MO HEALTHNET OVERSIGHT MEETING
May 25, 2023
Via WebEx Conferencing

ATTENDANCE

Committee Members Present:
Dr. Nick Pfannenstiel, Chairman
Dr. Bridget McCandless, Co-Chair
Sam Alexander, MD
Jonathan Patterson
Senator Tracy McCreery
Carmen Parker Bradshaw
David Ott
Jennifer Bax on behalf of Val Huhn, DMH Director
Todd Richardson, MHD Director
Mark Sanford
Sarah Oerther
Gerard Grimaldi
Joseph Pierle
Robert Knodell, DSS Director
Dr. Heidi Miller on behalf of Paula Nickelson, Acting DHSS Director

Members Not Present:
Dr. Ingrid Taylor
Senator Mary Elizabeth Coleman

DSS/MHD Staff:
Abbie Barker, MHD
Adam Crumbliss, DSS
Alexander Daskalakis, MHD

Anna Wainscott, MHD
Ashley Wilson, MHD
Cory McMahon, DMH
Christine Clark, OA
Frank Devin, OA
Leslie Bittle, MHD

DSS/MHD Staff:
Justin Clutter, MHD
Tony Brite, MHD
Jennifer Tidball, DSS
Jennifer Hunter, MHD
Kristen Edwards, DSS
Kim Evans, DSS
Leann Hager, MHD
Gayle Dougan, MHD
Josh Moore, MHD
Kirk Mathews, MHD
Jessie Dresner, MHD
Patrick Luebbering, DSS
Ryan Conway, DSS
Taylor Jones, DSS

Guests:
Brian Colby
Jim Eschen

Jill Schupp
Iva Eggert
Sheldon Weisgrau
Kathryn Brown

Tina Bradshaw
Emily Kalmer
Emily O'Laughlin
Heath Clarkston
Heidi Geisbuhler-Sutherland
Heidi Miller

Jessica Petrie
Russell Oppenborn

Guests:
Daris Davis
Lynn Morsches
Emily Gibbons
Mike Mitchell
Tim McBride
Jeana Pringer
Paula Medlin
Sen. Holly Rehder
Clara Bates
Claudia Alley
Lucas Caldwell-McMillan
Maura Gray

All meeting presentations are located on the web at:
http://dss.mo.gov/mhd/oversight/meeting.htm

AGENDA

Welcome/Introduction/Approval of Minutes

- Dr. Bridgett McCandless, Co- Chair, called the meeting to order at approximately 1:00 p.m. The committee approved the minutes from the February 23, 2023 meeting.

MO HealthNet Division (MHD) Director/Deputy Director Update

- Jessie Dresner, MHD Chief Operations Officer on behalf of Todd Richardson, MHD Director, provided an overview of the 12-month post-partum Bill that passed. MO HealthNet and Family Support Division have put together a team to meet with CMS regarding the next steps. With direction from CMS, MHD will have to develop a State Plan amendment to add to the eligibility state plan pages as well as an amendment to the CHIP State Plan. MHD will also have to make an amendment to the FMAP State plan pages as well.

  MHD is aware of other bills, that are not currently signed, that could affect MO HealthNet, in preparation of those bills, the legal and policy teams are reviewing the bill language to better anticipate changes that will need to be made in the future. In 2019 The Advancing Care for Exceptional Kids Act (ACE Kids) passed and that allows the states to provide coordinated care through a health home arrangement for children with medically complex needs. MHD has hired a full time employee, Gale Dougan, who will be working closely with Jennifer Hunter who runs MHD's Primary Health Home Care Program. Gale is getting acclimated and cross training throughout the health home program. MHD and CMS have been in frequent meetings to discuss next steps on the 1945a authority and how that will be submitted to CMS.

  Jessie gave a Building Renovations Update for the Howerton Building in Jefferson City.

  In past meetings, we have discussed the future of the oversight meetings in terms of the only virtual option, an in person option, or the combination of both. Once the construction is completed, here at Howerton, MHD would like to conduct an in person meeting for the committee members to allow everyone to see the great work that has been done.

  MHD CIO Update: Many of you know that Tisha McGowan retired and as of now, MHD is still in search of a Chief Information Officer. Once this position is filled, an update will be provided.

