Health Care Transparency

in Quality, Price, Interoperability in Health Systems and Incentives to Reward Outcomes

Missouri Department of
SOCIAL SERVICES
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Introduction

On March 2, 2007, Governor's Executive Order 07-12 was issued. This executive order charged state agencies administering health care programs to develop a plan to address transparency in the delivery and administration of health care. This is the sixth report detailing how the Department of Social Services (DSS) is promoting transparency for the MO HealthNet, MO HealthNet for Kids, and Missouri Rx Plans.

The DSS transparency plan centers on current initiatives and implementation of the Missouri Health Improvement Act of 2007. The DSS plan focuses on these four areas from the executive order:

- *Support interoperable health information systems and products so long as the maintenance or exchange of health information includes provisions to protect patient privacy as required by law;*
- *Support the development and implementation of objective quality standards for services supplied by health care providers in that program, ultimately making provider performance on these standards available to consumers of the program's services;*
- *Support making information available regarding the prices for procedures or services under the program; and*
- *Make every effort to deliver high quality and cost-effective health care that may include consumer-directed health care plans and reimbursement methods that reward providers for results.*

What is health systems interoperability?

There is no one health care system; health care is delivered through an assortment of disconnected providers with varying levels of technological sophistication. The basic concept of interoperability is easily sharing data. Standards are set so one system can talk to another and they can exchange data accurately, efficiently and securely. By connecting providers and payers, we gain a data supply to dependably measure cost and quality. Dollars saved by minimizing redundancies can be redirected to improving care.

Health Systems Interoperability

- **MO HealthNet's Electronic Health Records in CyberAccess℠** – More than 17,000 physicians and other health care providers use this web-based portal to access electronic health records for MO HealthNet patients. Treating providers can view a patient's medical history including diagnoses, procedures and prescribed medications. Providers can electronically submit prescriptions and request pre-certification for imaging procedures, durable medical equipment, inpatient hospital stays and optical services. CyberAccess℠ improves efficiency of health care delivery by using a rules-based engine to determine if a requested drug or procedure meets the appropriate clinical criteria. All of this is done in a secure environment and the entire system is Health Insurance Portability and Accountability Act (HIPAA) compliant. The tool now includes lab and clinical trait data imported from provider medical records, as well as increased functionality to allow physicians to input notes. The tool supports the prior authorization of services provided to participants to ensure appropriate utilization and efficient use of funds. The MHD recently implemented a health home program in Missouri to provide case management services for participants with chronic behavioral or medical conditions. The CyberAccess tool provides the case management service providers with claims information and clinical tools to support the delivery of the care management services and coordination of care for the participants.

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- **Medicaid Management Information System (MMIS)** – MHD is reengineering the current MMIS. The state awarded the MMIS fiscal agent contract to Wipro Infocrossing, Inc. on September 7, 2007. The fiscal agent contract includes implementation of key enhancements to the core infrastructure of the MMIS as well as new functionality. The enhancements will be available through a modernized system that will support information sharing among health care partners. Key enhancements and MMIS related projects include the following:

  - Conversion to a Relational Database – This enhancement includes the conversion of MMIS data from a flat file structure into a relational database managed by a relational database management system. The first phase of this enhancement was completed in June 2011, and second phase is scheduled for completion in October 2013.

  - Development of the Business Rules Engine – This enhancement includes the development of a rules engine to capture and maintain business rules including decision criteria and system actions. The first phase of this enhancement was completed in June 2011. The next phase of the business rules enhancements will occur after the HIPAA required ICD-10 enhancement.

  - Metadata Management – This enhancement will promote data sharing between business partners by providing easy to understand data definitions that will enhance the accurate transfer of information between systems. Ad Hoc and utilization review reporting tools were implemented in June 2011. Administration reporting tools will be implemented in December 2012.

- HIPAA Enhancement – 5010 and D.0 Transaction Sets – As part of the 1996 HIPAA Title II Act – Administrative Simplification Standards 2009 Modifications, the Accredited Standards Committee Version 5010 and National Council for Prescription Drug Programs D.0 transaction sets was implemented for all HIPAA-covered entities on January 1, 2012. The Version 5010 and D.0 transaction sets are new versions of the electronic transactions used to exchange information with partners and providers. The MMIS is now capable of receiving and processing these new transactions. The second phase of this enhancement will be implemented in January 2013 and will focus on utilization of the additional information contained in the new transactions.

- HIPAA Enhancement – ICD-10 – As part of the 1996 HIPAA Title II Act – Administrative Simplification Standards 2009 Modifications, the International Classification of Diseases Version 10 code set must be implemented for all HIPAA-covered entities. ICD-10 is a method of coding the patient's state of health and institutional procedures for efficient handling in data systems. The implementation is scheduled for October 2013.

- **Managed Care Organizations (MCOs)** – MCOs, through a contracted relationship with the state, currently provide health care services for approximately 429,000 people enrolled in the MO HealthNet Managed Care Program. The MCOs have claims processing and management information systems that interface with the state's MMIS. This provides valuable encounter data on managed care enrollees. The state, in conjunction with its contracted actuarial firm and external quality review organization, conducts encounter data validation reviews of the MCOs on an annual basis to improve the comprehensiveness and accuracy of encounter data for use as the primary data source for capitation rate development. The state's contracted actuarial firm began using encounter data in the development of the capitation rates effective October 1, 2009. These reviews also serve as a basis for implementing and improving best practices by the MCOs. Additionally, the state uses encounter data for reporting of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) well child visits (MCO capitation rates were developed based on MCO performance on receipt of well child visits) and supplemental delivery payments to MCOs when a delivery occurs. The state uses encounter data for supplemental low-birth weight newborn payments beginning July 1, 2010. The state holds quarterly conference calls with the MCOs for purposes of addressing encounter data problems. The Centers for Medicare and Medicaid Services (CMS) previously recognized the state's efforts to improve the validity of MCO encounter data as a noteworthy practice during the onsite review conducted during the week of March 9, 2009.

