MO HEALTHNET OVERSIGHT COMMITTEE
MEETING MINUTES

February 13, 2020
221 Metro Drive
Jefferson City, MO

ATTENDANCE

Committee Members:
Todd Richardson, MHD Director
Representative Tracy McCreery
Gerard Grimaldi
Dr. Bridget McCandless
Dr. Nick Pfannenstiel
Donna Siebeneck for Mark Stringer
Senator Jill Schupp
Joe Pierle
Kaylyn Lambert
Sarah Oerther
Dr. Sam Alexander
David Ott
Senator David Sater (via phone)
Carmen Parker-Bradshaw (via phone)

Members Absent:
Representative Jon Patterson
Dr. Ingrid Taylor
Mark Stringer, DMH Director
Mark Sanford

DSS Staff:
Jessie Dresner, MHD
Caleb Neeley, DSS
Caitlin Whaley, DSS
Gail Luecke, MHD
Leann Hager, MHD
Tony Brite, MHD
Kirk Mathews, MHD
Leann Hager, MHD
Glenda Kremer, MHD
Darin Hackman, MHD
Teresa Wortmann, MHD
Josh Moore, MHD
Lisa Smith, MHD
Patrick Luebbering, DFAS
Kim Evans, FSD

Guests:
Abigail Barker, Washington Univ.
Joe Miller, CHC Strategies
Alyssa Wiles, Senate Appropriations
Brian Kinkade, MHA
Kylie Ahrendsen, Accenture
Russ Oppenborn, Mo Care
Tynan Stewart, St. Louis Post Dispatch
Jim Moody, Husch Blackwell Strategies
Joan Gummels, Polsinelli
Michelle Unterschutz, Berry Dunn
Michael Hely, STL Business Health Coalition/MHI
Jackie Schmitz, Senate Staff
Ryan Stauffer, Mo Health Care Association
Megan Fast, Conduent
Jennifer Colozzi, Conduent
Jodie Earney, Barry Dunn

Handouts from the meeting may be found on the web at: http://dss.mo.gov/mhd/oversight/meeting.htm

AGENDA

Welcome/Introduction/Minutes/Director's Update

- Dr. Nick Pfannenstiel called the meeting to order at approximately 12:11 p.m. The minutes from the November 13, 2019 meeting were approved with an addition.
- Dr. Pfannenstiel introduced new committee members:
  - Dr. Samuel Alexander, who is an ER physician at Cox Hospital in Springfield, Mo.
  - David Ott, who has 25+ years in healthcare in the business administration portion; he is also the co-founder of Principal of Innova Health Solutions; and past experience as President and CEO of Healthlink, an Anthem/Wellpoint company.

Director's Update

- Todd Richardson, MHD Director, gave an update on the Non-IEP related Behavioral Health services in our schools. Since the program started in April of 2018, we have processed fee-for-service claims for 486 participants in the amount of $240,544.88 and managed care claims for 905 participants in the amount of $318,455.70.
  - **Comment:** Dr. Pfannenstiel asked if is there a way to know if these numbers are representation of a large number of schools or are they primarily coming from a small number of schools?
  - **Action Item**: Mr. Richardson said we probably could take a look at how many schools we have participating in the level of claiming but probably could not have the detail down to what services we provide to those schools. Mr. Richardson advised he would get this information sent out to the committee members.
  - **Comment**: Dr. Bridget McCandless asked Mr. Richardson to talk about Administrative Claiming.

- **Comment:** Mr. Richardson advised administrative claiming allows the school districts to enjoy some federal participation for the dollars they are spending through administration to help us operate the Medicaid program. In the same way, the state can claim federal participation on the dollars we spend, the school districts can, through time allocation, account for the time they are spending.
- **Comment**: Senator Jill Schupp commented that she feels that the schools are a great place to reach the parents to get the most accurate information on the families. There are still over 100,000 kids that have dropped off Medicaid. Senator Schupp asked how we were utilizing the school district data to get the most accurate information and to stay on top of the best way to reach the families.
- **Comment**: Mr. Richardson advised we are doing a lot of outreach to the schools about the redetermination process and have had Family Support Division (FSD) staff available onsite at the schools in a number of instances. The other piece we want to explore is the ability of having someone in the school to have access to the system and the ability to update an address or other contact information. Because of the way CMS rules work around eligibility determination, we have to be careful since certain eligibility determinations must be done by state staff.

- Mr. Richardson reviewed the Long Term Services & Supports section of the McKinsey "Rapid Response" Report. This report is still available on the MHD internet site.

