

# April Meeting Notes

## **Medical Director Meeting**

### **Kentucky Medicaid Managed Care Plans**

Tuesday – April 15, 2014

1:00 p.m. – 3:00 p.m.

#### Location

#### **Humana/CareSource**

10200 Forest Green Boulevard

Suite 400, Louisville, KY 40223

502.213.4700

**Attendees (MCO's):** Dr. Donald Wharton (Humana/CareSource), Elizabeth McKune (Passport), Dr. Peter Thurman (Anthem), Dr. Howard Shaps (WellCare), Jerry Caudill (Avesis)

**Attendees (Invited Guests):** Charles Kendell (Consultant: K-HEN), Donna Meador (K-HEN Director), Dolores Hagan (K-HEN Education and Data Manager)

**Attendees (CHFS):** Dr. Allen Brenzel (BHDID), Dr. Ruth Ann Shepherd (DPH), Andrea Adams (OHP), Patricia Biggs (DMS), Judy Baker (DMS), Dr. William Rich (DMS), Adi Mittrache (UKMC), Dr. John Langefeld (DMS)

## **Agenda Discussion Items**

### ➤ **Update from past meetings**

#### • **Behavioral Health – Update**

##### ▪ **Follow up from MCO meetings with Secretary Haynes**

One-on-one meetings held last week with Secretary Haynes and Leadership with each MCO. Areas of focus included 1) Physical Health Issues, 2) Rate Issues, 3) Behavioral Health Issues. During these meeting specific emphasis was placed and extensive discussion and expectations were articulated around the expectation of development, support, measurement, and outcomes with the continuum of care in behavioral health and “full” integration with physical health.

##### ▪ **Impact Plus**

Dr. Brenzel discussed the future plans around Impact Plus and need to have them enrolled as active providers under managed care services.

##### ▪ **Network Adequacy & Substance Abuse Benefit**

It was discussed that MCO's must now add these services to existing provider contracts and work with DMS to credential new providers to insure Medicaid enrollees have adequate access to these services. MCO's will also have the responsibility to educate prospective new providers and reach out to develop new network providers to insure access and quality services for their Medicaid enrollees. It is also a DMS expectation that every MCO contract with all 14 CMHC's as they are our safety net provider for MH/SA. DMS will be tracking this

issue and drilling down on network adequacy for the regions without a contracted CMHC.

▪ **AG Grant Funds update**

Dr. Brenzel gave update of current active solicitation of proposals from providers regarding development of adolescent substance abuse resources utilizing AG grant funds. These proposals are being actively evaluated with a desire to make selections and disperse the funds ASAP.

▪ **Project Plan Team**

A list of identified members representing respective MCO's who would participate in a workgroup with DMS & DBHDID was distributed. There was a request to confirm members and/or make additions with a plan to convene in near future. The initial objective will be to develop a detailed project plan that will outline objectives, identify common issues (including coding and reimbursement/rate structure), discuss development of continuum of care resources, and clarify regulatory and provider enrollment issues. Members of this workgroup have tentatively been identified:

- Allen Brenzel, MD (DMS)
- John Langefeld, MD (DMS)
- Angelina Harmon (Anthem/BCBS)
- Kimberlee Richardson (Coventry)
- Kristan Mowder (Humana/CareSource)
- Elizabeth McKune (Passport)
- Paul Kensicki (WellCare)

▪ **Institutional De-certifications**

The group was notified of an active plan to convene all MCO representatives to review a long list (28 children) who has been "de-certified" for inpatient care. This meeting will focus on review of current cases and status; current protocols and criteria utilized; case management, discharge planning, and care coordination. It will also review contractual obligations and CHFS (DMS/DBHDID/DCBS) expectations.

**Summary as of 4/7/2014**

<b>CoventryCares:</b>	<b>16</b>
<b>WellCare:</b>	<b>8</b>
<b>Passport:</b>	<b>3</b>
<b>Humana:</b>	<b>1</b>

• **ER Super-Utilizer Meeting Debrief**

Update given regarding current status of ER SMART. NGA continues to provide support and are developing a template operational plan that can facilitate local work-group activities. MCO's are asked to maintain active involvement with these local groups as they work through care-coordination plans and development of economic support models.

