MO HEALTHNET OVERSIGHT COMMITTEE MEETING

April 10, 2012
600 W. Main Street
Jefferson City, MO

MINUTES

Members in Attendance
Margaret Benz
Rep. Keith Frederick
Gerard Grimaldi
Sen. Joseph Keaveny
Brian Kinkade
Rep. Jeanne Kirkton
Bridget McCandless
James McMillen
Carmen Parker Bradshaw
Joe Parks
Joseph Pierle

Members in Attendance (cont'd)
Mark Sanford
Sen. Rob Schaaf
Ingrid Taylor
Corinne Walentik

Members Absent
Kecia Leary
Timothy McBride
Margaret Donnelly

DSS Staff in Attendance
Ian McCaslin, MHD
Marga Hoelscher, MHD
Rhonda Driver, MHD
Andrew Bond, MHD
Paul Stuve, MHD
Karen Purdy, MHD
Samar Muzaffar, MHD
Kate Reimler, MHD
Sandra Nelson, FSD
Emily Rowe, FSD

Others in Attendance
Jim Burns, CMS
Jennifer Bauer, MO-AFP
Donnell Cox, DentaQuest
B. Pope, DentaQuest
Grant Cale, BMS
Dave Sprout, BMS
Earl Pabst, Flotron & McIntosh
Missy Waldman, Legal Services of Eastern Missouri
Diane Twehous, Wipro
Steve Renne, MO Hospital Assn.
Andrew Wheeler, MO Hospital Assn.
Melba Price, Price Consultants
Sam Richardson, Molina
Pam Victor, HealthCare USA
Chris Dunn, Missouri Senate
Terry Hildebrand, DHSS/DSDS
Leann Haslag, DHSS/DSDS
Jeanne Serra, DHSS/DRL
Teresa A. Generous, DHSS/DRL

WELCOME/INTRODUCTIONS/MINUTES – Dr. Corinne Walentik, Chair, called the meeting to order at approximately 12:00 noon. Minutes of the January 31, 2012 meeting were approved as submitted.

DIRECTOR'S UPDATE – Ian McCaslin, MD, Director-MO HealthNet Division, provided that the House of Representatives had passed their version of the FY2013 budget. Upon conclusion of the Senate mark-up process, the budget will go to a conference committee comprised of members from both the House of Representatives and the Senate. The MO HealthNet Division did not experience any staffing reductions. Program cuts suggested will not impact quality or delivery of services. Via Governor's amendment, $50 million has been added to the agency's budget to establish a new eligibility and enrollment system. The appropriation is essentially all federal funds and since it was not heard in the House appropriations process, will be discussed during conference committee. May 11, 2012 is the deadline for budget submission. More information on the proposed budget reductions for individuals eligible in the category of assistance aid to the blind will be available at the conclusion of Senate mark-up. It is anticipated the issue will be resolved during conference committee discussions.

Dr. Walentik indicated that she had received inquiries regarding the recently awarded managed care contracts, specifically about the reduction of number of health plans. In response, Dr. McCaslin provided

that it is the MO HealthNet Division (MHD) responsibility to administer the managed care program for Missouri Medicaid. The program began in 1995 and provides services to only children, pregnant women, and low income parents in select counties; elderly or disabled participants are not in managed care. Approximately 50% of the total MO HealthNet participants are enrolled in the managed care program. Managed care contracts are generally rebid every three years. The recent contract announcements were the result of the normal contract rebid process in response to the Request for Proposal (RFP) released last fall. Dr. McCaslin provided highlights of changes made to the program through the RFP including bolstered health plan expectations in the areas of accountability and quality. Contracts were awarded by Office of Administration, Division of Purchasing, to three health plans based on recommendation from MHD and a cross-department review team chaired by the Office of Administration buyer. HealthCare USA (parent company – Coventry); Home State Health Plan (parent company - Centene); and Missouri Care (parent company – Aetna) were awarded contracts and will serve participants in each of the three regions. The open enrollment process is currently underway and continues through mid-June. Those individuals who do not choose a health plan will be auto assigned. Services under the new contract begin July 1, 2012. There are currently no plans to expand managed care beyond the three existing regions.

In response to questions from Committee members it was provided that HEDIS indicators are available on the MO HealthNet Division website. Health plan financial information is available on the Department of Insurance, Financial Institutions, and Professional Registration website. MHD will provide those links. MO HealthNet health plan rates are actuarially approved.