  In 2018, we had 100,000 participants that accessed these services and represents over $2.9 billion of the Medicaid expense. These services typically tend to fall in the aged, blind and disabled category.

  We have a significant population accessing our services. The distribution of where these services are provided fall into three categories: Institutional services (Skilled Nursing & Intermediate Facilities), Waiver Home & Community Based Services (HCBS), and State Plan HCBS.

  There was a brief discussion regarding the waiver programs. Missouri has more waivers than any other state in the country right now. The upside to this is we have a lot of ways to access services for people with different needs; however, it also makes navigating into one of the waivers more complex. Many of the waivers programs have limits as to how many participants they can have. The department works with the participant through the process.
  - ***Action Item:*** A more in-depth discussion regarding the waiver process, different types of waivers, as well as how the participants stay up to date on their status, will be presented at the next meeting. (Due to COVID-19, this item will acted upon at the August meeting.

  The nursing facility reimbursement methodology and how we are paying was also discussed. The report states that "Nursing facility rates are based on historical costs, and they do not reimburse based on patient acuity or create incentives for quality or outcomes. Although a facility may receive a yearly adjustment, the reimbursement methodology does not necessarily reflect their current costs." Mr. Richardson explained that because of this, there is a substantial variance from what each facility may pay, based on when they opened their doors. Part of our transformation initiative is to get away from this type of methodology and we are working with some of our vendors on this project. The team, however, is in the very beginning stages of this process.
  - **Comment**: Dr. McCandless asked how long this transition might be; would it be over a 6-month period or more likely a 2-year period.
  - **Comment**: Mr. Richardson said we would have to have an extended implementation timeline to establish a better baseline. The state has attempted a couple of times to rebase the nursing home rates and to bring everyone up to a more current point and time on the cost report. The last time this was attempted, they tried to implement a 3-year rebase but never got the rest of it done. Whatever system we move to, with the extent that the baseline changes the rebase, it would have to be phased in. We would look to add the value-based arrangements; generally you would see states start with the upside incentives and then gradually add in some risk. Our approach would be similar. Acuity gets to be a different question and is dependent upon what the acuity is in the home. We need more current data before we can proceed.

  Other potential initiatives that the Rapid Response Report highlights are:
  1. Include an acuity adjustment in the nursing home reimbursement methodology.
  2. Rationalize rates for similar HCBS services provided through different programs and funding authorities.
  3. Complete and expand upon revisions currently underway to assessment algorithm and process.
  4. More directly employ assessment results in care planning process.
  5. Improve the consistency of the approval process for personal care services.
  6. Extend Money Follows the Person (MFP) through a new grant or waiver.

7. Implement additional waivers (e.g., waiver for children with developmental disabilities who do not require habilitative services) or expand current waivers.
8. Missouri could consider introducing Alternative Payment Models (APMs) for LTSS services.
9. Create transparency of the outcomes of care.

- Mr. Richardson gave a brief background and update on the Missouri Medicaid Information System (MMIS) Replacement Strategy. MMIS is the claims processing systems and was put into service in the late 70's. This system is comprised of several systems, hard to maneuver in; however, it does what it was intended to do. Currently, MMIS processes over 8-10 million claims per month. The Center for Medicaid & Medicare Services (CMS) provides 90/10 funding for implementation and 75/25 for operations.

  CMS wants states to pursue a modular approach to replace legacy claims processing system. The MHD replacement modules for MMIS include:

