes and the healthcare visit schedule followed by the care managers for the individuals in foster care.	●	MO.CM.01 Case Management Program Description, Foster Care Playbook
PTM Comments	Home State Health is fully compliant. Nil recommendations.	

5.2 Medical Record Review

Table 2 summarizes the medical records included in the study for each CM focus area.

Table 2. Medical Records in the Sample Study

	Foster Care CM	Autism CM	EBLLs CM
Sample size/oversample	20	20	20
Exclusions	0	0	0
Medical records reviewed	20	20	20
Cases closed/goals met	9	6	5
Active cases (in progress)*	4	5	11

Table 3 identifies medical records' compliance with the criteria required in the MHD contract, as applicable to all three CM focus areas.

Table 3. Compliance (%) with CM Criteria

Evaluation Criteria	Foster Care CM	Autism CM	EBLLs CM
Placement in Foster Care	40	N/A	N/A
Referral/Notification (State)	10	N/A	N/A
Referral/Notification (all sources)	*100	100	100
Initial screening within 72 hours of placement (within 24 hrs. for younger, chronic condition (by provider)	0	N/A	N/A
Initial Blood Lead Level	N/A	N/A	100
Offer CM (Assessment) within 30 days of notification from the State (new member)*	50		
Offer CM (Assessment) within 30 days or within the contractual timeframe for EBLLs from any source notification	70	90	5
Medical history	100	100	95
Psychiatric history	100	100	90
Developmental history	95	100	90
Psychosocial/Trauma history	100	100	90
Dental health	70	N/A	N/A
Legal issues	100	100	100
Education needs	100	N/A	N/A
Immunization history	100	N/A	N/A
Follow-up assessment in 60-90 days of placement (by a provider)	0	N/A	N/A
Health Encounters-three in the first three months of foster care (all ages)-by a provider	0	N/A	N/A
Assessment within 30 days of discharge from hospital or rehab. facilities after readmission or stay of more than two weeks or three Emergency Department (ED) visits in a quarter/within five business days of admission to a psychiatric hospital or substance use treatment program	73	47	N/A

Evaluation Criteria	Foster Care CM	Autism CM	EBLLs CM
Confirmatory venous lead level within the contractual timeframe	N/A	N/A	100
Family encounter#	N/A	N/A	40
Follow up Family encounter#	N/A	N/A	68
Care plan	100	100	95
Care plan updated	100	100	100
Sharing health information with birth parents, guardians, attorney, court, and school/involved in the care plan	100	100	95
Progress notes (follow-up)	100	100	100
Lab tests/follow-up tests within timeframes for EBLLs	100	N/A	65
Provider treatment plan	100	90	60
Transfer	100	100	100
Monitoring services and care, medication adherence	100	100	95
Coordination and linking of services	100	100	95
Behavioral health services availed	100	N/A	N/A
Discharge plan	44	40	22**
PCP notification of case closure	56	7	56**
Member closure letter	N/A	N/A	56**
Aggregate Score	**76**	**87**	**80**

Red highlighted figures (score < 75%) indicate areas for improvement.
*For informational purposes, not included in calculating the aggregate score.
**Small denominator (9 cases) as cases are not closed for UTC per the MHD's instructions.
Telephonic encounters replaced face-to-face encounters due to the Covid-19 pandemic.

5.3 Evaluation of Care Plan

Home State Health meets all the contractual requirements for creating a care plan based on the MHD contract, 2.11.1(e), listed earlier in this report (section 3.0). 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 reviewed at least quarterly; however, the frequency varies per the level of risk stratification. The care managers explain the CM rationale and relationship, the circumstances under which the information can be disclosed to third parties, and the complaint process. PTM does not have any issues to report.

6.0 ANALYSIS AND CONCLUSIONS

6.1 Issues and Recommendations

PTM analyzed the MRR results and categorized the issues in the domain of Quality, Timeliness, and Access to Care as follows (Tables 4-6). PTM provided recommendations for improving each issue.

