MO HEALTHNET MANAGED CARE
QUALITY ASSESSMENT & IMPROVEMENT ADVISORY GROUP
October 18, 2018
Harry S. Truman Building
301 West High, Room 490
Jefferson City, MO 65101

MO HealthNet Division
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Dr. Eric Martin
Rebecca Logan
Lori Bushner
Renee Riley
Mary McCleary
Kim Morgan
Amy Kelsey
Dr. Timothy Kling
Brenda Shipman
Melody Webb
Elizabeth Sissom
Beth Stokes
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Teresa Wortmann
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Home State Health Plan
Megan Barton
Dr. Sharon Deans
Douglas Watts
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Missouri Care
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MO Health Plus
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Children's Mercy Pediatric Care Network
Shanna Widener

Mid-MO Legal Services
Steve Kuntz

Legal Services of Eastern Missouri
Tiajuana Henderson

Legal Services of Southern Missouri
Kevin Luebbering

Legal Services of Western Missouri
Maura Weber

Missouri Coalition for Community Behavioral Healthcare
Rachelle Glavin

Other Agencies
Sam Joseph
Tracy Behnam
Amy Schwartz
Joe Cini

Community Care Missouri
Amber Dixon
Erica Immenschuh

Agenda Items	Discussion	Actions
Welcome **Introduction** **Minutes**	Mark Kapp, Missouri Care, MO HealthNet Managed Care Quality Assessment & Improvement Advisory (QA&I) Group Chair, opened the meeting at 9:00 am. Mark Kapp requested a motion to approve the minutes from the June 2018 meeting. A motion was made and seconded and the minutes were approved.	
Director Updates **Bobbi Jo Garber** **Rebecca Logan**	Bobbi Jo reiterated the plan that there are two bi-annual meetings for QA & I, and she believes it is working out well. It gives us time to process the information in between the meetings. The Department of Social Services (DSS or Department) has recently awarded a contract to McKinsey to work on rapid transformation for Medicaid. The process was stalled but started about a week and a half ago. This has created some additional work in the Department and the MO HealthNet Division (MHD). Bobbi Jo asked that everyone bear with us during the four-month process as we need to schedule a lot of meetings. There are approximately 15 people onsite from McKinsey; meeting with staff, working through processes and service packages, and looking for opportunities for improvement. Dr. Samar Muzaffar has resigned her position as Chief Medical Officer (CMO) for the MHD, and she has returned to Arkansas. We have no replacement as of yet, and Dr. Timothy Kling is the Interim CMO while Dr. Eric Martin is working on the Behavioral Health side. Bobbi Jo expressed her appreciation with everyone for helping her out this past year as she was new in her position. She also discussed putting together special workgroups and stated that there will be a couple of breakout sessions in the afternoon after this meeting. She states that people are welcome to stay and participate as we are wanting voices at the table for these sessions. Bobbi Jo stated that the Encounter Data Workgroup will likely be an ongoing workgroup. This workgroup has made some progress, with more work that needs to be done. Rebecca Logan announced that Brenda Shipman is retiring after 22 years of service. At one time, Brenda had her own daycare center, was the liaison for the Head Start Program, and worked at the Futures Program in the Family Support Division (FSD) training people for jobs. Brenda's primary responsibility at the MHD has been with the Consumer Advisory Committee (CAC) in the Managed Care (MC) Unit, and also with the marketing and policy compliance for many years. Rebecca talked about how one plan would send their national materials to Brenda for review before sending them to other states due to how thorough Brenda was with her reviewing of submitted	