- **Colorectal Cancer Screening project**

There have been several discussions around CRC screening including meetings with Dr. Whitney Jones. The group was made aware of a request from UK College of Public Health. Specifically the project involves:

UK’s CDC-funded Rural Cancer Prevention Center is submitting a research grant application to CDC, due April 24<sup>th</sup>. CDC is seeking a Prevention Research Center, preferably in a state with Medicaid expansion, to assess the feasibility of a population-based mail program to disseminate fecal immunochemical test (FIT) kits in an effort to increase colorectal cancer (CRC) screening.

The MCO’s were made aware that they would be contacted and asked to participate in this project and if agreeable, they would provide a letter of agreement & support for the project. Templates were provided.

DMS preliminary extract of the data summarized below:

**Results**

MCO	Members (51-75) screened who have had screening	Members (51-75) Eligible for Screening	Percentage Screened	FOBT in 2013	SIG in 2009-2013	Scope in 2004-2013
Coventry	9,862	24,901	40%	370	184	9,679
FFS	12,612	41,433	30%	586	314	12,323
Humana	321	1,052	31%	7	7	317
Passport	4,246	9,592	44%	193	87	4,145
WellCare	13,234	31,490	42%	598	290	12,953
<b>Total</b>	<b>40,275</b>	<b>108,468</b>	<b>37%</b>	<b>1,754</b>	<b>882</b>	<b>39,417</b>

- **Health Home Planning Update**

Andrea Adams provided an update regarding the Health Home planning activities. She has received three completed documents requested of the “Service Inventory” (WellCare, Anthem, and CareSource/Humana). There was a request to have these completed by all ASAP. Additionally, it was noted that during the Secretary Haynes/MCO meetings there was a discussion regarding the Health Home initiative and a request for providing a summary of “allocated” resources from each respective MCO related to case management/care coordination/care integration, etc.

- **Louisville Metro ACA Implementation Steering Committee**

A follow up from the presentation made in the March meeting was an invitation passed along from Gabriela Alcalde for all the MCO Medicaid Medical Directors to attend the next committee meeting.

**The Date/Time/Location is:**

Wednesday, April 23<sup>rd</sup>; 5:30 PM  
 Greater Louisville Medical Society (101 West Chestnut Street)  
 Museum Room

## ➤ New Discussion Items

- **Dental Items**

- **Fluoride Varnish**

There appears to be a system issue with the delivery of fluoride varnish to children in Physician's offices. Medicaid has reimbursed physicians for the application of fluoride varnish to young children for several years. Children having received this therapy exhibit a measurable reduction of tooth decay as compared to children who do not receive it. In the past Medicaid has reimbursed Physicians using a dental code (D1206) submitted on medical form 1500. Recently these claims have been rejected when presented to the medical MCO for payment. Dr. Rich requested that the MCOs work within their systems to correct this oversight and reimburse the Physicians for the delivery of these services.

- **The Commission for Children with Special Healthcare Needs (CCSHN)**

CCSHN is having similar issues with reimbursement. Dr. Rich and Dr. Caudill from Avesis explained the situation. The Dental MCO requires a credentialed dental provider (dentist) in order to pay for services. In the past the CCSHN was, and still is being paid by Medicaid under a separate contract which allows them to be reimbursed using the commission as the provider and not requiring the participating doctors to be credentialed Medicaid providers. The MCO's have a contractual obligation to pay for services rendered to these members via the commission. Dr. Rich encouraged the MCO's to negotiate a payment mechanism and rate with the commission for the delivery of services to these patients. **\*It is reported that some of the patients under the care of the commission have been waiting for 6 months for treatment.**

- **Kentucky Hospital Engagement Network (KY-HEN)**

Charles Kendell introduced K-HEN. The K-HEN is a quality improvement program for Kentucky hospitals and is supported fully by the Kentucky Hospital Association. The Kentucky Hospital Engagement Network (K-HEN) was developed by the Kentucky Hospital Association in partnership with the Hospital Research and Education Trust (HRET) of the American Hospital Association. The goal of K-HEN is to engage Kentucky hospitals in quality improvement programs with the goal to reduce patient harm by 40% and readmissions by 20% by 2013. The K-HEN includes most (but not all) hospitals in Kentucky and it was noted there were other HEN's in the state.