Table 4. Foster Care CM Review: Issues and Recommendations

Foster Care CM Issues	Recommendations
1. Criterion: The date of placement of a child in Foster Care. **(Timeliness)** Home State Health did not know this information for 60% of cases. Home State Health informed PTM that the State did not provide the placement dates.	Home State Health must work with the MHD* and Children's Division to receive the information on the placement of a child in COA 4 for effective CM (tracking initial screenings and health encounters by the providers).
2. Criterion: Referral/Notification dates. **(Timeliness)** The State notifications were captured by the Home State Health for 10% of cases even though they received 834 files from the State daily. The referral sources to initiate the outreach to the members were mainly internal notifications from Utilization Management reports.	Home State Health should maintain an accurate record of State notifications (834 files) about COA 4 members and start outreaching them for timely assessing the needs of COA 4 members.
3. Criteria: Initial screening within 72 hours/24 hours of placement (by the providers); three encounters within the first three months of placement; and follow-up health assessment within 60-90 days of placement. **(Timeliness)** Home State Health did not track these criteria as the placement date was unavailable. Also, Home State Health informed PTM that they were not required to track and report these criteria to the MHD from the last quarter of CY 2021. (An e-mail communication from the MHD, dated Oct 19, 2021, was submitted).	Home State Health and the MHD* must work towards addressing these three criteria. The MHD* must amend its managed care contract, section 2.11.1(d)(3), if the MHD does not require Home State Health to report on these criteria.
4. Criterion: Comprehensive assessment within 30 days of notification/enrollment. **(Timeliness)** Home State Health complied with the timeframe for 70% of cases when they received a notification from any referral source. Home State Health's compliance for	Home State Health must initiate its CM activity as soon as it receives notification from the State on the 834 file-COA 4 eligibles.

Foster Care CM Issues	Recommendations
assessing the Foster Care members following the State notifications was for 50% of cases (1 of 2 cases-small denominator).	
5. Criterion: Assessment. **(Quality)** Home State Health assessed its enrollees' dental health needs only for 70% of cases. Trauma history was limited to merely asking about any scary or upsetting things that happened to the member or family members. PTM acknowledged that dental education was a part of a care plan for all CM members. PTM noted that the Home State Health captured the start date of an assessment as the date on which a care manager began an outreach to a member. There were several unsuccessful attempts before a CM assessment was conducted.	The columns in the assessment should not be left blank even if the caregivers were unwilling to provide the information. The outcome of the encounter with the caregivers should be documented. Detailed trauma history should be elicited. The assessment's start date should be when a member is available for an assessment.
6. Criterion: Assessment within 30 days of discharge from hospital or rehabilitation facilities after readmission or stay of more than two weeks or three emergency room visits in a quarter/within five business days of admission to psychiatric hospital/residential Substance Use treatment program. **(Timeliness)** Home State Health was compliant for 73% of cases. The post-discharge assessment was not conducted for the remaining members due to UTC.	Home State Health should have a system of inpatient admission and discharge notifications from its providers so that timely post-discharge assessments can be conducted. A member's contact information must be obtained during the member's hospital stay. The MHD* must notify Home State Health about IP admissions and discharges in real-time so that Home State Health can outreach the caregivers for post-discharge assessment within the contractual timeframe.
7. Criterion: Case Closure-Lost Opportunities **(Access to Care)**	Maintaining an accurate record of member contact numbers and motivating them by demonstrating the

Foster Care CM Issues	Recommendations
Home State Health could not complete CM services, including discharge planning, in 56% of cases as they were unable to contact (UTC) the members or members refused CM. PTM noted that the cases were closed as "goals met" without discharge planning and contacting the members (2 of the 7 UTC cases).	value of the CM program is the key to successful care coordination. PTM recommends that any case should not be closed before three months of unsuccessful outreach attempts.** Additionally, Home State Health must check with the PCPs, Women, Infants, and Children (WIC), and other providers and programs and visit members' homes before closing a case for UTC.
8. Criterion: PCP notification about case closure explaining reason and condition at discharge. **(Quality, Timeliness)** Home State Health notified providers in 56% of cases about the case closure/goals met.	A written notification to the PCPs must be provided to comply with the requirements. Staff must be trained to document the date of communication with the PCPs in the medical records.

*Recommendations apply to the MHD.

**Adapted from the MHD contract, section 2.12.10 (d): The health plan shall make its best effort to conduct an initial screening of each member's needs within 90 days of the effective date of enrollment for all new enrollees, including subsequent attempts if the initial attempt to contact the member is unsuccessful.

