MO HEALTHNET OVERSIGHT MEETING
August 10, 2022

ATTENDANCE

Committee Members Present:	Jessie Dresner, MHD	Danielle McPherson
Nick Pfannenstiel, Chairman	Josh Moore, MHD	David Clement
Bridget McCandless, Co-Chair	Julie Schaefer, MHD	Devin Frank, OA
Carmen Parker-Bradshaw	Justin Clutter, MHD	Doug Crews
Daris Davis for Senator Holly Rehder	Kim Evans, FSD	Emily Wright
Donna Siebeneck for Val Huhn, DMH	Kirk Mathews, MHD	Ginna Rivera
Joe Pierle	Leann Hager, MHD	Grace Cobble
Paula Nickelson, Acting DHSS Director	Marissa Crump, MHD	Heath Clarkston
Representative Tracy McCreery	Nate Percy, MHD	Heidi Geisbuhler-Sutherland
Sara Oerther	Pat Luebbering, DFAS	Helen Jaco
Senator Jill Schupp	Ryan Conway, DSS	Iva Eggert
Todd Richardson, MHD Director	Ryan Conway, DSS	Jackie Schmitz, Senate Staff
Members Not Present:	Tisha McGowan, MHD	Jeana Pringer
Kaylyn Lambert	Ton Brite, MHD	Jennifer Colozza, Conduent
David Ott	Zana Stephenson, MHD	Jessica Petrie
Samuel Alexander	**GUESTS:**	Joel Ferber
Mark Sanford	Alex Curchin	Jim Moody
Representative Jon Patterson	Alisa Gordon	Kathryn Brown
Gerard Grimaldi	April Ash	Katie Reichard, MPCA
DSS/MHDStaff:	Blake Shrout	Kurt Erickson
Abbie Barker, MHD	Brian Kinkade	Lauren Pair
Adam Crumbliss, DSS	Cara Hoover	Mandy Hagseth
Alex Daskalakis, MHD	Chris Moody	Meg Cunningham
Anna Wainscott, MHD	Clara Bates	Megan Fast, Conduent
Ashley Wilson, MHD	Cory McMahon, DMH	Megan Price
Gail Luecke, MHD	Craig Stephenson	Peggy Gaddy
Glenda Kremer, MHD	Cynthia Hicks	Shantel Dooling

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

Welcome/Introduction/Approval of Minutes

- Dr. Nick Pfannenstiel, Chairman, called the meeting to order at approximately 1:00 p.m. The committee approved the minutes from the June 10, 2022 meeting with corrections.
    - **Comment**: Senator Jill Schupp recommended adding links within the minutes to the presentation or portion of presentation that is being referred to.
    - **Comment**: Dr. Pfannenstiel and Director Richardson concurred and MO HealthNet (MHD) will work on making it happen.

MO HealthNet Division (MHD) Director's Update

- Todd Richardson, MHD Director, reviewed four major policy initiatives that MHD has been working on for the last couple of years.

  The first initiative was the completely revamped and overhauled fee for service inpatient hospital reimbursement methodology that had not been updated since 2001. This included the elimination of out-of-state payments and repurposing and a revamped graduate medical education methodology. With these rebased rates, payments are made based on acuity. To minimize disruption of the system, we also included a stop loss mechanism to help smooth out the transition from the old to the new methodology. CMS approval is expected soon on the pending SPA.

  The second initiative was the alignment of the managed care payment methodology with our fee for service payment methodology for both inpatient and outpatient. This is being done through a mechanism that CMS encourages called a directed payment. Missouri's version of this directed payment is somewhat unique in that it employs a minimum and maximum fee schedule directed payment tied off of our fee for service payment rates. The minimum is set at 100% of the fee for service rate and the maximum is set based on hospital class, taking into account current cost, historical reimbursement, and current contracts. We are still in ongoing discussions with CMS regarding directed payment which involves concerns over our provider taxes and our pooling arrangement within those provider taxes; however, the payment methodology was approved by CMS on July 15.

  The third initiative is the complete revamp and overhaul of the nursing facility payment methodology. This process started over 2 years ago by the transformation office, including engaging stakeholders on the front end by looking at the structure of our current rates and what has been successful in other states. We had never adjusted our rates in Missouri for acuity in nursing facilities or had a true performance or value-based component of that rate. We have a SPA ready to go to CMS to implement this new methodology. In the meantime we have a continuation of a payment methodology scheduled to end at the end of this fiscal year to bridge the gap until the SPA is approved and the new payment methodology goes live. Director Richardson expressed his thanks to the Governor's office and the general assembly for the $200 million in additional rates flowing into our nursing facilities.