  Lastly, the update on Maternal Health Efforts will be given by Justin Clutter who is standing in for Kirk Mathews today. Justin will be sharing a dashboard, created by Dr. Abigail Barker to track the efforts around these projects. The teams are focused around data, research, access to current benefits, managed care payment and policy, and the innovations team. The dashboard

that Dr. Abby Barker has put together for us, it is not public facing at this point, but MHD wanted to share the efforts with the committee. Justin Clutter presented the MO HealthNet Maternal and Infant Health Initiative Tracking dashboard. Justin advised that essentially this effort has been broken down into several different subgroups, accessing current benefits and all the way through research. This allows each team to keep all of our lines of effort straight from the entry point or under consideration all the way through to going live with it, which some of these have already gone live. There are 50 to 60 people working on this very important initiative. Justin shared an example showing the innovations group, including sub categories of prenatal and birth outcomes and potentially adding additional doula coverage and services. MHD is exploring and making policy recommendations around that. The dashboard shows exactly where these lines of effort are at any given time and is updated in real time as meetings occur. Someone can get in here and update their information and it feeds directly to this dashboard. MHD is very proud of it and is tracking a lot of data through power point slides and having meetings every 2 weeks.

- **Comment:** Girard Grimaldi: I saw remove NICU rate cell, is that something that will be discussed later today? Are there things in there that address issues regarding health equity and maternal health equity?
- **Comment/Response:** Jessie Dresner: Yes that would be Center for Healthcare Policy at the University. They have our claims data, and they understand it and they will be partnering with us on this particular topic.
- **Comment/Response**: Bridget McCandless: Will there a point where this will become public facing? Or is this more a tool for you to track your work?
- **Comment/Response:** Jessie Dresner**:** There is a lot of information on this, so this version will remain internal. We are planning to have an external version eventually. Just like we have done with the managed care dashboards that are public facing now.
- **Comment/Response:** Senator Tracy McCreery: I have a question regarding the 12-month postpartum state plan opportunity. There was a trigger in the language in both Senate bill 45, 90 and 106 connected to a number of participants removed from our roles. Do you have any update on the number of folks who have been removed since the redetermination April 1st? Because one of my concerns is that, the language in that provision could cause a delay in implementation in the healthcare extension.
- **Comment/Response:** Jessie Dresner: There are several moving parts to this. In case not everyone is familiar with that provision, the language in the bill states that the department will submit a state plan amendment to the Centers for Medicare and Medicaid services. When the number of ineligible MO HealthNet participants are removed from the program in 2023 pursuant to section 208.239 exceeds the projected number of beneficiaries likely to enroll in benefits in 2023 under this subdivision. We have a projected number of beneficiaries. If we have a woman in the expansion group and she becomes pregnant, and then receives postpartum coverage, she will remain in the expansion group. There are about 8,000-10,000 women in the Medicaid category who would not transition into the adult expansion group. Director Evans is going to

speak about the projections for folks coming off the roles of the renewals moving forward. At the end of the day, I believe we will see that in a month. In addition to that, I want to remind everybody that when we were first contemplating coverage for our moms, in case this did not pass, we had spoken with Director Evans to speak about the order in which we would do the renewals, especially for our moms with an SUD disorder. We would not be closing any of those moms until the end of the determination period, so operationally all these women will be receiving the services, whether it is just to the benefit of the unwind period or this new program taking place.

- **Comment/Response:** Director Evans: Just to add a little bit to that, this will be a manual process. We are going to have to look at these cases to determine if they are in a 12-month period. And those women will move their date out so that the system will automatically exparte at the end of their postpartum period, but for the women that are not eligible for this extended program we will be doing exparte, then trying to get them into a new program. If they should be extended, they will be. We have been working very closely with MO HealthNet to ensure this is a seamless transition.
- **Comment/Response:** Girard Grimaldi: Timing question, technically has it been signed into law yet?
- **Comment/Response:** Jessie Dresner: No not yet.
- **Comment/Response:** Nick Pfannenstiel: Can I run through an example of postpartum coverage? I realize it has not been signed yet, but let us assume that the governor signs, I have an expected mom who is in my chair today. She has pregnancy coverage whether it is under PHE or whatever. When can I expect this mom to no longer have postpartum coverage if she delivers July 1st?
- **Comment/Response:** Director Evans: Let's say the bill is signed and she delivers on July 1st she will have 12 months from that date, so for this analogy, that would be 2024. We will then look at an exparte to see if she is eligible for any other Medicaid program, if she is not, a notice will be sent to her notifying her of this before her coverage is ended.
- **Comment/Response:** Nick Pfannenstiel: One more clarifying question, same scenario but patient delivers May 1st?
- **Comment/Response:** Kim Evans: This is why we are doing this as a manual process. We will check to see how long she has been receiving postpartum and then add those months to that date. That is why we are really looking at this population, those that have already served their postpartum, and then there are actually a group of women who are in that period and get pregnant again and go back into the postpartum period. That is why we want to take a close look at this population to ensure we are meeting their needs.
- **Comment/Response**: Bridget McCandless: Often women come in to Medicaid during their pregnancy who might be eligible by income for the adult expansion group at the end of their postpartum coverage. Would they automatically transition to adult expansion or are they going to have to reapply?

