MO HEALTHNET OVERSIGHT COMMITTEE MEETING

July 31, 2014
600 W Main Street
Jefferson City, MO

MINUTES

Members in Attendance:
Margaret Benz
Rep. Keith Frederick
Gerard Grimaldi
Celesta Hartgraves
Sen. Joseph Keaveny
Rep. Jeanne Kirkton
Kecia Leary
Timothy McBride
Bridget McCandless

Members in Attendance (cont'd)
Joseph Pierle
Mark Sanford
Sen. Rob Schaaf
Ingrid Taylor
Carmen Parker Bradshaw

DSS Staff in Attendance:
Alyson Campbell, FSD
Rhonda Driver, MHD
Kristen Edwards, MHD
Darin Hackmann, MHD
Jan Heckemeyer, MHD
Timothy Kling, MHD
Debbie Meller, MHD
Samar Muzaffar, MHD
Joe Parks, MHD

Others in Attendance:

Lovey Barnes, Missouri Care
Kim Brandt, Wipro InfoCrossing
Albert A. Reine, Jr.
Steve Renne, MO Hospital Assn.
Larry Rohrbach, Leading Age
Misty Snodgrass, MO Coalition of CMHC's
Dave Sprout, BMS
V. Young, Post Dispatch
Heidi Geisbuhler for Sen. Dempsey

WELCOME/INTRODUCTIONS/MINUTES – Dr. Tim McBride, Chair, called the meeting to order at approximately 12:00 noon. Dr. McBride went over "housekeeping" information and to save time, gave a brief overview of the last meeting, regarding the future of the committee. There was legislation introduced to eliminate the current committee and create a committee in the legislature. The legislation was passed but was vetoed by the Governor. Minutes of the April 10, 2014 meeting were approved as submitted.

DIRECTOR'S UPDATE – Dr. Joe Parks, Director, MO HealthNet Division discussed the significant changes in the Managed Care RFP for which Dr. Stuve prepared a handout entitled "Highlights Managed Care Rebid". Dr. Parks explained that there will be four actions that will be taken.

Plan Viability and Stability:

1) Awards will be limited to three plans in the new RFP, which is the same as the previous year. Senator Schaaf suggested developing a rule specific to procuring Managed Care Contracts that would stipulate three bids or another limit. Dr. Parks will discuss the matter with OA Purchasing.

2) Market share to have a higher minimum size of the smaller plans, with not as big of a maximum size of the larger plans. A more even plan distribution should lead to more stable smaller plans and to make the rebid more attractive. We will be doing a cap by region – these are rate sell regions, not enrollment regions. It was discussed that some areas in the state do not have very many providers for managed care participants. The plans have to show a calculation called a "Sound Network." Currently the maximum market caps for plans the maximum share is being lowered to 60% from 65%. This will be for both adults and CHIP plans. New enrollees would not be able to choose plans that have 60% and would have to choose between the other two plans. Previous participants will be able to keep their old plans unless that company loses the bid. There will not be rules promulgated for this because they have always been there in the background. Bids will only be accepted from those companies who can provide care for the whole state, not just certain regions. Right now there are nine contracts for the three plans and this will reduce it to three contracts for three plans.

   In discussion, the point was made that Health Insurance companies can drop providers any time during the year with no explanation and providers have no chance to find out why they were dropped. Can there be a rule or some sort of mediation for this? Dr. Parks states that this type of language is not in the current contract or the ones that will be done. Dr. Parks can not commit one way or the other but acknowledged the feedback.

3) We are part way through the process of moving to risk adjusted rates. Previously the capitation rate was not based on previous year health care needs. This last year we have been basing on pharmacy claims only by July 1st we will be using all of our medical claims also. So the cap rates will have some adjustments based on how sick the people in that plans pool are.

4) The fourth item is starting a separate rate cell for pregnant women for both pre- and post-natal . Post natal I usually 6 months post-natal unless they meet general eligibility.

The new adjusted rate is cost neutral and will not cost the taxpayers more money. These changes are designed to make the size and risk more standardized so that things become more stable and predictable across all plans and within individual plans performing.

It was discussed whether these changes would allow health companies to pick people who were less sick than others. The Plans will be given a broad range but there is no evidence that this will happen or has happened in Missouri.

Emphasis on Better Health Outcomes and Health Care Reform Initiatives. The committee discussed legislative session actions to reform or fix Medicaid. This included: implementing changes in the new RFP; requiring health homes or accountable care organizations statewide to incrementally implement

provider based care coordination and case management, a requirement for incentivizing personal responsibility (i.e. misuse of ER, keeping appointments, etc.) and to start requiring pay-for-performance (providers have opportunity for performance based bonuses). Three major areas of scoring the plans will be for improved access, quality of care, and reform requirements.

