MO HEALTHNET OVERSIGHT COMMITTEE MEETING

July 31, 2012
600 W. Main Street
Jefferson City, MO

MINUTES

Members in Attendance
Margaret Benz
Celesta Hartgraves for Margaret Donnelly
Sen. Joseph Keaveny
Brian Kinkade
Rep. Jeanne Kirkton
Kecia Leary
Timothy McBride
Bridget McCandless
Mark Sanford
Sen. Rob Schaaf

Members in Attendance (cont'd)
Donna Siebeneck for Joe Parks
Corinne Walentik

Members Absent
Carmen Parker Bradshaw
Rep. Keith Frederick
Gerard Grimaldi
James McMillen
Joseph Pierle
Ingrid Taylor

DSS Staff in Attendance
Ian McCaslin, MHD
Marga Hoelscher, MHD
Andrew Bond, MHD
Tina Dake, MMAC
Rhonda Driver, MHD
Susan Eggen, MHD
Darin Hackmann, MHD
Samar Muzaffar, MHD
Karen Purdy, MHD
Emily Rowe, FSD
Jennifer Tidball, DFAS

Others in Attendance
Jim Burns, CMS
Jennifer Bauer, MO-AFP
Donnell Cox, DentaQuest
B. Pope, DentaQuest
Dave Sprout, BMS
Earl Pabst, Flotron & McIntosh
Alan Freeman, Grace Hill Health Centers
Susan Zalenski, J&J
Elizabeth Crisp, St. Louis Post-Dispatch
Danny O'Neill, MO Primary Care Assn.
Susan Wilson, MO Primary Care Assn.
Eric Crowder, Legal Services of Eastern Missouri
Barb Oerly, Infocrossing
Kimberly Brandt, Infocrossing
Steve Renne, MO Hospital Assn.
Ron Fitzwater, MO Pharmacy Assn.
Chris Moody, James Moody and Associates
Charles Bentley, Dept. of Mental Health
Kathy Aebel-Groesch, Davita Dialysis
Erin Ostmann, Fresenius Medical Care
Shawn D'Abru, MO Council for Independent Living
Pam Victor, HealthCare USA
Lovey Barnes, Missouri Care
Adam Koenigsfeld, MO Senate
Amanda Schneider, Regal Services of Eastern MO
Susan Henderson Moore, Polsinelli Shughart
Carrie Craig, Adapt of MO
Charlotte Moten, Adapt of MO
Fielding Jezreel, Adapt of MO
Lana Baker
Grant Cale, BMS

WELCOME/INTRODUCTIONS/MINUTES – Dr. Corinne Walentik, Chair, called the meeting to order at approximately 12:00 noon. Minutes of the April 10, 2012 meeting were approved as submitted.

DIRECTOR'S UPDATE -- Ian McCaslin, MD, Director-MO HealthNet Division, provided that it has been a busy summer for the MO HealthNet Division (MHD). An example of projects underway include budget preparation for the FY 2014 state budget which is due October 1, conversion of ICD-9 codes to ICD-10, electronic health records, Affordable Care Act, continued work on health homes.

MO HEALTHNET ENROLLMENT BY ELIGIBILITY CATEGORY– Summarizing the handout, Emily Rowe, Family Support Division, reported that participants as of June 2012 totaled 889,159. The chart reflected that of the 889,159, 60.8% are children, 18.6% are persons with disabilities; 8.9% custodial parents, 8.6% seniors defined as individuals 65 or older; and 3.1% are pregnant women.

In addition, 64,578 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.

Managed care enrollment as of June 2012 totaled 413,905. Managed care health plan enrollment was requested to be reported at future Committee meetings.

In response to questions from Committee members it was noted that eligibility has remained relatively stable over the last two years, fluctuating between 2000-3000 participants monthly. A graph depicting historical enrollment over the last few years will be provided at the November meeting.

Question was also posed on the application processing time. In response, Ms. Rowe provided the following:

Category	Time Period for Processing
Children	30 days
Permanently and totally disabled	90 days
Seniors	45 days
Pregnant women	15 days

BUDGET UPDATE – Speaking from a powerpoint, Andrew Bond, Director of Finance, MO HealthNet Division, charted SFY 2013 total MO HealthNet funding across all agencies in general revenue, federal funding, and other funds. Total across all agencies is $8.5 billion, with the lion's share, $6.9 billion, in the Department of Social Services (DSS). Major decreases in the MHD budget for SFY 2013 resulted from savings of brand drugs being available generically, and savings from implementation of the health care home program. General revenue funding for health care for the blind pension program was transferred from the MHD budget to the Family Support Division since that division administers the pension program. The program will continue to operate as in the past. Provider rate increases in the MHD budget were provided in areas such as Program for All Inclusive Care for the Elderly (PACE), hospice, and primary care rates.