- **Comment/Response:** Kim Evans: No that is part of the exparte process, at the end of their postpartum, we will evaluate their situation and see if they are eligible for any of our Medicaid programs, including the expansion group and move them to the best coverage.
- **Comment/Response**: Bridget McCandless: Another question for Jessie regarding children with medically complex needs. Do we have any time frame for when we think that might be an operating program?
- **Comment/Response:** Jessie Dresner: Dr. McCandless I will need to check with Jennifer and Gayle who are working on that program and see what the most recent conversation with CMS was around that, how close they are to submitting something. So I do not know today, but I am making a note of it and as soon as I know I will get that information out to the group.
- **Comment/Response**: Bridget McCandless: Would the health homes be coordinated inside Managed Care or would that be coordinated outside of Managed Care?
- **Comment/Response:** Jessie Dresner: It would be both. Right now, we are looking at the criteria along with CMS guidance because we want to serve a larger population than our medically complex children. As we all know this is a small population that we have for the medically complex children that we define right now, that are receiving private duty nursing. Most of them are opted out and they are in Fee for Service, but there are some in Managed Care. So by expanding we will capture more than the children that are receiving PDN. So it will be both.

Family Support Division (FSD) Update

- Kim Evans, FSD Director, presented the FSD update. Director Evans reported on the unwinding of the annual renewals. FSD has about 1.5 million individuals on coverage. The pending MAGI applications are under 90 days. FSD was pending 4,500 applications. In the non- MAGI, the adult disabled world is pending 7,500 so we are doing a good job. FSD continues to receive approximately 600 applications a day. This may be the new average. There is a lot of participation from the hospitals and clinics that are assisting individuals with applying online. The majority of these applications are coming through the MEDES portal. Which means they are being received via communication between providers or a community partner helping them to apply. The electronic data services are being utilized and have been helpful with the ability to move through these applications quickly. There are currently 335,000 individuals in the expansion group now and you can always track that every Monday morning on the caseload counter.

  Secondly, implementation technology for centralized mail has begun. Currently a vendor opens all mail, scans, and indexes it. This process gets it to our staff quicker. As of May 6th the new citizen portal opened. With the prepopulated forms, that puts us in compliance with CMS. As of the first of the week, there were 2,000 established accounts. There has been approximately 100 annual renewals completed online. When Individuals sign onto the portal, they will see their due date. Currently, if they are not due for the annual renewal they will not see their renewal date. Only those who are currently due for June will see the annual renewal screen. If

the member is in the non-adults, disabled category, they will see a blank form. These forms are not currently pre-populated, but this is the plan for the portal. The form mentioned, will be available through the end of June and the following 90 days into the members reconsideration period. So for members who did not get their form in by June 30th, they will have access online to complete during the 90 day period. For example, the individuals who are due for annual renewal in July will start to see their forms in the new portal.

Thirdly, FSD is working on the next phase within the Citizen portal, and that is the SNAP feature. This will allow members to see their online information such as online annual renewals, give them the ability to report changes, schedule appointments with FSD staff as well as chat live with an agent. Soon FSD will be implementing a virtual worker that will be similar to how WebEx works, where they can have face-to-face interaction. Individuals using this feature will require a cell phone for use. The platform does require an email address, which has been identified as a barrier for some members. This is an enhanced authentication process to protect the members PHI.

FSD is using the insight engine as guidance for the manual piece for the applications. This process allows the workers to get the information and start the work on the application. This process was used for April and May. June will begin the automated process. This server will be able to read every individual paper that is dropped off to FSD versus having individuals manually typing this information in.

- **Comment/Response**: Bridget McCandless: I have a question about the citizen portal. Can that only be accessed directly by the person or will there be push messages telling them to come into the portal to update information for whatever contact you have for them or the last email you have?
- **Comment/Response:** Kim Evans: That will be the next phase coming. So part of the emails and cell phone numbers that have been collected will be used for that. So that we can push messages to them when we put a document in.
- **Comment/Response:** Nick Pfannenstiel: The comments that I've heard is that the portal works well except in the case where the cell phone does not have enough data or the authenticator app cannot be downloaded. That is becoming a barrier or a problem. I would offer that as advice. What is the next step to offer a patient in my office experiencing these issues?
- **Comment/Response:** Kim Evans: I am glad you brought that up. This was brought up recently as well. Participants are having trouble knowing where to go when that happens. FSD is working with a vendor to simplify the process and make it where there is a button to click for help, or a number to call; so I will be working on that and on the best way to navigate this and get the information back to you.
- **Comment/Response:** Nick Pfannenstiel: Yes, because if I have to let the patient go from my health center and not renew their application that day in office, then unfortunately we just do not know if it will happen. When you look into that, if you could prioritize by simplicity, of this to get it done the same day that would be the ideal situation. Is there another way to send the authentication other than

downloading the app, like a telephone call? What we have seen is barriers to the patient being able to download the app on the patient's phone.