- **Non-Emergency Medical Transportation (NEMT)** – NEMT is provided under a contractual relationship and, like the MCOs, the contractor is providing encounter data in a readable format that interfaces with the MMIS. The encounter data is tracked on a monthly basis to assure consistency. The MHD uses encounter data in connection with required reporting to track utilization.

- **Medicaid Transformation Grant - Development of a Web-Based Tool for Home and Community Based Services** – A Medicaid Transformation Grant was awarded to MHD by the Centers for Medicare and Medicaid Services (CMS). This grant provides funding to develop an electronic assessment and services allocation tool for home and community based services. This tool was developed through a cooperative effort with the Department of Health and Senior Services (DHSS). Legislation passed in May 2010 allowing DHSS to use an independent third party assessment contractor to conduct the assessment and care planning. The tool has undergone necessary changes to accommodate this requirement for implementation in May 2011. The contract for the third party assessment contractor was terminated in September 2011. Budget recommendations were made for FY 2013 to have DHSS staff complete the assessment and care plans for initial referrals for Home and Community Based Services (HCBS) and for HCBS providers to assist with providing information for annual reassessments. All Reassessments must be reviewed and approved by state staff. Assessments and Reassessments along with care plan authorizations are entered into the tool created with the grant funds. The tool was implemented in May of 2011 and currently has approximately 6,000 plus users. The Medicaid Transformation Grant ended January 31, 2012.

- **The Missouri Office of Health Information Technology (MO HITECH) and the Missouri Health Connection** – This initiative promotes the use of certified electronic health records (EHRs) by doctors, hospitals, clinics and other health care providers, and to support secure, statewide health information network (HIN). The Office will be part of the Department of Social Services (DSS), led by DSS Interim Director Brian Kinkade, who also serves as the HIT Coordinator overseeing MO HITECH.

- In collaboration of a large volunteer stakeholder contingent, MO HITECH applied for and was awarded $13,765,040 in federal stimulus money, made available by the American Reinvestment and Recovery Act (ARRA) through the U.S. Department of Health and Human Services, to design and implement a statewide health information network (HIN).

  In July 2010 Missouri Health Information Organization (HIO), now Missouri Health Connection, incorporated as a public-private, multi-stakeholder organization charged with implementing the infrastructure to achieve a statewide health information exchange. The new organization is overseen by a 17-member Board of Directors with representation from hospitals, physicians, consumer advocates, state government, health plans, associations and independent citizens.

  Since its incorporation, the new Board of Directors created bylaws and organizational policies for the new public-private corporation. In addition, Missouri fulfilled federal requirements to gain access to the $13.8 million Statewide HIE Cooperative Agreement program award. In January 2011, when the Office of National Coordinator (ONC) approved Missouri's Strategic and Operational Plans, Missouri was one of 20 states to obtain ONC's approval. ONC recognized Missouri's successful stakeholder engagement and commitment to broad and meaningful stakeholder participation.

  Various committees and workgroups have achieved the following in the last year:

  - A technical services partner was selected and a contract negotiated with the vendor. The contract will be completed by June 2012.

  - A plan was developed for implementing the Health Information Exchange in two phases. Each phase will have alpha and beta groups of providers willing to pilot the establishment of the HIE. The alpha and beta pilots for the first phase are scheduled for completion by December 2012. The alpha and beta pilots for the second phase are planned for 2013. Missouri Medicaid plans to participate in the alpha pilots for both phases.

  - The financing models were reviewed and a recommendation was made to pursue a membership/subscription fee model. The pricing model will be finalized as the HIN implementation pilots are completed over the next year.

  - Privacy and security policies for the first phase of technical implementation were developed.

  - Consent options and practices in bordering states were reviewed.

  - A Consumer Advisory Council to provide feedback to the Board and Workgroups on policies and messages was instituted.

  MHD implemented the Medicaid Electronic Health Record Incentive Program in May 2011. The program provides incentive payments to eligible hospitals and health care professionals for adoption of Electronic Health Record technology. In the first year, applications for the incentive payment were received from over 1,200 hospitals and professionals. To date, Medicaid has paid out over $70 million in incentive payments.

  For continued participation in the incentive program, the eligible hospitals and professionals must demonstrate "meaningful use" of the Electronic Health Record. The criteria for meaningful use include creation of electronic orders, submission of electronic prescriptions to pharmacies, and the receipt of results electronically from labs. The meaningful use criteria will also require hospitals and professionals to participate in the statewide health information exchange.

Why is measuring health care provider performance important?

We want to spend our health care dollars where we will get the best care. Quality of care is of interest to everyone, but measuring it is complex. There is a void of publicly accessible, accurate information on cost and quality, so we are continuing our efforts to make information easier to access and easier to understand.

Quality of Provider Performance

- **Health Home Initiative**
  MO HealthNet has implemented an eight-quarter primary care health home program. In parallel, the Department of Mental Health has implemented a behavioral health Health Home program. Both Health Home programs require a state plan amendment, which have been approved by CMS.