  The fourth initiative is the increase in our provider rates. This includes not only those overseen by MHD but also by the Department of Mental Health and Department of Health and Senior Services. It is one of the most significant sets of frontline provider rate increases in the state's history. With this type of rate increase, we are going to make up significant ground and be consistent with our other payment methodologies. The bulk of the rate increases are pending CMS approval of our SPA.
    - **Comment:** Senator Schupp requested that meeting presentations be sent earlier than 24 hours prior to meeting, even if partial, to allow committee members to review and be better prepared to ask questions. She also asked if the provider taxes that Director Richardson referred to were the federal reimbursement allowance (FRA) and hoped it did not involve lowering of this reimbursement.
    - **Comment:** Director Richardson advised that he was speaking about the FRA; however, he was referencing a concern CMS has expressed over a number of years regarding the structure of Missouri's provider tax as it relates to the distribution. We will continue to work with CMS on their concerns and he said the agency would not be advocating to draw down less federal dollars than we do today.
- Director Richardson advised that MHD would be working on the next iteration of the hospital reimbursement methodology transition to diagnosis related groups as a base payment methodology that is employed by Medicare and many other states.
    - **Comment:** Dr. Pfannenstiel asked that once CMS does approve the pending SPAs, will we go back 90 days or retroactive to the effective date.

- **Comment:** Tony Brite, MHD Chief Financial Officer, advised that as soon as CMS approves the SPA, it will be retroactive to July 1. The decision process can take up to 90 days depending on how complex each payment methodology is. For example, the ones where we are completely overhauling will take longer than one where decision items can be pretty quick.
- **Comment:** Dr. Pfannenstiel has received some positive feedback in regard to the provider rate increases and the potential of new providers being added. He asked if MHD would be tracking applications and status of new Medicaid providers and reporting back to the committee at some point.
- **Comment:** Director Richardson advised MHD would be doing that and said one of the reasons we want to execute the provider rate increases is to make sure we not only maintain access to providers across the state but also add more providers.

Chief Operations Officer's Update

- Jessie Dresner, MHD Chief Operations Officer, presented MHD's operations update. She briefed the committee on what steps MHD has been taking in preparation for when the PHE unwind begins. Provider bulletins and hot tips have been written and are ready to be published that will explain what the flexibilities were, and what will terminate at the end of the PHE.

  Ms. Dresner talked about the importance of telemedicine, flexibilities that were added and how it was utilized during the PHE. At the onset of the PHE, MHD really needed to do a better job educating providers about telemedicine because our coverage is quite liberal compared to other states and Medicare. She pointed out that the use of the telephone is appropriate and continues to be allowed, as is providers working from home or an alternate site. A couple of flexibilities that will be discontinued with regard to telemedicine have to do with having an established relationship with the patient before providing services and the other has to do with being licensed in the state of Missouri. The state law addressing this in more detail is 191.1146. With collaboration from MHD and input from external stakeholders, MHD produced a new regulation 13 CSR 70-3.330 that provides safeguards but also allows the flexibility that we want to increase access and maintain quality of care.

  Ms. Dresner provided links to the MHD fee for service and managed care provider resource pages and encouraged the committee to take a look and provide any feedback to Ashley Wilson at MHD.
  - **Comment:** Senator Schupp asked for clarification regarding "physician must have an established relationship with the patient before providing services via telehealth."
  - **Comment:** Ms. Dresner answered an "established relationship" could include (a) in-patient visits; (b) a referral; and (c) via telehealth appointment where a medical history is collected. A patient completing a questionnaire is not acceptable.
  - **Comment:** Senator Schupp commented she was surprised how the different type of provider rates varied after she reviewed the recent provider bulletins regarding the rate increases. She asked about the methodology that was used to determine the rate and if it was based on a percentage of Medicare rates for the same services.
  - **Comment/Action Item:** Director Richardson advised that most of the rates are tied to an updated Medicare rate. Previously we paid at 62.5% of the Medicare rate and then applied across the board increases the general assembly appropriated. We are now paying, in most cases, a minimum of 75% of the Medicare rate and in some cases higher than that. There are certain things that Medicaid pays that Medicare doesn't. Dental services would be an example of this where there aren't comparable Medicare rates. We would then use a usual and customary charge ratio. We would look at a mix of private pay and private insurance and set the rate off of a percentage of that. Director Richardson did not know the specifics of the optical rates and would follow up with Senator Schupp.
  - **Comment:** Senator Schupp asked if usual and customary was done by region or statewide.
  - **Comment:** Director Richardson said it was a statewide rate taken off of a national survey that looks at Missouri specifically.