In response to a question from a committee member it was noted there were 23,400 seniors in nursing homes during state fiscal year 2012. The number of nursing home days stays relatively consistent. There has been, however, a lot of growth in community-provided services and supports.

PRIMARY CARE RATE INCREASE – Dr. McCaslin discussed a recent federal law that requires Medicaid payments for primary care services furnished by a primary care practitioner with a primary specialty of family medicine, general internal medicine, or pediatric medicine to be paid at parity with Medicare beginning January 1, 2013. The law defines covered services as those Evaluation and Management (E&M) codes and immunization services that are covered by Medicare, as well as primary care codes that Medicare does not currently cover but for which it publishes and sets relative value units. The law provides 100% federal funding in calendar years 2013 and 2014 for the incremental cost of meeting this requirement. The 100% federal funding of the incremental cost is calculated based on the Medicaid rate as of July 1, 2009. Currently, across the board Missouri Medicaid (MO HealthNet) reimbursement is approximately 60% of Medicare, with less disparity in primary care reimbursement.

The intent of the law is to enhance access in the Medicaid program. While access to primary care is generally good in Missouri, currently many providers limit Medicaid patients in their practices. With this increased reimbursement in E&M codes the state hopes more clinicians will enroll as providers and expand the number of Medicaid participants they will serve.

The law applies to both fee-for-service and managed care providers. A meeting was conducted on July 17, 2012 with provider associations and managed care plans. MHD is working with these partner associations to disseminate the information. A provider bulletin is also under development that discusses the provisions. The bulletin will be posted to the MO HealthNet Division website and provided to committee members upon finalization.

There are exclusions in the provider groups eligible for the increased reimbursement. Federally qualified health centers and rural health clinics are not eligible because those facilities are already paid on a cost-based basis. OB/GYN providers are also currently excluded. Nurse practitioners who bill through a physician are allowed to benefit but nurse practitioners who bill independently are not eligible.

If a practitioner's provider enrollment file indicates they are board-certified as a specialist in one of the applicable areas they are automatically eligible for the increased reimbursement. Others will have to submit a provider form attesting that 60% of their practice is billed in the E&M categories. The form is available on the Missouri Medicaid Audit and Compliance website at http://mmac.mo.gov/providers/provider-enrollment/provider-enrollment-forms/ and can be submitted via mail or fax.

Dr. McCaslin provided information on the impacted primary care services eligible for the increased reimbursement. He noted there are a number of codes not covered by Medicare and will be addressed in the Centers for Medicare and Medicaid Services (CMS) final rule.

Provider reimbursement in calendar year 2015, when the federal funding lapses, was discussed in follow-up to the presentation. Legislative action would be required to continue the enhanced reimbursement of these codes.

ICD-10 PLANNING – Darin Hackmann, Director-Information Systems, provided background on the federal rule which mandated the change from ICD-9 to ICD-10 codes. Original implementation date was October 1, 2013. However, a proposed rule issued in 2012 will delay implementation to October 1, 2014. Issuance of the final rule is anticipated by the next Oversight Committee meeting.

The ICD-10 is the new version of codes used for describing diagnoses for all providers and inpatient hospital procedures. The conversion is very complicated, converting approximately 16,000 ICD-9 codes to 155,000 ICD-10 codes. The conversion to ICD-10 affects not only the Department of Social Services programs, but also programs within the Departments of Mental Health, Elementary and Secondary Education, and Health and Senior Services. No impact to participant services is envisioned. As budget neutrality must be maintained, minimal impact to provider payments is expected to comply with the federal mandate. Within MO HealthNet, a variety of program items is impacted, including clinical edits, system parameters, medical criteria, exception codes, preferred drug list edits. The projected cost to the MO HealthNet program is $10-15 million. The majority of the work will be in the Medicaid Management Information System (MMIS), which is separate from the FAMIS eligibility system. Given the timely filing requirement, the MMIS must be able to accommodate both the ICD-9 and ICD-10 codes for a couple of years.

In follow-up discussion with Committee members, it was explained that it is anticipated the conversion to ICD-10 codes will assist providers nationwide in better managing health care by providing more specific data. Provider outreach and education will be conducted via ICD-10 seminars anticipated for the months of September through November, 2012. MHD is also partnering with the Missouri Strategic National Implementation Process (MOSNIP) to educate providers regarding the upcoming changes.