Table 5. Autism CM Review: Issues and Recommendations

Autism CM Issues	Recommendations
1. Criterion: Assessment within 30 days of discharge from hospital or rehabilitation facilities after readmission or stay of more than two weeks or three emergency room visits in a quarter/within five business days of admission to psychiatric hospital/residential Substance Use treatment program. **(Timeliness)** Home State Health complied for 47% of cases, as applicable. There was no post-discharge assessment or a delay in assessment for the remaining cases.	Home State Health's Hospital Care Transition (HCT) team should coordinate with the utilization management team and care managers for the discharge dates and latest member contact information. The HCT team should educate the members on the significance of CM and motivate them. The care managers should be trained to promptly outreach the members for a post-discharge assessment or an assessment within five

	business days of admission to a psychiatric hospital as applicable.
2. Criterion: Case Closure-Lost Opportunities. **(Access to Care)** Home State Health could not complete CM services, including discharge, planning in 60% of cases due to UTC.	Maintaining an accurate record of member contact numbers and motivating members by demonstrating the value of the CM program is the key to successful care coordination. PTM recommends that any case should not be closed before three months of unsuccessful outreach attempts. Additionally, Home State Health must check with the PCPs, Women, Infants, and Children (WIC), and other providers and programs and visit members' homes before closing a case for UTC.
3. Criterion: PCP notification about case closure explaining reason and condition at discharge. **(Quality, Timeliness)** Home State Health notified providers in 7% of cases about the case closure/goals met.	A written notification to the PCPs must be provided about case closure, the reason for closure, and the member's condition at the time of discharge. The staff must be trained to document the date of communication with the PCPs in the medical records.

Table 6. EBLLs CM Review: Issues and Recommendations

EBLLs CM Issues	Recommendations
1. Criterion: Offer CM and complete an assessment within time frames for blood lead levels.* **(Timeliness)** The assessment was conducted for 85% of cases, but timeliness was achieved only in 5% of cases.	To reduce the number of unsuccessful contact attempts and increase member participation, the care managers must obtain a date and time for future communications on initial contact.
2. Follow-up lab testing within the contractual time frame.** **(Timeliness)**	Same Recommendation as above.

All members had a follow-up blood lead level tested. However, only 65% of members were tested within the contractual timeframe.	
3. Criteria: Family encounter (Face-to-Face/Telephonic) within two weeks of confirmatory venous blood lead level and second encounter within an interval of three months. **(Quality and Timeliness)** First and the second family encounters (telephonic) were completed timely in 40% and 68% of cases, respectively, to provide lead poisoning education, family/member assessment, develop a care plan, and deliver CM's name and phone number and assess member's progress, reinforce education and medical regimen. Both encounters were made in almost all cases (19 of 20), but they were delayed due to several UTC attempts.	Same Recommendation as above.
4. Criterion: Inform the members about CM rationale and relationship, circumstances of disclosure to third parties, and complaint process. **(Quality)** Home State Health followed the requirements only in 25% of cases.	All the members enrolled for CM must be provided with the information listed in the criterion. The information can be included in the letters mailed to the members. The care managers must be trained to document the requirements in the medical records.
5. Criterion: Provider treatment plan/collaboration with providers ensuring health needs are assessed. **(Quality, Access to Care)** A letter about member enrollment in the CM program and a copy of the care plan were shared with the providers in 60% of cases.	Care plans must be shared with the providers for their input via letters, online provider portal, or faxes, and the care managers must be trained to document in the medical records.
6. Criterion: Case Closure-Lost Opportunities **(Access to Care)** Home State Health could not complete the CM services, including discharge planning, in 78% of cases due to UTC.	Maintaining an accurate record of member contact numbers and motivating them by demonstrating the value of the CM program is the key to successful care coordination.