It was discussed that the plans will be given broad parameters but each plan will have their own individual incentive program. It will not be based on geographical location.

The committee discussed whether the "pay-for-performance" requirement will allow providers to cherry-pick clients who are less sick. Dr. Parks stated that it will have to be monitored and there will have to be dialogue between all parties, not sure how to avoid this.

Nonperformance of Plans: there will be a 2-3% withhold of the capitation rate until the plan meets their contract requirements. Four areas of focus are: 1) encounter data accuracy and completeness; 2) improving EPSDT screening rate; 3) provider panel accuracy and completeness; and, 4) internal plan for case and care management. This will be enforced through a capitation withhold.

Administrative Efficiencies and Transparency related to administrative effectiveness and transparency (on third page of handout). Require managed care plans to pay FQHCs and rural health centers at 90% of previous year costs. This will reduce fee-for-service payments outside of managed care plans. This will reduce costs administratively for providers and MHD. CMHCs upper payment limit enhancement to be used for providing services for mental health issues.

There will be no cost saving to the state -- however, it will more accurately reflect in the capitation payment what the actual cost of managed care is.

Timeline for New Managed Care RFP

Late September/Early October – RFP and Data Book available to successful bidders
Mid-October – Pre-proposal conference
Mid-November – contract bids due
January/February - Evaluations
March – Contract Award
Mid-April – Open enrollment
Mid-June – Auto Assignment
July 1 – Plans begin

Dental benefits will not change.

Quality Comparison - Paul Stuve presented data comparing clinical quality outcomes to show where we are in the fee-for-service and managed care programs. Dr. Stuve provided a hand-out "Fee-for-Service/Managed Care comparisons on Quality Metrics: An Evolving Analysis". More data will be provided over time to keep everyone informed.

Additional discussion occurred regarding specifics on prescriptions and the coverage of them.

MEDES Update - Alyson Campbell presented a follow-up report on MEDES, a handout was provided.

A question was presented as to why the government can't identify potential Medicaid patients more accurately. Ms. Campbell explained that they have been in conversation with CMS about the criteria they are using and are still in talks with them about this.

It was discussed that the rejection rate of account transfers from the market place is much higher than those outside of the market place. The rejection rate in the market place is about 90% whereas the normal rejection rate is around 35%. The committee would like to see a comparison between our state and other states similar to ours on rejection rates, as well as an explanation for why applicants were rejected. Only three states have a negative growth rate and Missouri is one of them.

It was asked: why Missouri has a negative rate while other non-expansion states are growing? Dr. Parks stated that other states might be a determination state. A determination state is the option that the state chose. Some decided to make their own determination while others agreed to take any citizen if the federal market place deemed them Medicaid eligible. It is about a 50/50 split on which states chose to be a determination state or not. Dr. Parks will be able to provide a table showing the states.

There was discussion on the application processing time and what factors are causing the delay. At this time more applications are being processed than what are being submitted. There is concern about the delay in processing, especially for newborns. There is a mitigation strategy that was put in place early in the process of transition to the new program. The Department is working on a way to more quickly send in emergent cases for coverage with large volume facilities. Now there is the ability to change the coverage date to the proper coverage date, which was not available in the beginning. Discussion was held regarding staffing issues and whether additional staffing would help.

Since open enrollment has ended for the Federal government the volume of applications received from the marketplace is not nearly as high.

The committee asked whether: When staff reports they have a big up-kick in the number of applications and a new program is being used, as a manager, wouldn't that say you need more staff? Director Brian believes that it is not a staffing issue, but a new process and new program that are the issue. There will always be new material coming in the front and material going out the back. The number will never be zero. This is a new major system. The work that is needed to make the transition is the change of process. The goal is to keep driving number down but the system will never have a zero amount of material. Dr. Leary shared her concerns in the backlog for newborns and children. Alyson Campbell states that now we are able to change dates of coverage to the correct starting day. Brian also stated that the state basically bought an "off the shelf package" for the new system. They have to change procedures and work within the limits of our state laws. There has been tremendous amount of pressure on staff and contractors to push through an 18 month project in six month time frame.

Overall, there are numerous factors in the processing time of applications and the Division is working constantly to resolve these issues and to bring the processing time of applications down to within the time limit the Federal government requires.

MO HEALTHNET ENROLLMENT BY ELIGIBILITY CATEGORY June 2014 Participants as of June 2014 totaled 825,974 with an additional 67,616 receiving women's health services. The women's health

services program is a limited benefit eligibility category, essentially family planning services. A higher federal match is allowed for these services. The number of participants is not typically included in overall MO HealthNet eligibility numbers. The chart reflects that of the 825,974 MO HealthNet participants, 61.1% are children, 19.0% are persons with disabilities; 8.2% are custodial parents, 9.1% are seniors defined as individuals 65 or older; and 2.6% are pregnant women. Out of the total 504,582 children enrolled there are approximately 68,286 children enrolled in the Children's Health Insurance Program (CHIP). The chart reflects that out of the 847,385 MO HealthNet participants 388,857 are currently enrolled in Managed Care.