  Primary care organizations wishing to become health homes under the program went through an application process to MO HealthNet and needed to meet certain criteria, including having a substantial portion of patients enrolled in Medicaid. Eligible Health Home providers include:
  - FQHC's
  - RHC's
  - Primary care clinics operated by public entity hospitals

  There are currently 24 primary care Health Home organizations, each of which has one or more clinic sites enrolled as Health Homes. Practice sites are physician or nurse practitioner-led and the Health Home team consists of a behavioral health consultant, nurse care manager, care coordinator, and others per practice. The practice is paid a per member per month payment for each patient enrolled in the Health Home.

  The Health Home program focuses on the highest risk and highest cost patients. Eligible patients have at least two of the following:
  - Asthma
  - Cardiovascular disease
  - Diabetes
  - Developmental disabilities
  - Overweight (BMI>25) or
  - One of the above and tobacco use or
  - Diabetes as single condition

  The Key Health Home Services for MO include:
  Comprehensive Care Management
  - Care Coordination
  - Health Promotion
  - Comprehensive Transitional Care
  - Individual and Family Support Services
  - Referral to Community and Social Support Services

  The Health Home program intensifies care coordination and care management with the aim of improving patient health and outcomes, reducing emergency department utilization and hospital admissions, and reducing health care costs. MO HealthNet will be trending data for the program over the next two years and will report results as they become available.

- **Healthcare Effectiveness Data and Information Set (HEDIS)** – HEDIS is a tool used by more than 90% of America's health plans to measure care and service performance. HEDIS makes it possible to compare the performance of health plans on an apples-to-apples basis. Health plans use HEDIS to see where improvement is needed. Annually, DSS requires MCOs to submit independently audited HEDIS performance rates as specified by the National Committee for Quality Assurance (NCQA). The MCO's 2010 HEDIS data demonstrated improvement in:

  - Annual dental visits ages 2-3, 4-6, 7-10, 11-14, 15-18, 19-21 years and the combined rate;
  - Asthma ages 5-11; 12 to 50, and Asthma Combined
  - Childhood immunization (Combo 3) and (Combo 10)
  - Adolescent well-care visits;
  - Adolescent Immunizations
  - Adolescent Immunizations (All Three Shots)
  - Well-child visits in the first 15 month of life 0, 1, 3, and 6+ visits.
  - Postpartum care; and,
  - Chlamydia screening, ages 16-20 and 21-26, and combined rate.

Support the development and implementation of objective quality standards for services supplied by health care providers in that program, ultimately making provider performance on these standards available to consumers of the program's services

- **External Quality Review** – CMS requires an annual, independent, external evaluation of the MO HealthNet Managed Care program. An external quality review is an analysis of aggregate information on quality, timeliness and access to health care services furnished by MCOs and their contractors for MO HealthNet managed care recipients**.**

  The 2010 MO HealthNet Managed Care Program External Quality Review Report of Findings was issued in December 2011. Overall, the External Quality Review Organization (EQRO) found continued improvement by the MO HealthNet managed care health plans through validation of health plan performance improvement projects, performance measures, encounter data and compliance with managed care regulations. The 2010 External Quality Review Report may be accessed at http://www.dss.mo.gov/mhd/mc/pdf/eqro2010.pdf.

- **Children's Health Insurance Program (CHIP) Annual Report** – Effective September 1, 2007, Missouri's Children's Health Insurance Program (CHIP) was moved from an 1115 Waiver to a combination program on the Medicaid State Plan and CHIP State Plan.

  The October 2011 CHIP Annual Report concluded the CHIP population represents approximately 1% of the entire state population. Without CHIP, approximately 70,000 additional children would most likely be uninsured, raising the state's percentage of uninsured children to 14.5% and lowering Missouri's rank for uninsured children to 46th in the nation.

  In Missouri in the last 5 years, it appears that the increases in Medicaid-covered kids and uninsured kids more than offset the decreases in employer sponsored coverage (ESI) and private insurance, but if crowd-out is occurring it is at the lower income level of Medicaid, not in the CHIP program, and that children receiving coverage through CHIP would likely be uninsured without it. It is important to note that the Missouri General Assembly's action to extend premium and affordability requirements to a greater portion of Missouri's CHIP population has provided mechanisms to address crowd out.

The positive impact of CHIP is reflected in the following quality results:

- More children received immunizations in 2011 than in 2010. The rates improved in the following areas: pneumococcal conjugate vaccine, Hepatitis A Vaccine, rotavirus vaccine, Influenza, Combination vaccines 3, 4, 5, 6, 7, 8, 9 and 10.
- The 2011 Chlamydia screening rate is 3.91% greater than the National Committee for Quality Assurance (NCQA) national average.
- Well child visits in the first 15 months of life improved by 2% in 2011.
- Adolescent Well Care Visits increased by 1.75% in 2011.
- From 2010 to 2011, there was a 34.95% increase in Combo 1 adolescent immunizations, a 23.43% increase in Meningococcal immunizations, and Diphtheria, Tetanus, and Acellular Pertussis (DTaP) immunizations increased by 19.63%.
- The total number of eligibles who received preventative dental services increased by 15.52% from 2010 to 2011.
- The number of children receiving dental treatment in 2011 increased by 8.1%.
- There was a decrease of 5.17% in the number of emergency department visits from 2010 to 2011.
- From 2010 to 2011, there were increases in consumer satisfaction of over 2% in Getting Needed Care, Rating of Health Care and Rating of Plan. There was an increase of between 1% and 2% in Getting Care Quickly, Customer Service, How Well Doctors Communicate, Rating of Doctors and Rating of Specialists.