Committee members also reported receiving contacts from providers who appear on health plan panels without the providers' consent. Dr. McCaslin asked for additional information on those specific cases for MHD could investigate. There were also questions from Committee members regarding case management requirements. MHD will provide that information. MHD was encouraged to track managed care opt out of disabled children.

MO HEALTHNET ENROLLMENT BY ELIGIBILITY CATEGORY– Summarizing the handout, Emily Rowe, Family Support Division, reported that participants as of February 2012 totaled 895,479. The chart reflected that of the 895,479, 60.6% are children, 18.7% are persons with disabilities; 9.0% custodial parents, 8.6% seniors defined as individuals 65 or older; and 3.1% are pregnant women.

In addition, 64,667 women are receiving services through the Women's Health Services program. This category is reported separately as benefits for this group of eligibles are limited to family planning services, not the full MO HealthNet benefit. A higher federal match is received for these services.

An update on managed care enrollment by health plan was requested to be included in future Committee meetings.

SPENDDOWN DOCUMENTATION – Sandra Nelson, Family Support Division (FSD), updated the Committee on the spenddown documentation issue discussed at the November 2011 and January 2012 meetings. During a December 5, 2011 hearing before the House of Representatives, Department of Social Services posed several action steps:

- FSD will meet with stakeholders to explain policy/regulations and discuss potential impact:
  - Meetings were held on December 14, 2011 and January 10, 2012 with the entire stakeholder group
  - Subgroup meetings were held January 30, 2012 and March 9, 2012
- An administrative rule will be filed:
  - Proposed rule 13 CSR 40-2.395 -- Spend Down Program – was filed March 1, 2012 and published in the April 2, 2012 *Missouri Register* at http://sos.mo.gov/adrules/moreg/current/v37n7/v37n7a.pdf.

- FSD will communicate with impacted spenddown recipients to advise them of spenddown clarification and how it will affect them and discuss alternatives:
  - FSD has made contact with 85-90% of the 8,500 affected individual and will continue efforts to reach the remaining.
- Specialized spenddown caseload staff will be identified and intensive scenario based training will be conducted:
  - Staff were identified and training completed in January 2012.

A new model for meeting spenddown for individuals with known treatment regimens and therapies, being referred to as The Prospective model, was introduced at the January 10, 2012 stakeholder meeting. Under this model, providers of participants with a known medical need, i.e., dialysis patients, are asked to set up a receivable to ensure the participant has that much personal liability in the month, allowing their MO HealthNet coverage to start the first of the month. Another model being explored uses remedial expenses to meet spenddown. This model allows expenses to be accumulated for three months to determine if assistance is periodically needed. The model is already in regulation and allowed by the Centers for Medicare and Medicaid Services (CMS). Work with stakeholders on the models continues and FSD is moving toward submitting the proposals to CMS for review.

Statistics on spenddown participants as of February 2012 was also provided, as follows:
- Seniors and Persons with Disabilities enrolled in MO HealthNet – 245,005.
- Total spenddown participants -- 71,824.
- Participants who met eligibility based on spenddown – 23,330.
- Of those 23,330 spenddown persons, 7,317 incurred expenses to meet spenddown and 16,013 paid-in.
- 48,494 spenddown participants did not meet their required spenddown.

In response to questions from Committee members regarding provider write-off of participant spenddown liability and required copayments, it was reported that providers must apply the same collection policy to the MO HealthNet participant spenddown or copayment amount as is done with other patient debts. While there is great variability about how providers pursue amounts due, the specific practices have not been reviewed.

Committee members discussed the impact on individuals not receiving services because their spenddown requirement wasn't met. This includes participants delaying services, not filling prescription, or seeking considerable services in the same month that their spenddown is met. MO HealthNet was encouraged to partner with Health Literacy Missouri to ensure language on information sent to participants is clear.

Dr. Walentik indicated that CMS is starting to look at the impact of dual eligibles and that studies suggest Medicaid should take over what is not paid by Medicare. In response to questions Dr. McCaslin reported it has been suggested for a number of years that duals, or a subset of nursing home patients, receive all services through Medicare. A substantial amount of money is involved and it is anticipated changes will not occur any time soon. However, there are currently a lot of initiatives to better coordinate care for duals.