Family Support Division (FSD) Update

- Kim Evans, FSD Director, presented the FSD update. As of July 1, FSD had received 271,666 Medicaid application; as of August 10, they were pending 34,060 applications; and, as of August 5, 205,173 individuals have been added to the adult expansion group (AEG). This data can be found on the caseload counter and is updated every Monday.

  FSD has been working diligently with CMS since November. FSD did receive a letter from CMS for noncompliance for processing applications outside the 45 day requirement; however, FSD was already drafting a mitigation plan. The plan was submitted on May 13, approved in July, and must be in compliance by September 30. For those interested, you can view the mitigation plan at Medicaid.gov. Missouri has been approved for some flexibilities that will help with processing and prevent some barriers for individuals as we move forward with processing applications.

  Director Evans advised that the Gateway program will sunset in December, 2022. As of August 10, all individuals who were in the Gateway program have been evaluated and moved to other Medicaid programs if they were eligible. Approximately 1000 individuals were not eligible for any Medicaid program; however, they will retain coverage until the end of the PHE or until CMS gives additional instructions.
  - **Comment**: Senator Schupp asked why the August 1 deadline was not met.
  - **Comment**: Director Evans advised a State Plan Amendment (SPA) was approved for presumptive eligibility, which has a requirement that these individuals must apply for Medicaid and would increase the number of applications to be processed. CMS was hesitant and feared FSD would not be able to keep up with the volume of applications it would receive. They worked together and agreed upon the September 30 date.
  - **Comment**: Senator Schupp asked if the Federal Market Place data could be used to qualify people.
  - **Comment**: Director Evans advised that they are allowed to use this information as long as it has been verified before FSD receives it. They also did some updates to their system that should help as well.
  - **Comment**: Senator Schupp expressed her concern and asked what happens after the 45 days.
  - **Comment**: Director Evans said CMS continually monitors them. The new tasking system that was put in place last year before the expansion has been a tremendous benefit. It enables FSD to see how much work is there and track how much work the employees are doing. FSD will also be monitoring the work continually to ensure the September 30 date is met.

  Director Evans reported that since the PHE is still active, no Medicaid cases can be closed except for those who are incarcerated, move out of state, or someone requests their case be closed. Missouri is planning to do a 12-month unwind strategy to ensure we are doing a good job and not overloading ourselves with more renewals than we can handle. They are also working with the managed care plans to get change of address information for participants that can be used to update records and do not have to re-verify. The current focus is to have the most current information once the PHE ends.

  Director Evans reviewed technology enhancements FSD has in place. The robust customer portal allows the participants to self-serve. They can go to the portal and complete applications, recertify, do annual renewals, update their contact information, set up appointments and more. It also allows FSD to communicate with them via texts/email reminders of due dates and provide documents they might need. The portal also has a voice activation feature and participants will also be able to upload documents as well. Other enhancements that have been mentioned at previous meetings include centralized mail, enhanced technology to read documents and update the eligibility systems, and enhanced electronic verification. These enhancements will help with the flow of information with the expected volume of annual renewal applications rather than the manual process in place today. Director Evans advised CMS has clarified with states that systems cannot automatically verify information. They still have to have staff

look at the information, look at the final determination and then can "hit the button" to authorize the case. All this will increase the processing time and reduce the amount of churn.

- **Comment**: Senator Schupp asked what was being done to reduce the issue of long wait times.
- **Comment**: Director Evans advised that overtime and flexible work hours are offered to FSD employees and individuals that have limited time are encouraged to set up an appointment, which can be done through the portal or at the Resource Centers. FSD will continue to monitor; however, they do feel the technology enhancements will help and also free up more staff to assist with the call volume.