- **Comment/Response:** Kim Evans: I will check on that. I know statewide we have all gone through a new authentication process where it gives options, to email, text or call. I want to make sure we are giving that same product so that we can put some instructions out and do some communication around that. We can get some fliers out to clinics that will help individuals with this. I appreciate the feedback because this lets us know what we need to work on.

Lastly, Director Evans gave an update on the PHE Unwind. April 1st the exparte process started for individuals with an annual renewal date of June and those have been manually completed. On May 6th the prepopulated MAGI and annual renewal forms for Non-MAGI annual renewal forms were mailed out. The exparte process simply means that FSD was able to use the electronic sources and other available benefit programs to verify all the information for a determination. That does not mean that individual will be eligible but we are able to complete the annual review process without speaking with the participant. Pre-Covid, the completion rate was roughly 10%. That percentage has increased to 47% as this has expedited the process. Director Evans stated she is very excited with these preliminary numbers. Annual renewals will be completed as they are returned. Adverse actions will be sent 10 days before the end of June to those individuals who have not returned the annual renewal form or requested information. Individuals will close in the batch process on Friday June 30th if the annual renewal form has not been returned. And Individuals closing for failure to return the form will have 90 days to return the form for consideration without having to reapply. After 90 days, a new application is required.

New numbers will not be available until the end of June. Which will be the next reporting piece for CMS. The exparte process for July has already begun and FSD is two thirds of the way through.

- **Comment/Response:** Girard Grimaldi: Question on the notice that triggers the 90 day return of the renewal form, does it state pretty clearly that all they have to do is to return the form and is the form included in the reminder?
- **Comment/Response:** Kim Evans: We are adding language that tells them the remedies. But it does tell them that their case is closed. And that the member can return the form in 90 days. The form is not included because we want the member to go online. The member has already been sent a renewal form previously.
- **Comment/Response:** Girard Grimaldi: How difficult would it be to add a form to the mailing and is this in house mailings or a vendor?
- **Comment/Response:** Kim Evans: We could look at that. We would have to see about the capacity on the mail room as that will add some time to mail those out due to the mailings being in house.

- **Comment/Response:** Girard Grimaldi: That seems like it would be very participant friendly, which is what we want right? I will defer to others on the call.
- **Comment/Response**: Bridget McCandless: I agree as one who receives piles of mail. It's always nice to get a reminder with clear instructions.
- **Comment/Response:** Nick Pfannenstiel: No objection especially if the statement of not receiving a lot of return mail is accurate. That seems to line up.
- **Comment/Response**: Bridget McCandless: In previous meetings your group had looked at a much more approachable set of language in these letters, are you still working on that? Making sure the language is simple and that the recipient clearly knows exactly what they need to do?
- **Comment/Response:** Kim Evans: We are, and you know we are actually looking at the language. You know this is the first time we have done any renewals for the expanded Medicaid group. We have gone back to look at our notices. To ensure that they understand on this expanded group. It will be August before we can get it done, but we expect to make these changes. Director Evans presented the following question to the group: We send a 10-day notice before the end of the month, would you prefer it be in the annual renewal notice or after we have closed the case?
- **Comment/Response:** Girard Grimaldi**:** I would say both. I know that the postal service would just raise the postal rates.
- **Comment/Response:** Kim Evans: I will take this back to the team, because technically their case is closed. But I'm thinking if we send it at the adverse reaction period they will still have time to remedy that. Those letters go out 20 days before the end of the month. So that would give them an opportunity, I am just wondering which would be most beneficial.
- **Comment/Response:** Girard Grimaldi**:** So you sent out 37,000 pre-populated forms you said 47% you did not need to due to exparte, so basically 30,000-35,000 continued with coverage right?
- **Comment/Response:** Kim Evans: Yes, that is correct. The piece that we do not know is this, 37,000 that we sent pre-populated forms too, were part of a group we did expartes on and we found them to be ineligible. We cannot make that determination yet and report on them.
- **Comment/Response:** Girard Grimaldi**:** So some of the 37,000 that got the exparte notice said that they were ineligible for coverage. Do you know how many of that 37,000 got that notice?
- **Comment/Response:** Kim Evans: No, the exparte said they needed to complete an annual renewal. We did not tell them they were found to be ineligible. We want them to have an opportunity. And we are required to give them an opportunity to tell us if their situation is different now. We are currently trying to pull that data to identify how many got the notice. This is the first month of doing this. Discussion has occurred with other states in order to watch for issues they are experiencing so that Missouri does not face the same issues.