NON-EMERGENCY MEDICAL TRANSPORTATION—Speaking from a powerpoint, Theresa Valdes, MO HealthNet Division staff, provided that the non-emergency medical transportation (NEMT) program provides transportation services to allow eligible MO HealthNet participants to access MO HealthNet covered medical services. There are some services for which NEMT is not available and those services were outlined. NEMT is delivered to fee-for-service participants through a transportation broker under contract with the state. The current transportation broker is LogistiCare Solutions, LLC, St. Louis, Missouri.

NEMT for managed care participants is arranged directly through the individual's health plan. There are minimum requirements that the managed care plan NEMT program must contain, and managed care plans can offer additional services if desired.

The contract with the NEMT broker is awarded via competitive bid conducted by the Office of Administration, Division of Purchasing. The contract is an at-risk contract and the broker is required to bid actuarially sound rates. The broker receives a capitated per member per month rate which varies by region and population. The fee-for-service program expenditure history from FY2009 to the current fiscal year was reviewed.

Only participants receiving MO HealthNet benefits through a federal category of assistance are eligibility for the NEMT program. For example, those individuals eligible for MO HealthNet through state only funded programs such as blind pension and women's health services are not eligible for NEMT services. In addition, participants must not have access to other no cost transport, i.e., hospice, Medicare, transportation through a public entity. Participants must be eligible on the date of service. Reservations must be made at leave five days before the date of the medical appointment, and there are provisions for urgent appointments. LogistiCare averages 40,000 reservations calls per month.

Travel standards are established by the Missouri Department of Insurance, Financial Institutions, and Professional Registration and vary by urban and rural counties. Exceptions made to the travel standards were outlined in the powerpoint.

Modes of transport include public transit, gas reimbursement, multi-passenger van, taxi, para-lift van, stretcher van, ambulance, and volunteer driver. Ms. Valdes outlines the situations in which each mode was utilized. Pick-up and drop-off requirements are outlined in the contract and were reviewed in the powerpoint. A toll-free number is available for participants to use when the transportation provider is more than 15 minutes late.

All calls to the NEMT call center are recorded and routinely reviewed upon initiation of a complaint. An average of 171 complaints monthly are currently being experienced for 104,000 trips. 99.8% of trips are completed without complaint.

In response to questions from Committee members, Ms. Valdes reported that an electronic eligibility file is shared with the NEMT vendor so that eligibility can be verified. There are provisions in the contract to address when patients or drivers are running late. Round trips can be arranged when an individual schedules a trip. If a specific pick up time is not known, the return trip will be designated as "will call" and upon contacting LogistiCare at the conclusion of their appointment, the contract requires the individual to be picked up within 60 minutes. Brochures regarding the program are available at the county FSD offices. It was suggested that NEMT brochures also be distributed at major health centers in the event participants need assistance during their medical visits.

Ellis Fischel Cancer Center submitted a letter to the MO HealthNet Division for forwarding to MO HealthNet Oversight Committee members. The letter depicted concerns encountered with the NEMT program. MHD staff reached out to Ellis Fischel to investigate the concerns. As a result of that contact it was learned that there were three complaints against the program dealing with required letters of medical necessity, gas mileage reimbursement, and the biggest complaint dealt with the lack of NEMT service for physical therapy visits. Each complaint was investigated and resolution reported to the letter's author. Since physical therapy has not been a covered service for adults since 2005, NEMT cannot be provided. Ellis Fischel had not reported the concerns to MHD prior to submitting the correspondence.

At the request of Committee members, the quality measures NEMT subcontractors must meet will be provided.

STRONG START FOR MOTHERS AND NEWBORNS – Paul Stuve, Quality Manager, MO HealthNet Division, reported that Strong Start for Mothers and Newborns is a grant opportunity from the Centers for Medicare and Medicaid Services Innovation Center, the goal of which is to improve maternal and infant health outcomes. One-year grants will be awarded to successful applicants which are renewal for up to four years. The four year period is comprised of three years of services and one year of data collection. Applicants must choose one approach from the following three: enhanced prenatal care through centering/group care; enhanced prenatal care at birth centers; or enhanced prenatal care at maternity care homes. The site must enroll 500 women per year for the three years of the grant. While neither MO HealthNet Division or the Department of Health and Senior Services will apply for the grant, the agencies will partner with any eligible entity that wishes to apply. Letters of intent are due May 11 with full applications due by June 13. Award announcements are expected in September 2012.