	materials. Rebecca also stated that the previous director, Jay Ludlum, also relied on Brenda for her quick answers to numerous questions. Bobbi Jo turned the discussion to the MC Contracts. We serve children, pregnant women, and we have discovered through research that there were "Aged, Blind, & Disabled (ABD)-like" people in MC. In our research, out of 7,028 individuals receiving SSI, 80 of those are adults, and of those there are 20 that are already being worked by DSS through ex parte to determine their eligibility for ABD Medicaid. Those 20 will likely be moving to Fee For Service (FFS). If there are higher cost individuals, we need to work with Mercer to adjust the rates. MO is only one of a few states that are 209B states, and the Affordable Care Act (ACA) was written for 1634 states (they use SSI to determine disability, and we use the medical review team). CMS agrees that there is conflicting information in the regulations and the intention is not to have those individuals in MC, but since they are Modified Adjusted Gross Income (MAGI) eligible we cannot just move them to Fee-For-Service (FFS) and change their eligibility to ABD because we also need to know their assets, resources, etc., to confirm ABD eligibility. We are in the process of drafting letters with FSD to send to these individuals to obtain information on resources, assets, etc. If those people are eligible we will give them 30 days and then transfer them to FFS. This process will take a while, and we will be working with Mercer in the meantime to adjust the rates. FSD will train staff to review applications to determine if they are SSI eligible and can be processed as ABD applications. Tiajuana Henderson from Legal Services of Eastern Missouri stated that a lot of the children that are covered are disabled and receive certain services (e.g., care management) under MC that they do not get under FFS. She was concerned that families would not be allowed to choose between MC and the MO HealthNet for Disabled Children Program. Bobbi Jo clarified that they will not be forced to move to FFS, but they can remain in MAGI if they choose to. She also stated that we are in the process of reviewing draft letters and will confirm that all appropriate information is included. They can get other services under other programs, and we want to inform them of that as well. We will be talking to FSD about this and will stay in touch with Legal Services before we send letters out.
Quality Improvement Strategy and HEDIS **Amy Kelsey**	We have updated the Quality Improvement Strategy (QIS) because of the CMS requirement for an update by July 2018. It is a general plan for MC as a whole and goals are not intended for any individual health plan. The QIS was last updated in 2013, and it was due for reexamination. We had just extended MC statewide, added a new plan, and are revising Performance Withhold program. We reviewed the 2013 strategy and looked at how we did on the previously set goals and to improve the

	readability. Previous CMS guidance had resulted in a clunky report, and since they loosened up those rules we were able to make it a shorter and easier to digest. We posted a draft for public comments, and we also sent the draft to specific reviewers (Legal Aid, MCOs, and Primaris). We revised the goals somewhat, cut about 25% of the measures, and included HEDIS measures primarily but a few others as well. In the past we had 40 measures, and now we have 29. The HEDIS measures chosen are also included in the new Performance Withhold program. We added additional items of interest such as the Consumer Assessment of Healthcare Providers and Systems (CAHPS) data. For all measures, we set a general target of two percentage point improvement per year, or a six percentage point improvement by 2021and/or to reach the national median by 2021. We would like to review this annually and do some more reporting. If we look more frequently we can update as needed instead of every three years. The QIS currently only talks about the MC, but we want to add FFS eventually to align better across all of Medicaid. Two documents are currently on the website for review: 2018 QIS and the systematic evaluation of the past QIS. These documents will be marked draft until they have been reviewed by CMS. Steve Kuntz asked what happens if the QIS targets are not met. Amy responded that it is a general strategy, more like a vision. The MHD is the primary body responsible for the QIS, with the MCOs responsible for individual measures within the QIS. Bobbi Jo noted that we have those targets and will continuously monitor status and decide whether we need to stretch targets faster, or change them, etc. Bobbi Jo states there is no specific consequence or penalty for not meeting them; it is just a goal that you re-evaluate.
Show Me Healthy Babies/CHIP Report **Amy Kelsey**	These reports were completed and sent to the Governor and legislature. Amy stated that we can look for them to be posted in the near future.
External Quality Review (EQRO) **Vickie Alexander**	Brief update on the EQRO evaluations so far. The reports are done, draft reports have been submitted to state as well as the MCOs. We have received feedback and are reviewing and revising the final reports. We estimate it will take about 45 days to make the changes with the final reports due December 15th. At that point they are public record and the state sends them to CMS and posts them. We provided technical assistance with United HealthCare since they are a new plan this year. They will have a full evaluation next year and have put together a timeline for next year. This year was abbreviated due to late contract start, but everyone did a great job accommodating the condensed year. Next year will be on a regular schedule starting in January. Activities will be done at a pace that does not involve all 3 health plans at the same