- **1115 Demonstration Waiver, Women's Health Services** – On June 24, 2011, CMS approved renewal of Missouri's Section 1115 demonstration waiver, Women's Health Services Program, effective July 1, 2011. The Women's Health Services demonstration provides approved family planning services to uninsured (defined as not having creditable coverage) women age 18 to 55 years of age with net family income at or below 185% of the federal poverty level and assets totaling less than $250,000. As of September 30, 2011, 104,836 women were receiving coverage. An evaluation is conducted annually by an external agency. For the women enrolled in the Women's Health Services demonstration during the federal fiscal year 2011, rates of pregnancy were lower than the birth rates in the first year of the demonstration. The reduction in pregnancy rates means that 5,800 births were averted among the demonstration population. By averting 5,800 births, the Women's Health Services demonstration resulted in savings of $38.3 million. This savings figure is the result of avoided costs for pregnancy, labor and delivery. The savings are even greater—$75.2 million—when accounting for the cost savings related to expenditures incurred during the first year of life.

- **Home and Community Based Quality Strategy** – Missouri operates nine Home and Community Based Services (HCBS) waivers which allow individuals to remain in their communities and avoid institutionalization:
  - Aged and Disabled Waiver – Homemaker/chore, respite, and home delivered meals to individuals aged 65 or over and disabled individuals age 63 to 64;
  - AIDS Waiver – Expanded personal care services, private duty nursing, attendant care and supplies for individuals diagnosed by a physician as having AIDS or an HIV-related illness;
  - Autism Waiver – Behavior analysis, in and out of home respite, personal assistant, environmental accessibility adaptations, specialized medical equipment and supplies, support broker, and transportation services to children age 3 to 18 years who have a pervasive developmental disorder and receive substantial unpaid support from family members;

- Independent Living Waiver – Expanded personal care services, environmental accessibility adaptations, specialized medical equipment and supplies and case management for individuals age 18 to 64 who have a cognitive and/or physical disability and are able to self-direct their services;

- Comprehensive Waiver – Assistive technology, behavior analysis service, communication skills instruction, community employment, community specialist, community transition, counseling crisis intervention, day service, environmental accessibility adaptations, group home, host home, in home respite, individualized supported living, job discovery, job preparation, occupational therapy, out of home respite, personal assistant, physical therapy, positive behavior support, professional assessment and monitoring, specialized medical equipment and supplies (adaptive equipment), speech therapy, support broker, and transportation services to individuals who have a developmental disability;

- Missouri Children with Developmental Disabilities Waiver (MOCDD) Waiver – Day habilitation, behavioral therapy, respite, personal assistant services, community specialist services, crisis intervention, transportation, environmental accessibility adaptations and specialized medical equipment and supplies to individuals age birth to 18 who have a developmental disability and whose parent's income is not included in determining eligibility for MO HealthNet benefits;

- Community Support Waiver – Assistive technology, behavior analysis service, communication skills instruction, community employment, community specialist, counseling, crisis intervention, day service, environmental accessibility adaptations, in home respite, job discovery, job preparation, occupational therapy, out of home respite, personal assistant, physical therapy, positive behavior support, professional assessment and monitoring, specialized medical equipment and supplies (adaptive equipment), speech therapy, support broker, and transportation services to individuals who have a developmental disability and receive substantial unpaid support from family members;

- Partnership for Hope Waiver – Assistive technology, behavior analysis service, community employment, community specialist, day service, dental, employer provided job supports, environmental accessibility adaptations, job discovery, job preparation, occupational therapy, personal assistant, physical therapy, positive behavior support, professional assessment and monitoring, specialized medical equipment and supplies (adaptive equipment), speech therapy, support broker, temporary residential, and transportation services to individuals with a developmental disability who meet ICF/MR Level of Care and their needs can be met with the current support system. Participants must reside in one of 93 participating counties or the City of St. Louis and the waiver services cannot exceed an annual cost of $12,000. This waiver is county-based and a result of a partnership of the Missouri Association for County Boards for Developmental Disability Services, the Division of Developmental Disabilities, and the MO HealthNet Division; and

- Medically Fragile Adult Waiver – Attendant care services, private duty nursing and specialized medical equipment/supplies to individuals who have serious and complex medical needs age 21 or older and are no longer eligible for services under the Healthy Children and Youth program.

MHD maintains a Quality Management Strategy, which demonstrates to the federal government that DSS retains administrative authority of the HCBS waiver programs, and has systems in place to measure and improve its performance in meeting the waiver assurances. These systems assure participant access, participant-centered service planning and delivery, provider capacity and capabilities, participant safeguards, participant rights and responsibilities, participant outcomes and satisfaction and system performances.

- **MO HealthNet Managed Care Annual Report** – Each year evaluations of the MCOs in the MO HealthNet Managed Care program are performed. The evaluation contains information concerning the effectiveness and impact of the MCOs' MO HealthNet quality assessment and improvement strategy. The evaluation also reports on compliance with state, federal and MO HealthNet contractual requirements.

The SFY-2010 MO HealthNet Managed Care Annual Evaluation will be presented at the MO HealthNet Managed Care Quality Assessment and Improvement (QA&I) Advisory Group and All Plan meetings in July 2012. Evaluation of network adequacy; travel distance; consumer assessment of health care providers and systems (CAHPS) survey data; HEDIS indicators; provider surveys; performance improvement projects; fraud and abuse; credentialing and recredentialing; subcontractor oversight; and federal rule compliance revealed a continued commitment of the MCOs to provide quality health care to their participants.

- **Hospital Quality Initiative –** This initiative uses a variety of tools to help stimulate and support improvements in the quality of care delivered by hospitals. The intent is to improve quality of care by distributing objective, easy to understand hospital performance data. We anticipate that this will encourage consumers and their physicians to discuss getting the best hospital care, create incentives for hospitals to improve care, and support public accountability.