  Missouri is one of the few states that uses something called a predictive dialer. When a SNAP application is received, it is registered in the system, which prompts FSD to place a call the next day. With the waiver they have, they only have to make one attempt to reach the person, which causes more issues if calls aren't answered or if the person doesn't have time because they are at work. This causes the individual to call FSD, agents are busy, and so on. A SNAP application takes 30-40 minutes and is required in order for the applicant to receive benefits. FSD is working on a demonstration waiver that will allow staff to use the electronic verification to complete the mid-certification reviews and then hopefully convince FNS (Food and Nutrition Services, the Federal governing body for SNAP) to allow staff to waive the recertification interviews if they have all the verified information.
- **Comment**: Sarah Oerther asked how Missouri is doing compared to other states across the country.
- **Comment**. Director Evans said all states are struggling with staffing issues, increased volume of applications due to the economy, geographic areas and population.
- **Comment**: Ms. Oerther asked how many states are going through the same process issues having to meet CMS requirements.
- **Comment**: Director Evans said she had not looked at other states and that the information is not shared until CMS publishes the mitigation plan.

Chief Transformation Update:

- Kirk Mathews, Chief Transformation Officer, gave the transformation office update. Mr. Mathews advised that the hospital reimbursement rebase project that was just completed was a massive effort but only the first step towards a true value-based reimbursement methodology. The old methodology was too antiquated and we had to have something more closely tied to current utilization and expense environments at the hospitals. The next step will include ongoing modeling, running scenarios, stakeholder engagement, etc. and is predicted to take a minimum of two years to complete.

  He also mentioned a new initiative referred to as the ToRCH (Transformation of Rural Community Health) pilot and will talk more about it at a future meeting. The ToRCH pilot's objective is to improve rural population health by providing a revenue stream to rural hospitals that will serve as a health hub to allow rural hospitals to adequately address upstream causes of poor health mostly due to social determinants. The pilot has been shared with the Missouri Hospital Association and rural hospitals, which have shown a lot of interest and support for it. The hope is to launch next July and to start the pilot in six hospitals.

  Mr. Mathews advised a Maternal Infant Health group has just been launched and will be led by Lori Bushner with MHD. The focus will be on how we can change Missouri's historically poor outcomes in maternal infant health that includes mortality rate and low birth rate outcomes, and disparities we see in race and geography. The group will engage our managed care plans in this effort as well.

  Another initiative the Transformation team will be looking at is to see how we assess network adequacy with our managed care plans. When you look at managed care plans and the providers they have enrolled to help meet network adequacy, there is no meaningful claims history that shows if they are necessarily seeing any Medicaid patients. The goal of this initiative is to take a more practical look at

what network adequacy means for our managed care providers and what some of the root causes are, where those networks might be inadequate.

Justin Clutter, MHD Transformation Project Manager, reviewed the managed care dashboard, which gives you a more transparent look at the contracted managed care organizations' (MCO) performance and helps participants make a more informed decision on what plan to go with. MHD has included 15 of its HEDIS (Health Effectiveness Date and Information Set) measures, and the dashboard includes a 3-year trend of the national quality measure around Medicaid. COVID did impact these measures in 2020 and declined in every state, not just Missouri. Another feature is CAHPS (customer assessment of health care providers and systems). Medicaid participants fill out this survey. Our health plans in Missouri do pretty well on these measures. The Claims Adjudication feature shows the average number of days each MCO takes to adjudicate a claim, which is the process of the health plan reviewing a claim and accepting/denying it for payment.

- **Comment:** Carmen Parker-Bradshaw asked that given the timeliness of eligibility and enrollment, if there were any correlating measures that would show late diagnosis of conditions that do drive up high costs.
- **Comment:** Mr. Mathews said they did not have any data that would crosswalk between those but perhaps it was something we could research more and follow up with the committee on.
- **Comment:** Senator Schupp asked if there was any update with CMS on legislation that was passed that allows the extension of mental health care for a year post-partum for Medicaid recipients once the PHE ends.
- **Comment:** Ms. Dresner advised there has been no additional support or guidance from CMS specifically. MHD and the Department of Mental Health (DMH) are meeting to see what could be done in the interim. Nate Percy, MHD Finance, and Director Evans' team have also met on this issue. One thing they discussed is to pull the DCNs of the potential women affected and do their redetermination last, during the 12-month post-PHE redetermination period. Then, we have between now and the end of the PHE plus another 12 months of coverage for these women. MHD has also worked with DMH to gather information on potential women receiving Medicaid services through them and found a large percentage of them are. We will be following up with DMH again to see if we can proceed with the provision of services through some type of agreement with them.