	time. Timeline will be sent once the MHD approves it, and MCOs should let EQRO know as soon as possible if there are any anticipated conflicts with the schedule/timelines. The timelines will be adhered to once they are finalized. Mark Kapp asked how the timeline works with the fact that MCOs evaluate HEDIS 2018 (CY 2017). Vickie responded that the EQRO has a certified HEDIS auditor on staff and he has certified the timelines. Primaris will share the timeline in advance for review by the MCOs. Mark stated that they will not have performance measures data available until after June. Vickie stated the EQRO has noted this. EQRO has identified some areas of commonality that has been shared with the MHD regarding 834 files and problems with incorrect demographic data and its impact on effective Care Management (CM), etc. We continue to discuss with the MHD any challenges that affect all the MCOs and that are barriers for the MCOs. A full day of meetings with the MHD will be scheduled in the near future to discuss these sort of things. Another important item is the notification of key employee changes as per the contract. These changes need to be notified to the MHD as well as EQRO. The changes need to be in writing, so please let EQRO know as soon as possible of any changes that have occurred. Health plans have five days to notify the MHD and the EQRO of changes. Finally, the CMS protocols are not created by the EQRO and Primaris does not have much input into them. These are federal regulations that override local contracts. They use these protocols when writing reports, evaluating findings, etc. EQRO will notify the MHD to share with MCOs any changes that they are aware of in the protocols. Network adequacy has seen significant changes, for example, so pay particular attention to these. Steve Kuntz asked how the state's QIS works with the review that the EQRO is doing. Vickie stated that the EQRO looks at different documents to set up their work plan like federal protocols, current MCO contract, amendments or other changes, and the QIS. Up until recently, it was a very old document from 2013, but now we have the new 2018 one. If there are any elements that conflict, we will discuss them with MHD. There were some parts of the contract that had been amended and were unclear, so we have asked for a redline version of the contract showing changes, when effective, etc.
2017 MCO-Specific Birth Indicators Report	Wayne went through the figures on the CY2017 report with indicators by MCO and region.

Wayne Schramm	Vickie Alexander asked if tenure with MC enrollment is considered in his rates. Wayne stated that there are standards that consider enrollment for inclusion in the rates. Those continuously enrolled tend to have poorer rates, probably due to low socio-economic status.	
New Programs **Complementary and Alternative Therapy for Pain Management** **Beth Stokes**	New services are being added as the first line of therapy instead of opioids. These services include physical therapy (PT), chiropractic, acupuncture, and cognitive behavioral therapy (CBT). The risk level will determine the therapy limits and will need a qualifying diagnosis. Regulations are out for approval. The State Plan Amendment (SPA) has been reviewed by CMS, and they are working out the requested changes. The Public Comment period ended yesterday, and providers can now enroll via a paper enrollment. Services will start in February, and there is hope that a bulletin will be released next month. Megan Barton asked about codes for the new services and how the process will work. Beth stated that the new codes will be in the bulletin. PT is currently offered but not a paid-for service, but they can get it with the proper diagnosis. Rebecca Logan stated that guidelines will be in the manual that the MCOs will generally mirror. A meeting is coming up to discuss requirements for MCOs in this regard. Details are still to be decided, but guidelines will be in the provider manual. This will become a contract amendment, and please let us know if there are issues from the MCOs.	
New Programs **Diabetes Prevention Program Services** **Lori Bushner**	Looking at national evidence regarding diabetes/prediabetes, more than 84 million Americans have prediabetes, which is 1 in 3. In the last 20 years the number of adults diagnosed has tripled. CDC has put together a curriculum, and we hope to provide coverage for that program. It is a very prescriptive curriculum. The program is actually a 12-month program, and participants have to agree to take on the program when they enroll. There is a minimum of 22 sessions required to attend, and they are usually an hour long. In the first six month, they happen bi-weekly, and in the 2nd 6 months they occur about once a month. We are looking at making it a maximum of 26 sessions required in one year. Enrollment process for the program requires a physician's approval utilizing criteria set forth by the CDC. The physician will need to seek prior authorization for the services.	https://www.cdc.gov/diabetes/prevention/prediabetes-type2/index.html
New Programs **Proposed Coverage**	According to the United States Preventive Task Force more than 35% of adult men and 40% of adult women are obese. Approximately 17% of children and adolescents have obesity, and almost 32% are overweight.	https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/obesity-in-adults-interventions1