  CMS continues to implement its public-private initiative on hospital performance measurement and reporting. This is done in collaboration with several national hospital groups and a variety of federal and private organizations concerned with quality improvement and transparency of data. Through the CMS Hospital Inpatient Quality Reporting Program (Hospital IQR), a robust and standardized set of hospital quality measures has been refined for use in public reporting. These cover medical conditions such as myocardial infarction, heart failure, and pneumonia; surgical procedures; healthcare associated infections and hospital acquired conditions; and a set of measures designed to capture patient satisfaction (the Hospital Consumer Assessment of Healthcare Providers and Systems; HCAHPS).

  In addition, CMS implements a Hospital Outpatient Quality Reporting program (Hospital OQR), which consists of 11 outpatient measures including outpatient surgical measures, acute myocardial infarction (AMI) and chest pain cases that are transferred to another inpatient facility. This project also includes four claim-based imagery efficiency measures.

  CMS shares these Hospital IQR and OQR data publicly on its Hospital Compare website, http://www.hospitalcompare.hhs.gov. Similar data on home health and nursing home services is also posted on the Missouri Health Matters website (www.missourihealthmatters.com), sponsored by the Missouri Hospital Association (MHA: http://web.mhanet.com/default.aspx).

  Beginning in FFY 2013, CMS is launching a Value Based Purchasing (VBP) program to reimburse a portion of acute care hospitals' payment based on their performance on specific quality measures relative to their peers and national scores. Outcome measures for the FFY-2014 Hospital VBP program include measures of mortality, patient safety, and hospital acquired conditions. Many hospitals have already implemented performance improvement initiatives related to these measures.

  MO HealthNet will be implementing 13 CSR 70-3.230 Payment Policy for Provider Preventable Conditions in July 2012. This regulation applies Medicare prohibitions for healthcare acquired conditions (HCACs) in inpatient hospitals and ambulatory surgical centers to Medicaid. States are required by 42 CFR Parts 434, 438, and 447 Medicaid Program; Payment Adjustment for Provider-Preventable Conditions including Health Care-Acquired Conditions to develop regulations effective July 1, 2012, that identify and outline process for HCACs. As of July 1, 2012, CMS will prohibit payment to states for any amount expended for providing medical assistance to HCACs specified in regulations. The regulation aims to reduce health care acquired conditions. To operationalize the rule MHD convened two workgroups comprised of clinical and finance staff to develop the process for claim and payment review. States are required to implement provider self-reporting through claims systems. The legislation prohibits reduction in payment when the condition existed prior to the initiation of treatment for that patient by the provider. Reductions in payment are limited to the extent that the identified condition would otherwise result in an increase in payment and the state can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the condition. Otherwise, MHD will deny or recover payment for a HCAC when the event is determined to be preventable as defined in regulation. The regulation will be effective June 30, 2012.

- The Missouri Department of Health and Senior Services (DHSS) posts data on its Missouri Healthcare Infection Reporting System website (http://www.health.mo.gov/data/hai/) on hospitals' central line-associated bloodstream infections, specific surgical site infections, and compliance with a ventilator-associated pneumonia process measure.

  In 2005, the Missouri Center for Patient Safety (MOCPS; http://www.mocps.org/) was established by the Missouri Hospital Association, the Missouri State Medical Association, and Primaris, Missouri's federally designated Quality Improvement Organization (QIO). MOCPS' mission is "to be a leader in providing solutions and resources to improve patient safety and the quality of health care delivery by conducting activities in collaboration with health care providers, physicians, purchasers, consumers and government." They currently sponsor an Annual Patient Safety Conference, and maintain a Patient Safety Speakers Bureau. With its designation in 2006 as a Patient Safety Organization (PSO), the Center is able to collect and report information about medical errors under protection of federal law. Today 147 hospitals, 10 ambulatory surgical centers and 53 ambulance districts are part of their PSO. Additionally, Primaris announced in January 2012 that it had selected MOCPS to head a Comprehensive Unit-based Safety Program (CUSP) related to urinary tract infections. Seven Missouri hospitals are participating in this initiative.

  Increasing attention is being directed toward pre-term births. Research shows that infants born prior to 37 weeks of gestation are at risk for a variety of medical complications and health issues. CMS recently announced a "Strong Start" grant designed to look at three different models of prenatal care in an attempt to determine if any of them is effective at reducing the frequency of pre-term births. The grant application deadline is in June 2012, and several agencies in Missouri have indicated an interest in applying. MO HealthNet Division and DHSS are collaborating with applicants to provide the data necessary to evaluate healthcare services and outcomes for these women and their infants.

Why is sharing health care pricing important?

Freely sharing pricing information is necessary to control costs. We need reliable information so both consumers and government can make valid price comparisons and get the most from their health care dollar.

Sharing Health Care Pricing

- **MO HealthNet Fee Schedules** – MHD on-line fee schedules are updated quarterly and are available at http://www.dss.mo.gov/mhd/providers/pages/cptagree.htm. These schedules identify covered procedure codes, restrictions, allowed units and the MO HealthNet allowable fee per unit.

- **Children's Health Insurance Program Premium Schedule** – Individuals in families with income above 150% of the federal poverty level share costs through monthly premiums. Families pay no more than 5% of their annual income for premiums in a year. The premium amounts change effective July 1 of each year. The premium amounts are calculated according to state law (the state budget and MO Revised Statute Section 208.640). Monthly invoices are sent to those individuals owing a premium. Individuals who have questions about premiums should call the Premium Collections Unit at 1-877-888-2811. The premium schedule is posted on the website, http://www.dss.mo.gov/mhd/providers/pdf/puzzledterm.pdf.