AFFORDABLE CARE ACT – Speaking from a powerpoint, Dr. McCaslin provided a high level overview of the status of the Affordable Care Act (ACA). The recent Supreme Court decision provided clarification on certain provisions regarding the commercial insurance market.

Dr. McCaslin outlined the current major elements of the ACA, namely commercial market reforms, consumer protections, public health grants, and delivery system reforms. Current MO HealthNet eligibility limits were reviewed as well as eligibility provisions in exchange subsidies. The original intent of the ACA was that states expand their Medicaid programs when applicable to an eligibility threshold of 133% Federal Poverty Level (FPL). The Supreme Court decision altered the provision, making such an expansion a state option. Furthermore, the Supreme Court decision held that the Department of Health and Human Services (DHHS) may not penalize states that elect not to expand their Medicaid program by withholding all federal Medicaid funding for their existing programs. Discussion ensued regarding pros and cons of opting in or out of such an expansion. There are a number of questions from states to CMS that have been submitted in common through the National Association of Medicaid Directors. The committee requested the full list to be added to the MO HealthNet Division website.

HEALTH HOME UPDATE – Dr. Samar Muzaffar, MHD Medical Director updated the group on the primary care health home program. A background of the program was provided as well as the health home goals of reducing inappropriate emergency department utilization; reducing avoidable inpatient utilization; improving patient outcomes; and reducing health care costs. Key health home services include comprehensive care management; care coordination; health promotion; comprehensive transitional care; individual and family support services; and referral to community and social support services. Examples of related activities were outlined in the powerpoint presentation.

There are currently 24 primary care health homes made up of roughly 80 sites to provide services to approximately 19,000 enrolled individuals. Six of the health homes are public and private hospitals; the remaining are federally qualified health centers. To qualify as a health home the location has to be heavily involved in providing care to MO HealthNet participants and utilize an electronic health record system. The site's health home team is led by the practice site physician or nurse practitioner with a team comprised of a behavioral health consultant, nurse care manager, care coordinator, and others per practice, i.e., a dietician. Psychiatrists could also be included in the health home team per the practice. There are approximately 18,000 enrolled in the community mental health center health home program.

The behavioral health component is integrated with primary care. Credentials and the role of the behavioral health consultant were outlined. If the primary care health home does not have the capacity to manage a patient's mental illness referral is made to the appropriate mental health provider. Specific and goal directed interventions are conducted and education techniques tailored to the patient's specific issues utilized. These behavioral supports assist in improving the patient's health status and managing their chronic disease.

Tools to evaluate the health home program were discussed and include trending of clinical measures over time, starting with the baseline measurement; quarterly reports from the health homes; site visits; and trending of utilization and cost reports. In November six months data experience will be available. Further update will be provided at the next Committee meeting.

In response to a Committee member question it was reported the per member per month for the primary care health home provider is $58 and approximately $78 in the community mental health program.

MO HEALTHNET MANAGED CARE – Speaking from a powerpoint, Deputy Division Director Marga Hoelscher and Susan Eggen, Assistant Deputy Director - Managed Care, explained that the MO HealthNet managed care program operates via waiver authority granted by the Centers for Medicare and Medicaid Services under Section 1915(b) of the Social Security Act. The overall goals of managed care nationwide, not just for MO HealthNet, are assured network adequacy, enhanced access, quality requirements, and budget predictability. Health plans are paid a capitated per member per month rate to provide care. Federal and state legal citations outlining specific provisions of managed care were discussed and noted in the powerpoint as well as national trends. Nationally 72% of Medicaid participants received services through managed care in 2009 compared to 46% in Missouri. A map depicting MO HealthNet participation statewide was shared. MO HealthNet managed care is mandatory for certain populations in three regions of the state – east, central, and west. Those populations covered were reviewed. A map reflecting the counties in each region was included. A contracted enrollment broker provides each potential enrollee with information on the managed care program. Enrollees receive the same scope of services that the fee-for-service program offers. Almost all states carve out some services from managed care. Missouri, like 15 other states, carve out pharmacy services. The carveout benefits Missouri as a result of rebates and pharmacy tax benefits.

Effective July 1, 2012 three health plans are under contract to provide services to MO HealthNet managed care enrollees in each region. Enrollment by region and health plan was reviewed.