	PTM recommends that any case should not be closed before three months of unsuccessful outreach attempts.** Additionally, Home State Health must check with the PCPs, Women, Infants, and Children (WIC), and other providers and programs and visit members' homes before closing a case for UTC.
7. Criterion: PCP notification about case closure explaining reason and condition at discharge. **(Quality, Timeliness)** Home State Health submitted evidence of notification to the providers in 56% of cases about the case closure/goals met.	A written notification to the PCPs must be provided about case closure, the reason for closure, and the member's condition at the time of discharge. The staff must be trained to document the date of communication with the PCPs in the medical records and save a copy of the letter sent to the providers.
8. Criterion: A member closure letter must include the date of discharge, the reason for discharge, lab results, member status, exit counseling (telephone number for member assistance, and the status of care plan goal completion. **(Quality, Access to Care)** Home State Health submitted evidence of notification to the members about the date of discharge, lab results, medical condition, and exit counseling in 56% of cases.	The care managers must be educated to comply with the MHD contract, section 2.11.1(e)(5). They must send a case closure letter to the member, save a copy as evidence, and document it in the medical records.

*EBLL: 10 to 19 µg/dL within one to three (1–3) business days; 20 to 44 µg/dL within one to two (1–2) business days; 45 to 69 µg/dL within twenty-four (24) hours; 70 µg/dL or greater – immediately.
**Follow up: 10-19 µg/dL – two to three (2-3) month intervals; 20-70+ µg/dL – one to two (1-2) month intervals.

6.2 Key Drivers

PTM concluded the following strengths from the MRR and staff interviews **(Domain: Quality, Timeliness, and Access to Care)**.

- Detailed care plan per clinical practice guidelines to include all aspects of care, e.g., immunization, medication adherence, lab tests, and transportation services.

(CyberAccesssm is State's web-based, HIPAA-compliant tool that allows Home State Health to view drug utilization information in near real-time.)

- Monitoring, coordinating, and linking services with community resources, e.g., homestatehealth.auntbertha.com and the Home State Health app.
- Educating members on PCP, Urgent Care vs. ED Utilization, Rewards card, dental and vision services, transportation services, and Nursewise (24 hours Nurse Advice Line).
- Providing information about psychiatrists and counselors. Tracking and helping in scheduling appointments with the providers.
- Training care managers regarding linguistic and cultural competency.
- Provider engagement by sharing care plan as evident in Foster Care and Autism CM.

6.3 Improvement by Home State Health

CM review was not an assigned activity during the previous year (EQR 2021). However, in EQR 2020, the aggregate score for CM review was 90% compared to 81% in the current EQR 2022. Table 7 shows the scores for each focus area from EQR 2020-2022.

Table 7. Medical Records Compliance (EQR 2020-2022)

EQR/Focus Area	Foster Care	BH/Autism	EBLLs	Asthma	Opioid/SUD	Average Score
EQR 2022	76%	87%	80%	N/A	N/A	81%
EQR 2021	N/A	N/A	N/A	N/A	N/A	N/A
EQR 2020	N/A	85%	N/A	92%	93%	90%

PTM obtained the following data from Home State Health to see if the CM program impacted the quality, timeliness, and access of care to its members (Table 8).

Table 8. Assessing CM Impact: Quality Indicators

Quality Indicators	MY 2019	MY 2020	MY 2021
Inpatient Visits/1000 members	105	109	100
ER visits/1000 members	674	644	454
Lead Screening in Children	62.4%	62.5%	56.4%
FUH-7 days	29.5%	30.6%	23.2%
FUH-30 days	53.9%	51%	41.5%

Green: improvement/Red: decrease in performance compared to the previous year.

Response to Previous Year's Recommendations

As stated above, PTM did not review CM Program in EQR 2021. Therefore, there were no recommendations. However, in EQR 2020, EQRO provided recommendations for Behavioral Health CM that apply to Autism CM as well. Table 9 shows the degree to which Home State Health responded to EQRO's recommendations from EQR 2020. The actions taken by Home State Health were evaluated and categorized as follows:

- High (Two Points): MCO fully addressed the recommendation, complied with the requirement, and PTM closed the item. (Overall score > 90%)
- Medium (One point): MCO partially addressed the recommendation, the same recommendation applies, or a new recommendation is provided, and the item remains open. (Overall score 75-89%).
- Low: (Zero points) Minimal action/no action was taken, the same recommendation applies, and the item remains open. (Overall score <75%).