Support making information available regarding the prices for procedures or services under the program

- **MO HealthNet Managed Care Rates** – Capitation payments, supplemental delivery payments, and supplemental very low birth weight newborn payments are made to MCOs for contracted services. The MCO capitation rates are public information, which can be obtained from the state of Missouri, Office of Administration, Division of Purchasing and Materials Management. Beginning on January 1, 2013, managed care rates will be risk adjusted to reflect the acuity of the patients enrolled in each plan. Risk adjusted rates discourage plans from ~~"~~cherry picking" enrollees and reward plans taking care of patients with higher acuity levels.

- **Non-Emergency Medical Transportation (NEMT) Rates** - The NEMT provider capitation payment is the only payment made for transportation services. NEMT capitation rates are public information and can be obtained from the state of Missouri, Office of Administration, Division of Purchasing and Materials Management.

- **Pricing for Procedures and Services - Missouri Rx Price Compare (MoRx Price Compare) –** In January 2007, MoRx Price Compare (http://www.morxcompare.mo.gov/) was launched. The MoRx Price Compare tool was created to give consumers access to medication prices for the most commonly used prescription drugs. MoRx Price Compare uses information captured through the MO HealthNet claims process to create a user-friendly, web-based tool that allows consumers to comparison shop using retail prescription prices. The website tool allows Missourians to obtain the best local price for prescriptions by comparison shopping among pharmacies to get the best local price for prescriptions. County, city, zip code and area comparisons can be made. MoRx Price Compare lists prescription medication prices based on the usual and customary price reported by local pharmacies. An uninsured, cash-paying customer would normally pay this retail price without any discounts. Since its launch in 2007, over 68,000 search sessions have been initiated.

- **Medicare and Dental Rates** – SB 577 (2007 legislative session) requires the department to report each January 1 on the status of reimbursement rates compared to 100% of Medicare rates and average reimbursement for dental services by third party payers. On June 30, 2008, the department presented a four-year plan to the General Assembly to achieve parity with Medicare and third party dental rates. A copy of the report is available on the Division's website at http://www.dss.mo.gov/mhd/oversight/resources.htm.

  In December 2011, a provider reimbursement rate study was presented to the Governor and General Assembly, which compared current reimbursement rates to 100% of Medicare rates and the average reimbursement for dental services by third party payers.

- **Nursing Home and Hospital MO HealthNet Rates** – MO HealthNet reimburses participating nursing facilities on a per diem basis for actual days billed. In May 2009, MO HealthNet began posting the Nursing Facility Rate List on its website. The rate list includes information on participating nursing facilities including the facility name, MO HealthNet reimbursement rate, city, county and the number of licensed and certified beds. The rate list is in a user-friendly format (Excel) that can be downloaded to allow users to review and analyze the data to suit their needs. The rate list is updated on a monthly basis and is available at http://www.dss.mo.gov/mhd/providers/pages/nfrates.htm

  MO HealthNet participating hospitals receive payment for hospital services as follows:

  - Inpatient Hospital Stays – MO HealthNet reimburses hospitals on a per diem basis for actual days billed. Additionally, MO HealthNet makes add-on payments to compensate hospitals for costs not reimbursed through the per diem.

  - Uninsured – MO HealthNet reimburses hospitals serving a high or disproportionate share of Medicaid or low-income participants for the cost of services provided to the uninsured (i.e., disproportionate share (DSH) payments).

  - Outpatient Services – MO HealthNet reimburses hospitals for outpatient services based on a percentage of billed charges with the exception of certain lab & radiology services that are reimbursed based on a fee schedule.

  - MO HealthNet is developing a hospital rate list that includes the hospital inpatient per diem rates and the outpatient percentage that will be posted on the website and updated quarterly. The hospital rate list should be available in SFY 2013. The on-line fee schedule for outpatient lab services reimbursed on a fee schedule is available at http://www.dss.mo.gov/mhd/providers/pages/cptagree.htm.

Why is rewarding quality important?

We have a capitalistic society. For every MO HealthNet service there is a maximum fee, but historically we have made no payment distinction between good and bad care. To safeguard our health care we need to balance keeping quality providers in the system with cost effectiveness. To encourage quality, we need to reward providers who practice good medicine and consistently meet established standards of care.

Cost-Effectiveness, Consumer Involvement and Provider Rewards

- **MO HealthNet Managed Care Early Periodic Screening, Diagnosis and Treatment (EPSDT) Adjustments** In accordance with CMS guidelines, DSS requires 80% of eligible MO HealthNet Managed Care members to have Healthy Children and Youth (HCY)/EPSDT well child visits. Screening rate trends over the past six years are shown in the table below.

FFY	# of Children Screened	% Eligible Children Screened
2006	163,450	75.9%
2007	165,241	72.3%
2008	169,896	67.9%
2009	186,896	86.4%
2010	200,895	67.5%
2011	212,122	70.4%

- **High Quality and Cost-Effective Health Care (Direct Care Pro™) –** Direct Care Pro™ is a highly innovative Medication Therapy Management (MTM) tool. This application utilizes the pharmacist-patient relationship, focusing on quality of care, wellness initiatives and cost containment. This web-based system assists pharmacists and other appropriate healthcare providers to maintain standards of care for participants' multiple chronic diseases and co-morbidities by utilizing nationally recognized, evidence-based treatment standards. The statewide rollout of this tool started in summer 2010 by delivering actionable clinical information at the point-of-service, empowering pharmacists to provide clinical education to their patients. As of April 2012, there were 144 pharmacy sites with 190 pharmacists set up with MTM access and 1,437 encounters had been performed.