for Biopsychosocial Treatment of Obesity **Lori Bushner**	The overall goal is to improve health outcomes for both the youth and adult population by managing obesity and associated co-morbidities, including the prevention of comorbidity, such as diabetes. The intent is to provide integrated medical nutrition and behavioral health services, coordinated by the primary care physician, to facilitate behavior changes to manage obesity and associated co-morbidities. Eligible Medical Nutrition Therapy (MNT) Service providers must be a licensed dietician and have a certificate in Training for Adult Weight Management or Training for Child and Adolescent Weight Management. Eligible Intensive Behavioral Therapy (IBT) providers must be a licensed Psychiatrist, Licensed Clinical Social Worker, Licensed Psychologist (LP), or Licensed Professional Counselor (LPC) and have a specialist certification for working with participants with obesity. All providers must be enrolled as MO HealthNet providers. Amy Schwartz asked if the intent is that this program will need to be completed before someone can get, e.g., bariatric surgery; or is it just an additional offering and how providers become approved? Lori stated that it is just an additional service, an alternative to bariatric surgery. Providers enroll the same as any other Medicaid provider.	https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/obesity-in-children-and-adolescents-screening1
New Programs **Medication Assisted Treatment (MAT)** **Eric Martin**	This is not a new program, but we have goals to increase access to MAT for Substance Use Disorder (SUD). An evidence-based practice, and really the gold standard for opioid use disorders in particular, involves medication and counseling. The MHD pharmacy benefit covers all of the medications used for SUD. MCOs also cover behavioral health counseling. Megan Barton asked which providers opted out of being on the Substance Abuse and Mental Health Services Administration (SAMHSA) database? Eric stated that he has received aggregated data not individual provider data right now. He will investigate whether individual data is available.	https://showmeecho.org/ https://pcssnow.org/
New Programs **Mental Health Parity Update** **Eric Martin**	We are moving forward with adding coverage for Licensed Marital and Family Therapists (LMFT). A SPA has been submitted and is pending approval, but we hope to be able to start in January 2019. Daily, monthly, and annual limits are changing to soft limits that can be exceeded when medically necessary (e.g., 5 per month of individual psychotherapy). We will have a review process for medical necessity on the FFS side, and we assume the MCOs will do the same.	

New Programs **Community Health Worker Preventive Services** **Elizabeth Sissom**	MO HealthNet is planning on providing coverage and reimbursement for preventive services that are provided by a Community Health Worker (CHW). SPA and regulations have been drafted. A new CMS rule from 2014 allows for non-licensed persons to bill Medicaid. CHW are integrated members of a health care team, and are trusted members of the community being served. They provide linkages between communities and the health care system; provide health education and information; provided informal counseling; and, build individual and community capacity. The CHW pilot program has shown reductions in ED visits and hospitalizations. We hope to start the program in July 2019. Participants must be in a Health Home or a nationally accredited Medical Home, be identified as a high utilizer, and have a specified medical or behavioral health diagnosis. Providers must be certified as a CHW by the Missouri Credentialing Board or have a CHW certificate from an accredited institution of higher education. Current CHWs without the certificate will be "grandfathered" in. Megan Barton asked if the CHWs be employed by the Health Homes. Elizabeth said that will be employed by the Health Home or the Medical Home. Eric Martin clarified that the CHW is not necessarily in a Health Home, but in a practice that has a medical home accreditation.	https://www.cdc.gov/dhdsp/docs/chw_brief.pdf https://bhw.hrsa.gov/sites/default/files/bhw/nchwa/projections/communityhealthworkforce.pdf
New Programs **Home Births** **Melody Webb**	The MHD wants to be sure that health plans have a good plan in place for members that intend to have a home birth. Often these are last minute notifications. Melody encourages the MCOs to talk to Constituent Services and make sure they know the process or provide her with a contact person. Also, when making the initial contact with a pregnant member, ask if they want a home birth and tell them that they need to let the plan know so arrangements can be made. Midwives are covered in the member handbook, but home births are not. If anyone has any questions they can contact Melody at any time for further clarifications on home births. Dr. Sharon Deans asked if someone with a history of serious complications who still wants a home birth. Melody answered that the MCO must educate the member on the pros and cons, but it is the member's choice. Dr. Kling added that the patient signs a waiver when they request a home birth. It is their choice even if they have a complicated history. Melody stated that she always makes sure that they are aware that they are covered by FFS and can always go to the nearest hospital and seek regular services if they change their mind, even at the last minute.	