  1. Medicaid Enterprise Data Warehouse: The work on this project was delayed with the sale of Truven (the original vendor awarded the contract) to IBM. The MHD has worked very hard to get this back on track. The first round of data is expected to be available by the end of February, allowing us to begin doing testing and running reports out of the system by early fall.
  2. Legacy MMIS Claims Processing System: We are currently participating with a collection of states referred to as NASPO (National Association of State Procurement Officials). This group, which includes Missouri, Georgia, Wyoming, and Connecticut, works collectively to produce procurement processes and develop a Request for Proposal (RFP). The RFP will be modified for Missouri specific needs but should allow vendors to respond to not just one state but several in the hopes to get higher quality bids so that we can have more reliance and confidence in.
  3. Pharmacy & Drug Rebate: This is a very important part to the funding and financing our program. We collect nearly $300 million in rebate that helps make up the state share to how we pay for the $1 billion pharmacy program. Today, the MHD has a very manual (paper) process; do not have the electronic ability to invoice and miss some of the rebate capture that we should be getting. We will get the system project kicked off with the resources that we have in the transformation office. It will be a complicated procurement process, but it will get us in a better place.
  4. Beneficiary Support--Participant Enrollment and Premium Collections: This is what has been referred to as the enrollment broker function. We envision having someone centralizing the enrollment function in one of the health plans. Once eligibility has been established, the participant would then go through the enrollment process with one of the managed care plans, etc. The MHD is procuring a solution that will improve the enrollment process by providing participants the tools to compare health plans, search for providers, and enroll online. It will also provide an online provider directory. Another part of the procurement will allow a participant to make their premium payments electronically. Today their only option is to mail the payment in.
     - **Comments:** Dr. McCandless asked if a person would be able to see where they are in the process. Mr. Richardson said he will check on this; since this is really designed for post-eligibility, not sure if they would have access to such information.
  5. Managed Care Contract Management: The MHD intends to release an RFP during 2020 to procure a MCO contract management solution.
  6. Program Integrity: MMAC has procured a program integrity solution that includes data analytics and case management, and is scheduled to be finalized and operational this Fall.
  7. Electronic Visit Verification (EVV): This is a requirement where Personal Care and Home Health Care Service providers document and verify their visits electronically. Missouri has had this requirement for providers in place for five years; however, we haven't identified a specific system for providers to use. Some want a very robust system that includes an electronic health record and other small providers just want to comply with the requirement. For this reason, we have decided to purchase an aggregator to aggregate the data from the different systems rather than requiring all providers use one system. The MHD plans to release an RFP for procurement of the aggregator by the end of the first quarter 2020 with a target implementation of September 2021.
  8. Provider Enrollment: MMAC plans to seek funding in the FY20 budget and purchase a provider enrollment solution through the NASPO master agreement.
  9. Service Authorization and Professional Review Services: The MHD intends to seek a consolidated solution for the automated service authorizations and professional review services and seek additional opportunities to automate the service automation processes.
  10. Health Information Network Services: Although the state doesn't really administer this system, it is important to MMIS. On the provider side, the General Assembly appropriated money last year to onboard additional providers to the health information networks. There is also money for the state to

establish connection to those health information networks. This includes the clinical health information; not just the claims data, which we feel is very important.

- Mr. Richardson gave an update on Civila. They are very close to their final recommendation due the 2nd week of March. Their evaluation is completed and are in the recommendation phase. They have provided us with some initial insight and findings that we feel we can help to make improvements.
    - **Action Item:** We will go through what these recommendations and findings are but also what the MHD feels would be the most practical and tactical implementation strategy for these at the next meeting.

- Josh Moore, MHD Pharmacy Director, presented "SmartPA – Pharmacy Prior Authorization". ***The presentation is available on line.*** Josh reported that opioid utilization decreased over 50% in two years. Benzodiazepine utilization decreased 19% after the edit was implemented.

- Teresa Wortmann gave an update on the Maternal Opioid Misuse (MOM) Grant. The MHD was one of only 10 states selected for this grant. The grant is funded for one year, with a non-competitive continuation grant for years two through five, which the MHD plans to apply for. The first year is a planning year and we did infrastructure work this year and are in the process of hiring a full-time person to take over the implementation of this project.
    - **Comment**: Dr. McCandless asked who we anticipate to partner with in using the grant money.
    - **Comment**: Ms. Wortmann advised that we are partnering with 2 hospitals in the greater St. Louis area--St. Mary's Health System and Barnes Jewish/Washington University Perinatal Behavioral Health Services). We currently do not have any in the Kansas City area but hope to expand further once the planning year is over.

Legislative Update

- Caitlin Whaley gave an update on legislation currently introduced to the General Assembly. There are several bill around eligibility, Medicaid expansion, continuous eligibility, and various proposals around services and payment models. Senator Sater has a work requirements bill and a global waiver bill.
    - **Comment**: Senator Schupp commented that that there is also a bill that has to do with eligibility that makes a person not eligible to receive Medicaid payment for their own needs or treatment until they actually apply.
    - **Comment**: Ms. Whaley acknowledged the bill that Senator Schupp is referring to would get rid of prior quarter coverage; however, she clarified that there are specific populations that the federal government will not entertain getting rid of prior quarter when it has to do with pregnant women, kids and infants. It would only be part of MO HealthNet's prior quarter coverage that would be gone.
    - **Comment*:*** Dr. McCandless asked who was sponsoring the continuous eligibility bill.
    - **Action Item:** Ms. Whaley advised she would get that information to her.