Make every effort to deliver high-quality and cost-effective health care that may include consumer-directed health care plans and reimbursement methods that reward providers for results

- **Clinical Editing/Prior Authorization (SmartPA™)** – SmartPA™ uses a highly sophisticated clinical rules engine that uses algorithmic criteria derived from best practices and evidence-based medical information to allow transparent approval of service and product requests. It streamlines the prior authorization process for all stakeholders – physicians, allied health professionals and participants, as it adjudicates prior authorizations in real time. All providers who participate in MO HealthNet's fee-for-service program are subject to clinical editing and prior authorization requirements. Smart MedPA™ technology was implemented in July 2006 utilizing the same clinical rules engine used for SmartPA™. SmartPA™ and Smart MedPA™ process precertifications for pharmacy, durable medical equipment, radiology and optical services. MHD is phasing in psychology appropriate utilization and efficient use of funds.

- **CMS Medicaid Emergency Psychiatric Demonstration (IMD Demonstration Project).** CMS worked collaboratively with private non-profit organizations and across the Department of Health and Human Services (HHS) to develop the "Medicaid Emergency Psychiatric Demonstration" (IMD Demonstration Project). This demonstration is to test whether Medicaid programs can support higher quality care at a lower total cost by reimbursing private psychiatric hospitals for certain psychiatric services for which Medicaid reimbursement has historically been unavailable. Currently Medicaid does not reimburse psychiatric institutions, referred to as ~~"i~~institutions for mental disease" (IMDs), for services provided to Medicaid enrollees aged 21 to 64 (this restriction is known as Medicaid's IMD exclusion). Due to the IMD exclusion, many Medicaid enrollees with acute psychiatric needs, such as those expressing suicidal or homicidal thoughts, are diverted to general hospital emergency departments, which often lack the resources or expertise to care for these patients. For the Medicaid beneficiary, this may result first in a delay in treatment, and then when treatment is provided, inadequate care. General hospitals may delay the provision of care until a bed becomes available, or inappropriately assign them to medical beds. This demonstration enables private IMDs to receive Medicaid reimbursement for treatment of psychiatric emergencies, described as suicidal or homicidal thoughts or gestures, provided to Medicaid enrollees aged 21 to 64 who have an acute need for treatment. Federal funding for the demonstration is available until July 1, 2015.

  Missouri submitted an application in November 2011 to participate in the IMD Demonstration Project because it has a keen interest in improving access to medically necessary care, as well its overall quality for Medicaid eligible adults age 21 to 64 with an Emergency Medical Condition (EMC), and in the process, reduce the problematic practice of psychiatric boarding in general hospitals. In February 2012, Missouri was selected to participate in the Demonstration Project, anticipated to begin July 1, 2012, and will receive federal matching funds for the population of Medicaid eligibles aged 21 to 64 that are currently not covered in IMDs over the 3 year Demonstration period.

  The State will be responsible for collecting and reporting information to CMS for the purposes of Federal oversight and the evaluation of the Demonstration. This information will include regular reports by the institution about patient admissions and discharges, their diagnoses, time to stabilization, and lengths of inpatient stay. This information will be required for all Demonstration eligible patients whether care is provided through fee-for-service or managed care arrangements. The State is also required to cooperate with the CMS evaluation team to assist in the collection of information necessary to evaluate the Demonstration.

  For additional information, following is the CMS link to the ~~"~~Medicaid Emergency Psychiatric Demonstration": http://innovations.cms.gov/initiatives/Medicaid-Emergency-Psychiatric-Demo/index.html

- **CMS Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents (Initiative).** CMS is providing a new funding opportunity for organizations to participate in a demonstration titled "Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents" (Initiative) which is to cover the period from August 2012 – August 2016. CMS is currently soliciting applicants to participate as ~~"e~~nhanced care and coordination providers" in the Initiative. The purpose is to evaluate whether care models that have enhanced on-site services and supports in nursing facilities can improve the health and health care among nursing facility residents and ultimately reduce avoidable inpatient hospital admissions. Among the grant's application requirements is to receive a letter of support from the State Medicaid director and the State survey and certification director. MHD will be offering support to qualified agencies or organizations that are interested in applying for participation as enhanced care and coordination providers Initiative.

  For additional information, following is the CMS link to the ~~"I~~nitiative to the Reduce Avoidable Hospitalizations Among Nursing Facility Residents": http://innovations.cms.gov/initiatives/rahnfr/index.html

- **Inpatient Hospital Certifications –** MO HealthNet contracted with ACS at the end of 2009 to precertify inpatient hospitalizations for medical necessity. Over this time period, the program has been transitioned to a web-based request process through CyberAccess℠. Inpatient precertification requests can be initiated by fax, phone, or electronically using the CyberAccess℠ tool. At this time, 75% of all inpatient certification requests are entered through the web tool and processed using Milliman clinical utilization criteria.

- **Fraud and Abuse** – The Missouri Medicaid Audit and Compliance Unit (MMAC) is the unit within the Department of Social Services (DSS), the single state agency responsible for the administration of the Medicaid Title XIX Program in Missouri, charged with administering and managing Medicaid Title XIX audit and compliance initiatives and provider contracts under the Medicaid Title XIX Program. One of MMAC's responsibilities is to perform the functions and operations formerly under the MO HealthNet Division (MHD), Program Integrity, which includes monitoring compliance with the Missouri Medicaid Title XIX Program in accordance with all applicable federal and state laws and regulations for the detection of fraudulent and abusive practices.