Region	Total Enrollment	HealthCare USA	Missouri Care	Home State
East	205,511	137,268 (66.79%)	40,292 (19.61%)	27,951 (13.60%)
Central	80,490	40,257 (50.01%)	36,517 (45.37%)	3,716 (4.62%)
West	134,227	89,333 (66.55%)	27,860 (20.76%)	17,034 (12.69)

Missouri pays for MO HealthNet services via either managed care or fee-for-service. Per federal regulations rates paid to managed care entities must be actuarially sound. The Department of Social Services contracts with Mercer Consulting, an expert actuary for many states, to review managed care rates. CMS requirements applicable to ratesetting were reviewed. Per member per month rate cells were also reviewed by region. A committee member asked for comparable rates for the same eligibility groups in the outstate areas.

Key dates from the 2012 contract start-up were reviewed. An open enrollment period was conducted April 19, 2012 through June 16, 2012; the new contract was effective July 1, 2012. There were 122,000 participants required to make a choice of a new health plan during the open enrollment period. Of that amount, 80,000 (65.6%) did not make a choice and were subsequently autoassigned to a health plan. Risk adjusted rates will begin January 1, 2013. Risk adjusted rates are based on conditions and diseases of member enrollees. A risk adjusted payment methodology enables the state to pay based on the acuity of the care provided.

Quality provisions in the contract include service accessibility standards, performance standards, and performance improvement projects. Travel distance standards are required by the Department of Insurance, Financial Institutions, and Professional Registration, the state agency that licenses health maintenance organizations (HMOs); all HMOs are required to be licensed. There is an 80% EPSDT participation ratio built into the capitation rate, which is measured semiannually. If a health plan is

below the 80% threshold their rates are decreased in those rate cells. The health plan will receive an incentivized rate if their ratio is above 80%. The rate changes are based upon an algorithm developed by the actuary, never to exceed 100%. All health plans must be accredited by the National Council for Quality Assurance. The contract contains 48 different HEDIS measures, some of which are required by NCQA.

Two statewide performance improvement projects are mandated in the contract: (1) increase in adolescent health care visits; and (2) an oral health project to increase the number of children receiving preventive dental services. The oral health project relates to a CMS directive to increase preventive dental services for the Children's Health Insurance Program and 1915(b) waiver children by 10%. The project requires health plans to increase preventive dental services by 2% each year for the next five years and will be reported to CMS.

A short discussion of dental services ensued. At the committee's request, MO HealthNet Division will explore the baseline for dental access to determine penetration ratios of dental care throughout the state. Dental services are not provided for all adults, only those who receive MO HealthNet under a category of assistance for pregnant women, the blind, or a resident in a nursing facility. Dental treatment is also covered for an injury to an adult's mouth, jaw or teeth or if the participant has a qualifying disease.

SPENDDOWN DOCUMENTATION -- Brian Kinkade, Interim Department of Social Services Director, reported that new procedures for meeting spenddown were implemented for all participants July 1, 2012. The process is being monitored through the Family Support Division county offices. Mr. Kinkade noted that to ensure consistency in application of the new procedures, a limited number of caseworkers are making spenddown determinations. A lawsuit had been filed seeking a temporary restraining order to the July 1 effective date. While the state prevailed against the order, the lawsuit is continuing. A hearing on a preliminary injunction will occur sometime in August. Implementation time was lost in working through the lawsuit. It is anticipated during the next few weeks issues will be resolved.

Open comment was accepted during the spenddown discussion. Kathy Aebel-Groesch, Davita Dialysis, reported that there have been delays and inconsistencies with information received by providers. In addition, caseworkers are not applying the policy consistently. A survey conducted of social workers within the dialysis clinic noted a high percentage of participants have missed appointments due to lack of transportation, some have lost in-home services, others have gone without prescriptions. Another meeting of the stakeholder group was suggested.

A MO HealthNet participant in attendance noted she had not been able to obtain her medicine and has experienced problems with personal care services because her spenddown has not been met. She cautioned that participants with mental illnesses who go without psychotropic medications will lead to increased hospitalization.

Carrie Craig, Adapt of MO, has worked with numerous consumers recently who had to wait 3-4 weeks for their medication, despite submitting invoices to Family Support Division to meet spenddown. Caseworkers are unaware that CPRC services qualify to meet spenddown requirements. Specific concerns regarding the format of invoices were expressed.

Emily Rowe, Family Support Division, was to meet with the individuals providing comment to obtain specific information on these issues.

ADJOURN – Dr. Walentik adjourned the meeting at 3:45 pm. Next meeting is November 13, 2012.