- **Comment/Response:** Nick Pfannenstiel: What does the 47% represent?
- **Comment/Response:** Kim Evans: The total case selection was 71,048 and that's households, not individuals.
- **Comment/Response:** Nick Pfannenstiel: How many applications? You had made the statement that 37,000 applications were sent out for MAGI. Does this include both MAGI and NON- MAGI?
- **Comment/Response:** Kim Evans: Yes, 31,000 were sent out for the MAGI and about 6,000 were sent out for the adult program.
- **Comment/Response:** Nick Pfannenstiel: In the beginning of the presentation, it was stated that 1.5 million are enrolled in Medicaid. When dividing that by 12, I get an average of 125,000 individuals. Are the numbers not adding up, due to the mailings going to households versus individuals? If so, can I assume that 70,000-71,000 households in the month of April that were due for renewal would correlate to roughly 125,000 individuals?
- **Comment/Response:** Kim Evans: Yes, that is correct. When we report in the future, we will be very clear in regards to household versus individual.
- **Comment/Response:** Nick Pfannenstiel: Is it true that through the portal an individual can only renew an application 90 days in advance? In addition, are we currently working 90 days out, and only notifying people for the month ahead?
- **Comment/Response:** Kim Evans: Yes, an individual can only renew an application 90 days in advance. We are starting 90 days before, and giving individuals 55 days to return, the federal requirement is only 30 days. Annual renewals are being completed, then we are sending out pre-populated forms or annual renewal forms, and working on those as they are received. For example, FSD is working on expartes for July so that we can get them sent out in June.
- **Comment/Response:** Nick Pfannenstiel: So an individual that has an annual renewal due in August would be receiving information through the portal on renewal within the next couple of weeks?
- **Comment/Response:** Kim Evans: That would be available to them in July. Because not everyone will need to complete an annual renewal form. As we may have been able to complete an exparte then they would not need to do anything at all.
- **Comment/Response:** Nick Pfannenstiel: If that is the process, and they need to do a renewal is that a 55 day process?
- **Comment/Response:** Kim Evans: Yes, we also give a due date of when to return to us. Along with this process, I want to talk about our partnership with the Managed Care plan. The Managed Care plans are getting a listing of the pre- populated forms that have been mailed out. Managed Care has begun an outreach campaign and The MCO's will get another listing at the 1st of June to say hey these folks have not returned their renewals yet. That way when we create an adverse reaction saying you have till the end of the month to get this turned in or we are going to close on you. Managed Care will also receive the final listing of individuals that we close and they will do outreach in the

90 day consideration period trying to get individuals to get that annual renewal form back in to us.

- **Comment/Response:** Nick Pfannenstiel: Are the MCO's getting a monthly roster or a full roster including the redetermination date?
- **Comment/Response:** Kim Evans: I cannot remember if we sent a full roster, but they get the month to month for outreach.
- **Comment/Response:** Jessie Dresner: We initially sent all 3 health plans their full roster which was really helpful because it let them see where things didn't completely align correctly between our systems, and they have been working on making improvements. I believe Alex will be talking a about that in the Managed Care update too. Going forward they will be getting them monthly.
- **Comment/Response:** Kim Evans: I appreciate the partnership with the health plans. FSD and MHD has been engaging our health plans for 8-9 months and are seeing benefits with individuals contacting us. Hopefully this will reduce the return mail.
- **Comment/Response:** Nick Pfannenstiel: I agree this is great partnership. I probably misunderstood, but they had made it seem like they were just getting a monthly roster. But if they are getting the full roster then that's beneficial to know when patients are coming in for their visit.
- **Comment/Response:** Kim Evans: Exactly, we have been asking providers to help us, when they prepare their charts daily to take a look at that information and to remind the patient if they have an annual renewal coming due.
- **Comment/Response:** Nick Pfannenstiel: Are the exparte numbers trending to be similar to that of next month to the 47%, or is that too premature to ask?
- **Comment/Response:** Kim Evans: Yes, that is little bit too premature. We need to vet these numbers to assure that they are accurate and can make that public soon. But for the first several months we need to make sure we are pulling the correct numbers.
- **Comment/Response:** Nick Pfannenstiel: Would tier 1 members have the ability to input or help complete information through the portal. Or will this have to be printed off?
- **Comment/Response:** Kim Evans: Unfortunately, they will have to print that off. As far as the providers, there are conversations occurring on what that would look like and how the provider and community partner can support the member.
- **Comment/Response:** Nick Pfannenstiel: I would appreciate it if you could keep me informed on this progress so that I could help communicate to other providers about the potential.
- **Comment/Response:** Kim Evans: Once we get more information we will reach out and have a group to assist us design this so its user friendly.