Budget Update

- Tony Brite presented the budget update. ***This presentation is available on line.***
    - **Comment*:*** Sarah Oerther asked if the MMIS core replacement was not being replaced now or has it been delayed.
    - **Comment:** Mr. Richardson reiterated that we are moving forward with the replacement as part of the multi-state purchasing agreement; however, in reality, it probably will not be until FY22.
    - **Comment:** Gerard Grimaldi asked for an explanation of the outpatient hospital reimbursement changes that are in the budget.
    - **Comment:** Mr. Richardson advised that within the acute care section, outpatient services today are reimbursed on a facility specific percent of bill charges. We look at the cost to charge ratio and apply that to the bill to come up with these charges. As we pursue a reimbursement system that we feel is fair, transparent and rational toward program goals, we will move towards a simplified fee schedule.
    - **Comment:** Mr. Grimaldi commented that the MHA informed the hospitals that the number that is in the budget is expected to far exceed what has been proposed. A lot of it has to do with the timing and final outcome. The hospitals are trying to analyze it; however, there needs to be an awareness that the potential impact to some, if not a majority, of the Missouri hospitals can be far greater than the $40 million on the fee for service line magnified by the impact on the managed care line.
    - **Comment:** Mr. Richardson commented that there is some complexity getting to that analysis, which is why we are going through the lengthy process to ensure we price it appropriately. We need to recognize the need for a better reimbursement methodology independent of the question about are we paying too much, too little or not enough. We have to have a more rational way to pay for the services.

Our goal is to find a rational benchmark on which to base this. Other states were surveyed to see if the 90% Medicare rate was there. There is also a 25% upward adjustment in the fee schedule for critical access hospitals, recognizing there is a need to differentiate there. More dialogue is needed about the fee schedule and where that impact lands. We've shared what the fee schedule will look like with MHA and other hospitals. The MHD is working on a timeline for a proposed rule and will continue to have more informal dialogue as the rule goes through the normal process.

- **Comment:** Mr. Grimaldi requested the Department also consider a potential implementation of a 90% of Medicare for outpatient reimburse rate similar to the pretty significant possible change in the nursing home facility fee reimbursement suggestion asking for an extended implementation timeline.

Public Comment – None

Family Support Division Update

- Kim Evans, FSD Director, presented the FSD update. ***The presentation is available on line.***

- There was a discussion around the call centers' wait time and what steps FSD has taken to improve it. Patrick Luebbering, DFAS Director and former FSD Director, advised that FSD has an internal call center that primarily takes calls for food stamps and adult Medicaid. They also set up a vendor call center to take only MAGI and overflow calls; however, they were facing the same long wait time issues and turnover. To help alleviate this, more money was added to the contract so they could staff appropriately with a goal of staffing 75-80 on phones at all times. Since the implementations of these steps, wait time has improved from an average 30 minute to an hour to an average of 2-3 minute on a good day and 15 minutes on a heavier call volume day.

- Ms. Evans reported that FSD has been working with the school districts for well over a year. At the request of school officials, the division has been working on a portal that will allow school staff to update family information and has also trained nurses and other school officials on how participants can apply on line, etc. Some districts have opened their computer labs during school enrollment and FSD staff have attended to assist the families with applying online, updating information, etc. All of these measures enables FSD to have the most current information for these participants.

- Ms. Evans explained the payment process for the CHIP program. In CHIP, the participants are invoiced each month. They need to make a payment every 3 months to keep the invoicing going. If no payment is received for 6 months, FSD will receive a notice from the Premium Payment Unit. FSD will then send an adverse action notice advising that a payment will need to be made within 10 days to prevent the case from being closed. If the payment is not received, the case will be closed.
  - **Comment**: Senator Schupp asked about possible delay due to an address changed.
  - **Comment**: Ms. Evans responded that her staff have access to both systems (FAMIS and MEDES) and will check every avenue available to them to ensure they have the most updated information prior to closing a case due to nonpayment.

- Ms. Evans announced FSD's new centralized mail location. All of the mail received by the 114 counties, including the city of St. Louis will be routed to one location. The mail will be scanned and indexed; notices will be barcoded for quick scanning, which will allow them to pick up the information quicker and process applications and verify information more timely. It also lessens the burden on the resource centers, thus freeing up their time to work with individuals that come in and other issues that arise.

NEXT MEETING

May 28, 2020
Via WebEx