Public Comment

Stacy Schwab, Legal Aid Western Missouri: There are concerns with their clients being able to access Medicaid. There are a numerous documents being lost and clients have submitted the documents multiple times. Even after legal aid becomes involved they are asked to resubmit the information because it was never received or lost. The easiest way to resolve this is to have the client reapply. The other issue that is being seen is the delay in processing applications. They have clients who are still pending after eleven months. They had a pregnant client who applied and her application was still pending, and to make matters worse, the client gave birth to her child prematurely at 28 weeks. After two weeks, neither the mom nor her baby has coverage after being directly notified by the Legal Aid office. These are systemic problems that must be remedied.

Jeanette Von Oxford from MSW: They have been receiving problem calls regarding Medicaid. While they have tried different things, they worry about those who have not reached out to an advocacy program. The patterns that they are hearing over and over are lack of familiarity about a case, loss of documents or documents not being given to the correct person, call center employees lack the knowledge and are un-personable, talking to a case worker is nearly impossible, cases are being closed inappropriately, and recertification is becoming extremely hard. Several clients have navigated the system successfully in the past but cannot get resolutions today. They have real people, with serious problems, and they are not getting resolutions quickly enough. Think about the ripple effect of how these problems not getting solved are causing people to end up losing their stable housing, electricity and jobs. MSW is willing to help solve this problem.

Dr. McBride asked how the changes are affecting those in the community from her prospective. Most clients do not like change. Those who do not have a stable home/personal life need help to access the new systems. Either clients do not have access or do not know how to work with the new changes. We need to help those clients. Clients who are physically delivering documents or have faxed in documents are having problems because their paperwork is being lost. Something is wrong and we need to fix this.

Steve Koontz, Mid-Missouri Legal Services spoke on his experience with managed care services. He has never seen the level of concern that the applicants and recipients are expressing. The question that is posed now is what is happening with my case? Whereas, it use to be "look what FSD did" or is my verification right etc. Lost documents, misplaced documents, etc are again a problem. There is no substitute for a direct line of communication. Clients need a way to directly communicate about their cases. Mr. Koontz believes that workers do not know what is going on or the next step . Whether it is calling, mailing, or via internet there is no way to directly communicate. And this is a problem for new applicants and applicants going through a case review.

The following questions were asked: when we went to MEDES, how many locations were closed where people could travel to, to sit down with and have a face-to-face conversation about their applications?

How much money was removed from the budget and do we need to consider asking the legislature to move these locations on a bus line so that it is more accessible? The response was no locations were closed. There have been approximately 30 new locations opened. These locations are called Resource Centers. The person a client sees may not handle the cases but their sole focus is to help the client. Management Teams are going around the state to help resolve issues with lack of knowledge from staff. Staff has the tools to look at the case and see if it needs to be processed.

Lucas Caldwell McMillan, Legal Services Eastern Missouri: Expressed the same concerns as the previous speakers. Customer service is a big issue. When calling there is lack of knowledge, only getting the message that their status is pending, etc. Clients are not hearing back from Family Support Division about their application. Eventually they are told to reapply which also stacks up applications. There also are problems with newborns, where the parent reapplies to be in the new system, but the system says there isn't a kid in the system. Clients are also now receiving bills and being sent to collection agencies. This also affects not only the health problems, but also credit and financial histories. Senator Schaaf asked what the approximate time frame is starting from when the client first applies, to when their case is resolved. Response was: they do not track this, but they have seen 5-6 months others have been 1-2 months.

A handout from Steve Renne Vice President of Children's Health and Medicaid Advocacy was distributed and will be included in the public records.

Legislative Update

Val Huhn provided the legislative update including a handout. The session ended in May. Governor has taken action on all bills.

One piece of legislation deals with Assistant Physician, somebody that has completed their entire medical school training so they have a degree from an accredited school and they have passed their medical boards but they have not yet had their first year of supervised practice. So what has happened is that funding for medical school has outstripped funding for graduate medical education. So there is now a larger pool of physicians who have completed medical school but can't practice independently until they have at least one year of independent supervised practice. An Assistant Physician would allow people that have completed medical school to practice in a collaborative practice agreement with a fully licensed physician under their supervision and their authority. There are less than 20 of these in Missouri. The Physician Assistant will be allowed to enroll in Medicaid.

Budget Update

Val Huhn provided a handout with an update of the current status of the budget including what items were funded, which ones were restricted and which items were vetoed.

Adjourn

Dr. McBride adjourned the meeting at 4:00 p.m. Next meeting is scheduled for October 14, 2014.