Chief Transformation Officer Update

- Update given by Justin Clutter, Project Manager and Transformation Team. Justin gave an update on Transformation of Rural Community Health. Also known as ToRCH. This is a new pilot program under development approved by the legislature for the 2024 budget. It is still pending the Governor's signature of course. The Transformation Team is looking to partner with six hospitals. It basically gives additional funding to focus on social determinants of health, building their capacity, leveraging community based organizations such as food banks and transportation services in order to reduce ER utilization. For example, a patient that consistently comes to the hospital because they are hungry and do not have adequate housing. The Transformation Team is working to connect them to a community information exchange platform to focus those referrals within the community and provide funding to the food bank and the transportation providers. Originally, there were 14 hospitals that submitted a letter of intent and 11 of those remain interested. A few opted out and were uneasy about being in the first cohort and were undertaking massive building projects and do not have the capacity to do it, which is understandable. The Transformation Team has had 1-on-1 technical assistance with each one of these hospitals and some of them are really far along on their application. The applications are due May 30th. There is a procurement pending for a community information exchange, which all of these referrals will go through. This information exchange will allow providers to see co-occurring needs such as, if they have housing and food needs, or identify what their next basic need that is not being met and be able to follow their journey. Both the hospital and the community-based organization will have to leverage their efforts. MHD is still exploring the CMS approval for this project, as there are several different avenues. MHD is going to start working on getting face-to-face with CMS to sit down with them and identify how to obtain the federal match on this program.

    - **Comment/Response:** Girard Grimaldi: Justin how do you define a rural hospital? By bed size, by revenue?
    - **Comment/Response:** Justin Clutter: We are using the same definition that the Department of Health and Senior Services uses. There aren't many counties that would not be considered rural using that definition. We are hitting all four corners. We identified 51 potential rural hospitals that could participate.
    - **Comment/Response:** Joe Pierle: Is this through a state plan amendment or a waiver?
    - **Comment/Response:** Justin Clutter: We are looking at an ICM approach and possibly a 1915B waiver. We already have a 1915B that we can combine with. There are some states that have done an 1115 waiver but the time frame on that has been significant at almost 2 years.
    - **Comment/Response:** Joe Pierle: I would just reiterate that we have two existing MO HealthNet programs; we could aggressively address social drivers of health that have been in existence for some time. One is the Health Home program, which requires referrals to social community based organizations to assess social drivers but of course, there is no funding to address it at the community-based level. That and the LCCCP program through the managed care. Same expectations, but there is really no funding to

do any of the work. I know we would be interested in having conversations about how we can enhance and bolter existing programs to address social drivers, I talk about this often. I am passionate about it. But a friend of mine, Dr. Heidi Miller once said in session, why would we address patients within the four wall of health centers and then send them back to conditions that got them sick or kept them sick? I am a firm believer that we as a state collectively have to do more in this space, and that we have existing infrastructures that we could enhance to improve the quality of life for Missourians.

- **Comment/Response:** Justin Clutter: As far as the LCCCP, we have been putting a significant amount of work just in the Transformation Office looking at that program and seeing how we can improve it. We are looking at more value based incentives that could be utilized for different things. We are hoping to come up with some innovative things we can do around this.

Next, the NICU payment restructure is another line of effort that the Transformation Team has placed focus on. MHD is looking differently at some of the things that are being done with the NICU payment. Since 2017, MHD has historically made a lump sum payment when a baby enters the NICU. When introduced the payment was $187, 000 per NICU and to date the average is $300,000 per NICU birth. MHD took a different approach to identify how this looks as far as payment for prenatal or pregnant women. The Transformation Team worked with Mercer and identified 450 NICU births in the fiscal year 2022, a little over $134 million dollars. Collaboration with the MCO's began and we explored a plan to combine that into the COA 2 (pregnant women birth rate). By doing this, it would add about $5,100 to that rate cell. The effort here is to put more money upfront in the prenatal portion of the pregnancy. The goal is to spend those dollars up front rather than after the birth in the hopes, this will give women the incentive to get prenatal visits and receive the care they need and eventually avoid those NICU births. The graphs show the example of the expenditures. Missouri Medicaid had about 26,341 births total. They are a bit high because of the PHE. This is the number of births that are expected to transition to the COA 2 (Category of Aid for Pregnant Women) rate with anticipation of going into effect July 1st.

- **Comment/Response**: Bridget McCandless: What does COA stand for?
- **Comment/Response**: Justin Clutter: Category of aide.
- **Comment/Response:** Girard Grimaldi: So the issue is, a baby is born in NICU and the payment is made after the baby is born to the managed care plan. Will this be a pre-payment before the babies born?
- **Comment/Response**: Justin Clutter: It will be part of their prepayment before the baby is born, part of the per member per month rate.
- **Comment/Response:** Tony Brite: Previously they were paid per event and this will roll funds into the pregnant women rate cell, which will count towards a certain level of care.
- **Comment/Response:** Girard Grimaldi: Do you expect the payment to grow? In our two hospitals, we had 77 births under that 1st place and you are saying there is 450 statewide total, but that number has been going up. Except for that one Covid year. In

Kansas City, those numbers have been going up. Is there a way to adjust it to see the trends that those low birth weight babies are going even higher?