Table 9. Home State Health's Response to Recommendations from EQR 2020

Recommendation	Action by Home State Health	Comment by EQRO
1. CM Assessment within five business days of admission to psychiatric hospital/residential treatment program.	Home State Health's performance increased marginally from 45% (EQR 2020) to 47% (EQR 2022).	**Low** The issue persists. PTM has provided recommendations in Table 5 (issue 1).
2. The care plan should be shared with the providers and informed about how they can provide input or change the care plan.	This criterion was not evaluated in EQR 2020 per the MHD's instructions. In the EQR 2022, compliance is 90% for Autism CM.	**High** Home State Health should apply the same efforts to all focus areas. EBLLs CM is scored at 60% for the same criterion.
3. PCPs should be notified about case closure per instructions in the MHD contract, section 2.11.1(f).	The compliance dropped from 20% (EQR 2020-BH CM) to 7% (EQR 2022-Autism CM)	**Low** The issue persists. A recommendation is stated in Table 5 (issue 3).
4. Home State Health should address all points listed under the MHD contract, section 2.11.1(e), while developing a care plan for each member.	Home State Health created a care plan template meeting all contractual requirements and utilized it for CM.	**High**
5. Home State Health initiates a process that tracks all the issues	Home State Health educated staff members	**High**

related to the 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 improve communication with the MHD Pharmacy unit, and utilize the demographic reports sent by the MHD and the providers (of record) to locate the member for CM services.	on outreaching the pharmacies, including the member on the calls, and utilizing Home State Health's pharmacy director to assist when needed. While Home State Health continues to build on that relationship, there has been an improvement in communication and collaboration over the past two years.	PTM did not see any notation of pharmacy issues in the MRR.

The degree of Home State Health's response to the previous year's (EQR 2020) recommendations was assessed to be 50% (Table 10).

Table 10. Scoring Degree of Response						
Total	High	=	2	×2	=	4
	Medium	=	0	×1	=	0
	Low	=	2	×0	=	0
Numerator	Score Obtained					4
Denominator	Total Sections	=	4	×2	=	8
Overall Score= Low						**50%**

7.0 RECOMMENDATIONS

Home State Health

1. Home State Health must address the recommendations listed in Tables 4, 5, and 6 for the three focus areas. Also, "Low" scored criteria from the previous year's recommendations (Table 9) must be addressed.

2. PTM recommends that Home State Health children receive a complete mental health evaluation, including a trauma assessment, shortly after entering foster care. A mental health screening to assess suicide risk and acute mental health needs is important at the entry to care. Still, a complete evaluation is probably best conducted after the child has had

some time to adjust to their new living situation and visitation with the family.[4]

3. PTM recommends that the Home State Health CM team utilizes the Health Information Exchange (HIE) to increase coordination, reduce fragmentation and improve overall communication between care providers. All Missouri Medicaid providers have been offered free HIE enrollment.

MHD

The recommendations that apply to the MHD are provided in Table 4 (marked as *). Below are additional recommendations:
1. Criterion: CM Assessment within five business days of admission to psychiatric hospital/residential treatment program.
PTM recommends a change in the criteria by replacing "admission" with "discharge" and "business days" with "calendar days." Members may not be in a mental state to engage with care managers within five business days of admission. Home State Health may have several holidays/non-business days at the corporate level, which may delay members' care.

2. Case Closure Notification: The MHD contract section 2.11.1(f) states that a PCP must be notified in writing of all instances of children discharged from CM and the reason for discharge. The MHD should clarify whether the PCP notification requirement is limited to children (specify age limit) only and not applicable to older members.

3. The MHD should provide a minimum duration for Home State Health care managers to continue outreach before a case is closed for "UTC."

4. The MHD should consider setting benchmarks and incentives for critical clinical criteria in the Foster Care CM program, which can serve as a driving force for Home State Health to improve its efforts toward member outcomes.

5. Federal legislation, the Fostering Connections to Success and Increasing Adoptions Act (Pub L No.110-351 [2008]), requires that states, in consultation with pediatricians and other health experts, develop systems for health oversight and coordination for children in foster care. This act outlines the important pieces of coordinated care: periodic health assessments, shared health information, provision of care in the context of a medical home, and oversight of prescription medications (particularly psychotropic drugs).

[4] Health Care Issues for Children and Adolescents in Foster Care and Kinship Care 2015, American Academy of Pediatrics.

Note: PTM acknowledged the change in the MHD contract effective July 1, 2022, and the alignment of EBLLs guidelines for CM with the CDC recommendations. These guidelines did not apply to the MCO in EQR 2021.