  To aid in the detection process, MMAC uses Thomson Reuters Advantage Suite®, a comprehensive Fraud and Abuse Detection System (FADS), to identify patterns of inappropriate billing and potential fraud, waste or abuse. The tools available within the FADS include algorithms that are adapted for use with the Missouri Medicaid Information Systems database (MMIS). The FADS is used for efficient case development by using its detailed or drill down reports, which identify specific provider and/or participant information to isolate specific claims data for review. The FADS is used daily by MMAC staff to run queries and perform research to identify claims. Cash recoveries and cost avoidance total $34.9 million for SFY-2009, $60.8 million for SFY-2010, $48.2 million for SFY-2011 and $48.7 million for SFY-2012 (through May 2012).

- **Long-Term Care Insurance Partnership** – Under these partnerships programs, individuals purchase long-term care insurance plans. When long-term care is needed, typically later in life, individuals will use the benefits afforded by the insurance plan. This will allow them to retain a certain amount of assets (assets equal to the amount of long-term care benefits paid on behalf of the individual through a long-term care partnership plan) and still qualify for MO HealthNet long-term care benefits, provided all eligibility requirements are met including resources. This type of program provides an incentive for consumers to be directly involved with health care decisions while protecting individual assets and reducing reliance on publicly funded programs. The Department of Insurance, Financial Institutions & Professional Registration issued related state policies and regulations regarding the Long-Term Care Partnership Program. Partnership policies became available for purchase August 1, 2008. Information about these partnership plans can be found on the website at http://www.completelongtermcare.com/states/missouri/.

- **Direct Inform™** – MHD has developed a participant web portal allowing participants to access their medical claim payment information as well as a wide array of links to pertinent health-oriented websites. Direct Inform™ allows participants to self-report many treatments they may seek outside of the MO HealthNet benefit such as over-the-counter and homeopathic treatments. The Direct Inform™ website is a powerful, user-friendly tool that delivers actionable patient specific clinical and economic information regarding personal health and wellness. The tool complies with all applicable HIPAA privacy and security requirements. The rollout of Direct Inform™ began in the summer of 2010 with the Community Mental Health Centers across the state. This tool is integrated into the MHD Health Home initiative, allowing patients to engage in the process by providing them access to their health information. The Health Home staff are working to ensure patient access and provide direct assistance with navigation and patient self-reporting.

- **Deficit Reduction Act of 2005 (DRA)** – MO HealthNet continues to be the payer of last resort. When another payer is liable for the personal injury, disability or disease of a MO HealthNet participant, benefits are assigned to the Department of Social Services, MO HealthNet Division (MHD) who pursues collection. The participant is required to aid in this pursuit**.** Provisions in Section 6035 of the DRA are incorporated into RSMo. 208.215 and 208.217:

  - Within 60 days of receipt of a settlement, a MO HealthNet participant who receives any third party benefit or proceeds for a covered illness or injury is required to pay MHD up to the total MO HealthNet benefits provided or to place the full amount of the third party benefits in a trust account pending final judicial or administrative determination.

  - Judgments, awards or settlements cannot be reached in actions in which MHD may have an interest without first giving the division notice.

- Upon request by MHD, all third party payers shall provide the division with information contained in a 270/271 Health Care Eligibility Benefits Inquiry and Response standard transaction mandated under HIPAA.

- MHD is not required to seek reimbursement from a liable third party on claims when the recovery will be less than the cost of recovery.

- Any third party administrator, administrative services organization and pharmacy benefit manager doing business in Missouri or administering or processing claims or benefits for residents are subject to MO HealthNet third party liability data match requests and must provide information in compliance with HIPAA.

- Third party administrators, administrative services organizations, health benefit plans and pharmacy benefit managers shall process or pay all properly submitted MO HealthNet subrogation claims for a period of three years from the date services were provided or rendered.

- The MO HealthNet Division shall enforce its rights within six years of the state's submission of the claim.

- Certified computerized MO HealthNet records shall be prima facie evidence of proof of moneys expended and the amount due the state.

- Unless waived by MHD, a participant's probate estate cannot be closed until the personal representative of the estate obtains a release from MHD evidencing payment of all MO HealthNet benefits, premiums, or other such costs due to the state under law with the court.

- **MO HealthNet Responsibility Report** – On November 27, 2006, Governor's Executive Order 06-45 was signed, directing the DSS to prepare a Medicaid beneficiary employer report and submit the report to the Governor on a quarterly basis to be known as the Missouri Health Care Responsibility Report.

  In the 2007 legislative session, the Missouri General Assembly enacted Senate Bill 577, which transformed the Missouri Medicaid program into MO HealthNet. Section 208.230 of SB 577 is known as the "Public Assistance Beneficiary Employer Disclosure Act." It directs DSS to prepare a MO HealthNet beneficiary employer report. The requirements of Section 208.230 and Executive Order 06-45 are virtually identical.

  Starting with the first calendar quarter of 2008, 120 days after each quarter, DSS prepares a report listing each employer in the state with 50 or more workers who are MO HealthNet participants, have a spouse who is a MO HealthNet participant or who are a custodial parent of a MO HealthNet participant. The public version of the report is available on the MO HealthNet Division website at http://www.dss.mo.gov/mhd/general/pages/hcrr.htm.

Conclusion

DSS' successful implementation of the principles contained in the executive order to achieve transparency requires engaging all health care partners. Policy and contractual agreements will continue to embody these principles and to be continually scrutinized to ensure they incorporate the best in transparency practices.