	Bobbi Jo Garber wanted to be sure that we have presented information on these programs well in advance of their start date in order to make sure the plans have the information in advance, can think about it, contact us if there are questions, help us make sure the bulletins are clear and contain all the necessary information. But there will be comprehensive services and will be things that we want the MCOs to cover also.
Break for Lunch	Lunch from 11:30am to 12:30pm
Legal Aid **Maura Weber**	Advocates for Family Health (AFH) advocates for members of MO HealthNet for Kids, etc. We have quarterly conference calls with MHD. Some of the trends and issues are 75% of clients sought AFH assistance regarding CHIP, MO HealthNet for Families, and MO HealthNet for Pregnant Women. About 30% had issues with initial eligibility, and while this has improved since the early MEDES days, it is still a problem and causes delays with payments, leads to medical debt, etc. AFH and MHD are working with FSD on this, but not everyone can find legal aid services. There are inaccurate provider directories online, and many clients need assistance in finding specialists. The online directories have many problems: multiple listings for the provider, listings for providers who are not available, not accepting the MCO, or not even practicing medicine anymore. The MCOs have been helpful when this was brought to their attention for the specific clients, but there are still problems with inaccuracy. Maura urges the MHD and MCOs to consider a policy of retroactive enrollment, even limited, as it is especially helpful in cases of FSD errors and medical bills in the interim. There was recently a significant increase in clients seeking assistance with orthodontia denials. Most of those have been overturned by the plan based on a review of records and without a hearing. Rebecca Logan asked if legal aid was aware that as of July 1, 2018 we started same day enrollment in MCOs for children and foster care to try to make that connection as quickly as possible so the MCO can reach out and provide needed services. Steve Kuntz said it his understanding that the MHD was prohibited from allowing plans to retroactively enroll due to federal regulations. He recently looked for that regulation and could not find it. FFS coverage during gaps is sometimes fine, but not always, and

	the option to let the plan do that makes sense. Bobbi Jo clarified that the prohibition is in the contract, not a federal regulation, and we're looking at possibly amending that. Jamie Bruce added that it is not the plan's discretion to change eligibility. Steve Kuntz clarified that date will change from various errors. Bobbi Jo said that FSD is finding errors and changing dates retroactively. We are looking at amending the contract, but there are rate variables and other things we need to consider. May need to start another workgroup. Amy Kelsey said that Primaris is finished with the Secret Shopper Survey and that report could help understand issues with provider directories.
Data Update/Validation **Paul Stuve**	Paul is providing data to the CEOs in attendance on a disk. The disks contain multiple reports for review to identify any questionable data. MCOs can make corrections and resubmit, return the attestation from the CEO, and the responses are due by November 30th. With regards to the Care Management Log, revised specifications were provided on October 2, 2018, and the revisions go into effect with the Jan-Mar 2019 Quarter, and will be due by April 30th, 2019. We are finding some data with the quarterly data submissions that seems inconsistent between the plans, and we will be emailing the MCOs to check on these. We will also be starting new quarterly webinars with the MCOs to review submitted data and address questions, possible errors, clarify specifications, etc. Our goal is to involve EQRO with these webinars. We are also considering extending the annual submissions to August 31st of each year instead of June 30th.
Strategic Workgroup Introduction **Bobbi Jo Garber**	This afternoon we have two workgroups related to Federally Qualified Health Centers (FQHC). You can stay, or exit, if you wish. We will focus on whether the FQHCs have the same NCQA accreditation requirements as the MCOs, and if this impacts HEDIS, etc. We will discuss if the requirements need to be the same or not. Another topic we will be working on is around eligibility, demographics and fixing the problems in the daily files, etc. The recertification should be winding down with regards to catchup, probably by the end of November, and thereafter just the monthly recertifications. But we hear that it is hard to get ahold of people and we want to fix that. We had thought of splitting those up, but we think we will just have them both with the large group.
Public Comment/Questions	Vickie Alexander asked if the conversation will cover the 834 file. Bobbi Jo confirmed that it will.

Mark Kapp		
Adjourned	Normal meeting adjourned at 1:30pm, and the Breakout Sessions adjourned at 2:30pm.	Next meeting scheduled for April 24, 2019 in Room 493-494, in the Truman Office Building