- **Comment/Response**: Tony Brite: We are hoping that with management process and the other items we have in place with managed care, the outcomes will be less and we can reduce that.
- **Comment/Response:** Girard Grimaldi: Is there a way you can share the care management suggestions or agreements, either from plans or that you give to the plans that they are planning to use or that the department has suggested in terms of care management approaches?
- **Comment/Response**: Justin Clutter: I believe there is a performance improvement plan in the Managed Care contract that is publicly available that ask the health plans to focus more on this effort. Many of their incentive programs are proprietary. I am not sure what they publicly publish or the specific dollar amounts.
- **Comment/Response:** Girard Grimaldi: Yes, I am looking for the modality and the methodology. I am not interested in the numbers necessarily. Such as, what are the plans doing to help our physicians and nurses to know so that there can better coordination on the clinical side?
- **Comment/Response:** Jessie Dresner: One of the teams for the maternal health focus is the Education Team. During these meetings, we had all three health plans come talk about what they offer for our pregnant moms and babies. There are some obvious similarities and then each have their own unique approaches as well. These meetings included discussion about utilization and other great resources the health plans offer, but it is under-utilized because our participants can be difficult to reach. Just like with annual renewals. The goal is to work collaboratively with the health plans and leverage this knowledge to inform the providers of all of these programs. As everyone knows, if the providers don't know then they can't talk to the participants or the moms about incentives and programs available to them. We are still in the first step stages about identifying these and then figuring out what is next. But it is a big part of the conversation.

Managed Care Update

- Update given by Alex Daskalakis, Director of Managed Care. Alex gave an overview on how MHD continues to work very closely with the health plans on the unwinding period coming off PHE. There is ongoing and constant communication with the health plans including weekly calls every Thursday to report any issues they have or areas that MHD can assist with. Fluid communication is necessary to ensure a very smooth transition. MHD generates five reports per month, which as Director Evans mentioned, for each annual renewal with feedback from the plans on this.

  Secondly there is a 4th amendment to the Managed Care contract that will be effective July 1st. Some of the highlights and updates include changes to outdated language or updating certain rates. Adjustments are being made to sections on inpatient stays, especially pediatric hospitals.

There will also be adjustments to the hospital fee schedule in some places. Language updates will be made on Managed Care enrollment to make the language easy and clear to understand, as well as moving the NICU payment language.

- **Comment/Response:** Girard Grimaldi: Will any of those changes to the contract require a rule change?
- **Comment/Response:** Alex Daskalakis: No, I do not believe so.
- **Comment/Response:** Nick Pfannenstiel: Back to the reports the Manage Care Plans receive, did I hear Director Evans say that one of those reports inform the plan that one of their members have not been able to enroll through the exparte or that those members have to log onto the portal to renew the application?
- **Comment/Response:** Alex Daskalakis: Yes, that is the second of the five reports.
- **Comment/Response:** Nick Pfannenstiel: This question is for Director Evans. As an example, if I am a provider and I know that my patient is a tier 1 and they will roll off this month, or next month in June. I am able to determine that my patient is eligible for Medicaid and I go forward and see that patient, and assist them on getting their application renewed within that 90-day period after it expired, will that visit be covered?
- **Comment/Response:** Director Evans: Once FSD receives the application, we will begin to reopen that coverage and start the process of redetermination. Depending on how quickly the issues are resolved in regards to member information, we will go back and open that coverage to July 1st, until determination has been completed.
- **Comment/Response:** Nick Pfannenstiel: I am unclear on if I see a patient during that 90-day period, even if they determine whether or not the patient would be eligible for Medicaid.
- **Comment/Response:** Director Kim Evans: If they return the form, we will open that coverage back up and they will be covered. If they do not return the form, then they will not have coverage. The coverage will be backed to July 1 if the form is returned. Again, we cannot reopen the coverage period until the form is returned.
- **Comment/Response:** Girard Grimaldi: As far as the fee schedule related to inpatient hospitals, is that update routine stuff?
  Comment/Response: Alex Daskalakis: Yes, it reflects changes to the percentage rates for inpatient and one category for outpatient.

  Lastly, Jessie Dresner added that the system operation team is currently working with the MCO's in perusing the redetermination date on the 834 file and they have discovered a place to put it. This is great progress for both MHD and the MCO's.