Chief Information Officer Update

- Tisha McGowan, MHD Chief Information Officer, and Zana Stephenson, MHD Data Manager, gave an overview on the BIS-EDW dashboard rollout project and highlighted some of internal dashboards MHD uses: Pharmacy, the Adult Expansion Group, and Provider Enrollment. Future topics for BIS-EDW dashboards include Certified Community Behavioral Health Organizations, Telehealth, Drug Rebate, and Finance to name a few.
  - **Comment:** Dr. Bridget McCandless asked how long the turnaround was from start to finish, and when and how much are managers able to query their own data so they can modify and ask questions themselves.
  - **Comment:** Ms. Stephenson advised that the goal is to build the dashboards in 4 weeks or less; however, they are not there yet. Ms. McGowan said that the information is available in our public folder and we encourage employees to use them.

Managed Care Update

- Alex Daskalakis, MHD Managed Care Director, reported that the new 5-year Managed Care contract went into effect July 1. The first amendment to the contract also went into effect July 1and includes directed payments for inpatient and outpatient hospital services. The contract is normally amended twice a year.

  Mr. Daskalakis highlighted a couple units within his organization. The Provider Education unit works with providers to connect with the managed care plans. They encourage all providers to attend the webinars

that cover items such as durable medical equipment, dental services, and behavioral health services. The goal of this unit is to engage with as many of our providers as they can so those providers feel comfortable working with the managed care plans.

The Managed Care unit also oversees the PACE program that provides a comprehensive package of services designed for participants who would normally qualify for a nursing facility level of care but this allows them to remain in their homes. At this time, New Horizons in St. Louis is the only facility we have operational in the state with 17 participants. A second facility, PACE-KC, is under construction in the Kansas City area and plans to be operational by the end of 2023.

- **Comment**: Dr. Pfannenstiel asked how many participants were anticipated to be in the Kansas City facility.
- **Comment**: Mr. Daskalakis and Director Richardson advised that is still to be determined since there is still some facility work to be done and become operational.
- **Comment**: Dr. Pfannenstiel asked how the long process was for a provider to generate the PACE documentation (enrollment, acceptance, and then become operational).
- **Comment**: Director Richardson advised that it wasn't a typical process. The two sites we have now were part of a pilot presented to the general assembly in 2019/2020, included in the department's budget language, and had to be approved by CMS. Then the provider has to get their facility ready for development. For additional sites, we're currently talking about what our internal process looks like for new providers who may want to look at other markets in the state and apply. Since the program is already established, it obviously won't take as long as the first two sites.

Pharmacy Update:

- Josh Moore, MHD Pharmacy Director, gave an update on Pharmacy Audit. MHD hired a program integrity pharmacist approximately two years ago and has been working through a variety of items to ensure what we are paying for drugs is accurate or whether it should be less or more. It is important to have an accurate claim, especially in pharmacy, to ensure appropriate reimbursement, manufacturer rebate invoicing and utilization. He provided a couple examples of White Bagging, which is when two providers billing for the dispensing of a participant's medication when one provider should be billing for only the administration of the medication. He went on to explain the way that drug rebate works for Medicaid is that as long as we pay a penny for a product, we get the rebate.

  Educational opportunities have been held to aid providers in proper billing of drug claims for MO HealthNet. MO HealthNet questions or issues, unrelated to prior authorizations, can be directed to the MHD Pharmacy Unit as well by calling the hotline at 573-751-6963 or email MHD.PharmacyAdmin@dss.mo.gov.

  Provider bulletins are sent out to providers on what edits or criteria are changing. These bulletins can be found on the MHD website at Provider Bulletin page.

  Mr. Moore reported that a very big Preferred Drug List (PDL) renewal is coming in January that will touch 90 classes worth of products, which is about $480 million worth of drug reimbursement.

Budget Update: There was no budget update.

Legislative Update:

- Ryan Conway, DSS Legislative Liaison, advised the Department was very pleased with the outcome of the budget. No items were lined out. He advised they are in the process of collecting legislative proposals from all of the agencies. He should be able to report more at the next meeting.

Public Comment: There were no public comments.

The meeting adjourned at approximately 3:45 p.m. The next meeting is scheduled for November 9, 2022.