During ensuing discussion it was noted that MHD has issued a provider bulletin announcing the opportunity to the provider community. Webinars have been hosted by CMS. MHD has received an inquiry from a national group, but is unaware of any letters of intent submitted at this time. $43.2 million is available over the course of the study. Both MHD and Department of Health and Senior Services have expressed willingness to write letters of support for entities pursuing a grant, however there are specification and technical requirements that must be met. The state's role in the opportunity is to provide data.

INITIATIVE TO REDUCE AVOIDABLE HOSPITALIZATIONS – Dr. Ian McCaslin reported that CMS recently announced a new initiative designed to improve the care for individuals living in nursing facilities who are enrolled in both the Medicare and Medicaid programs. The initiative aims to reduce costly and avoidable hospitalizations by funding organizations that would partner with nursing facilities to provide enhanced on-site services and supports to nursing facility residents. State agencies are not eligible to apply, but are critical partners in improving care and reducing avoidable hospitalizations. A letter of intent to apply is due to CMS by April 30, 2012. State letters of support are due with applications by June 14, 2012 with notice of award anticipated August 24, 2012. The initiative covers the period August 25, 2012 – August 24, 2016, and there is $128 million in funding available nationwide. It is anticipated that seven awards will be made, ranging from $5 million to $30 million each.

PROVIDER PREVENTABLE CONDITIONS – Dr. Samar Muzaffar provided background information which led up to the Federal law enacted June 6, 2011 in 42 CFR 434, 438, 447 – Medicaid Program: Payment Adjustment for Provider-Preventable Conditions including HealthCare-Acquired Conditions. State Medicaid programs are to be in compliance by July 1, 2012. Per the federal regulation, states are required to implement provider self-reporting through claims systems. In response, the MO HealthNet Division filed proposed rule 13 CSR 70-3.230 – Payment Policy for Provider Preventable Conditions with the Secretary of State. The rule becomes effective June 30, 2012. To operationalize the rule MHD convened two workgroups comprised of clinical and finance staff to develop the process for claim and payment review. Target date for completion is late May, 2012. It is anticipated that reviewers will be sought through independent contract arrangements with provider groups.

EMERGENCY PSYCHIATRIC DEMONSTRATION – Dr. Joseph Parks, Department of Mental Health, provided that CMS recently announced that Missouri is one of 11 states to share in up to $75 million in federal matching funds over three years to enable private psychiatric hospitals, Institutions for Mental Disease (IMD), to receive Medicaid reimbursement for emergency care provided to Medicaid participants ages 21-64 who have an acute need for treatment. Historically, federal law has prohibited Medicaid from paying for IMD services for Medicaid participants in this age group. This prohibition led to individuals seeking services

in hospital emergency departments. The demonstration will test whether Medicaid reimbursement to treat psychiatric emergencies in IMD settings will enable states to increase the quality of care for people experiencing mental illness at lower cost. It will also test whether such expanded coverage reduces the burden on general acute care hospital emergency departments. An IMD is any facility with 17 or more beds where more than half are there for mental health or drug abuse status. Three of Missouri's five IMDs expressed interest in participating – Royal Oaks Hospital, St. Louis Regional Psychiatric Stabilization Center, and Two Rivers Behavioral Health System. An evaluation of the demonstration is required.

In follow-up discussion it was shared that the target deadline for implementation is July 1. Funds through the demonstration are be used for increased federal matching funds and cannot be used for marketing or administration. Any marketing activities will be done with existing funds.

In response to questions Dr. Parks also provided that the CMHC health home program is operational, with approximately 18,000 individuals enrolled. Good results are expected in October. The Department of Mental Health Office of Consumer Affairs accepts complaints regarding services through its hotline. No complaints have been forwarded about health home.

HEALTH HOMES/SHARED SAVINGS UPDATE – Dr. Muzaffar provided that 25 enrolled organizations have started health home services, providing services to approximately 20,000 patients. Organizations receive a $58 per member per month payment for these services. Systems work is nearing completion for both the primary care and Community Mental Health Center health home initiatives.

An overview of two health home shared savings models is also being explored with CMS. The first is a program for Medicaid health home patients in which the state shares savings with the health home providers. The second model is a program for dual eligible health home participants in which CMS shares savings for duals with the state and the state shares with health homes. Under the models performance payment is based on estimations of avoided costs. Examples were provided in the powerpoint.

PUBLIC COMMENT -- Missy Waldman requested clarification on the three IMDs involved in the emergency psychiatric demonstration. No other public comments were offered.

ADJOURN – Dr. Walentik adjourned the meeting at 3:15 pm. Next meeting is July 31, 2012.