Budget Update

- Tony Brite, MHD Chief Financial Officer presented on any changes for the general assembly actions for this year. Overall, there were good outcomes for both Social Services and MO HealthNet in terms of budget requests. All items were funded across the board as well as

additional items added to the budget. For SFY23, the supplemental budget was approved and signed by the Governor. This was reduced by about $48.5 million state share funds related to more current projections. There was also a MO MAPS increase in the authority that was fully funded.

Mr. Brite gave an update on the hospital rebase and nursing facility rate increase. The hospital rebase SPA was approved prior to the last meeting. The payments have been ongoing and the update to the rebase design will be coming up in July. MHD will provide more information on that in the near future. MHD received CMS approval on the Nursing Facility SPA. Payments began last financial cycle, roughly 2 weeks ago. There will be a larger mass adjustment to get them back to July 1 of last year. There is also work being done and awaiting the Governor's approval for the rate increase for nursing facilities.

- **Comment/Response:** Girard Grimaldi: Tony, is that the $10.00 PMPM
- **Comment/Response:** Tony Brite: Yes, the nursing facility rate increase is roughly $10.00. There is a value-based piece of that as well.
  Additionally, Mr. Brite gave an update on the cost to continue. This was reduced by about $81.2 million state share funds, equivalent to 75% of the cost to continue after adjustments related to more current projection. There is a slight reduction in the Pharmacy PMPM by$3.2 million GR. The MMIS also had a slight reduction, reflecting $7 million total ($1.75 million GR). All of the other Governor's recommended items were funded. Some of the items added to the general assembly included the increase to the current women and minority health programs ($3million), QRTP rates ($11million), Hospice rates ($6.4million), Nursing facility rate ($86.2million), Inpatient Psych Facility ($25million), FQHC Substance Abuse prevention Network ($4.5million), and lastly the Non-Medicaid related infrastructure payments to 10 healthcare facilities totaling $21.4million GR.
- **Comment/Response:** Bridget McCandless: Can you please explain to me the cost to continue reduced by state share funds? Is that because of savings?
- **Comment/Response:** Tony Brite: The general assembly received updated projections from us. MHD updates the projections each month. So the General Assembly will look at the most current projection and may adjust the cost to continue items. There was a further adjustment of 75% of MHD projections, so that is about a 25% reduction of our cost to continue. So, MHD may have to come back for a supplemental.
- **Comment/Response:** Bridget McCandless: But it doesn't mean that you make programmatic adjustments, it means that they just didn't fund it at this time? Is that correct?
- **Comment/Response:** Tony Brite: Yes that is correct.
- **Comment/Response:** Girard Grimaldi: On the non-medicated related infrastructure payments, were those actually in the Medicaid section in house bill 11?
- **Comment/Response:** Tony Brite: Yes, they were throughout house bill 11, but primarily in one section. We are working through procurement.

Legislative Update:

- Taylor Jones gave an update in lieu of Ryan Conway, Legislative Director for DSS. Jessie Dresner covered the legislative section as we work on the bill review process, so I do not have any additional updates to provide.

    - **Comment/Response:** Girard Grimaldi: I have a question about the waivers, not specific to Taylor's update, but what is the status on the one substance use disorder waiver for patients?
    - **Comment/Response:** Jessie Dresner: They are currently with CMS, answering questions. The usual back and forth.

Public Comment: There were no public comments.

- **Comment/Response:** Dr. Heidi Miller: I would like to know if Missouri Medicaid is considering coverage of blood pressure cuffs for patients with hypertension and other elements of disease, in the same way that Missouri Medicaid covers glucometers for patients who have diabetes.
- **Comment/Response:** Jessie Dresner: This is a concern that has come up in several of our meetings. Lori Bushner is currently doing research and there have been conversation around this. I will follow up on this and give an update on this.
- **Comment/Response:** Dr. Heidi Miller: I wanted to bring up the issue of when two encounters occurs on the same day, can both be covered? For example, if mom brings baby in for a well-child check-up and visits the LPHA for a lead check, that 2nd visit isn't covered because the child already saw the pediatrician that day.
- **Comment/Response:** Jessie Dresner: I will follow up on that. The maternal health conversations that have been occurring identified the care management within the health plans as well as the LPHA's to identify billing issues. I will touch base with the group that is working on this.
- **Comment/Response:** Girard Grimaldi: This question is for Alex. Were there any changes in the contract related to network adequacy?
- **Comment/Response:** Alex Daskalakis: At this time, I do not see any changes or edits in the contract for network adequacy.

General Update: Once the responses have been collected, we will let everyone know if the meetings will continue as a hybrid option. The meeting adjourned at approximately 2:40 p.m. The next meeting is scheduled for August 9, 2023 at 1:00 pm.