### **Goals of Current Project**

CMS has defined very specifically the targeted clinical areas on which the national HEN's are focusing their work. CMS highlighted the **Obstetrical Harm** initiative as one of its focus areas from the beginning of the HEN project in 2012 with a particular **focus on reducing early elective deliveries (EED) to a rate of less than three percent.** The K-HEN along with The Kentucky Department for Public Health and the March of Dimes spearheaded the development of the "Kentucky SAFE Baby Initiative." The initiative was launched in July, 2012 with active participation among several Kentucky clinical leaders and maternal-child

health champions including Dr. Ruth Ann Shepherd, Dr. Molly Houser, Dr. Kelley Clark, and Dr. Connie White. 23 Hospitals and multiple clinicians have been involved. Preliminary data through Dec. 2013 was shared with the group. It reflected significant improvement in rates; with a baseline greater than 15% to a current 3 month average rate of 6.7%. This represents a 71% improvement. Several views of data and comparisons were shared (EED cohort comparison, Number of Hospitals reporting, Hospitals with and without “Hardstop” policies, NICU admission from elective <39 wks., C-Section rates). Dr. Shepherd noted that although significant progress has been made, Kentucky is still behind other states with similar initiatives with still a lot of opportunity (the goal is <3%).

Discussion of the group focused on understanding the current participating group, the metrics being utilized, the comparison with other national and regional benchmarks, and what next steps are planned. There was a request for consideration from the respective group that this may represent an opportunity for harmonization of clinical improvement initiatives (Specifically a potential opportunity around the required PIP’s from the MCO’s).

#### **Plans for 2014**

CMS has identified two new areas of Obstetrical Harm focus for 2014: Maternal Hemorrhage, and Preeclampsia Management. Each participating hospital will be asked to continue submitting data on EED and the other Obstetrical Harm measures in which they are currently engaged. In addition to the new areas of focus from

CMS, K-HEN will begin to analyze primary C-section rates and further explore the relationship between reductions in Early Elective Delivery and Primary C-Section Rates. There was also mention of pursuing an initiative around Neonatal Abstinence Syndrome (NAS).

- **I PRO Reports: Postpartum & Newborn Readmissions**

Judy Baker, Branch Manager for the Division of Program Quality and Outcomes gave an overview of findings from the I PRO reports:

Island Peer Review (I PRO) conducted two surveys for KDMS on the readmission of postpartum women and newborns using 2012 data provided by 3 Managed Care Organizations (MCO’s); Coventry Cares, Passport, and WellCare; along with medical chart reviews. They studied the readmission rates in relation to several risk factors and diagnosis. Chi-square test statistic and both binomial and multinomial multivariable logistic regressions were used to analyze the data. The Postpartum Readmission Study concluded that subpopulations at risk for readmission include women with obesity, hypertension, cesarean delivery, major puerperal infection or sepsis, and drug abuse. The Newborn Readmission Study indicated subpopulations at risk for readmission include newborn male sex, race/ethnicity other than White or Black, prematurity (especially early-term gestational age), as well as the following birth-stay diagnoses: respiratory distress, sepsis, and congenital anomalies, and the following invasive procedures: mechanical ventilation and intubation or irrigation. RSV and other respiratory problems, jaundice, gastrointestinal and feeding problems were prevalent in newborn readmissions.

I PRO concluded in both studies that lack of follow-up visits and lack of case management increased chances of readmissions. Possible interventions to improve postpartum and newborn outcomes include better care coordination/case management, better patient education and health assessments, and MCO/hospital collaboration for targeted clinical care enhancements.

There was also a summary of current activities from some of the MCO's. Passport utilizes a 24HR nurse line as well as an on-site nurse to educate mothers about the importance of follow up visits and answers to medical questions. Passport uses an OB Navigator to work with postpartum mothers during ER visits to help keep their treatment as an outpatient, a Mommy and Me program to send reminders for appointments and schedule EPSDT appointments, as well as, Tiny Tots nurses work with NICU to ensure case management services. WellCare stroller incentive program for meeting all pre and post natal appointments, a maternity obesity program, educational baby showers in the community, and a peer support called Mama to Mama for pregnant teenagers or those teens with infants less than 6 months of age. Both Passport and WellCare place pregnant teens in high risk groups and engage them in case management.

Next steps identified include collaboration between DMS, MCO's, and hospitals to identify high risk mothers and newborns to provide better discharge education and case management.

It was noted that the data submitted reflected that there was only 7% referral rate through MCO case management/care coordination. This appeared to be a very low rate of "capture" and the MD's were asked to follow up with their respective care teams.

Dr. Shepherd noted the overall rate in both studies of <2% was consistent with national benchmarks published. Dr. Shepherd also noted that there was active work around many related initiatives at DPH and described the "Safe Sleep" project and also the work focused on identifying best practices in "Safe & Healthy Beginnings". She also reinforced that many resources are available with referral to the HANDS program and the MCO's were encouraged to increase their active coordination and utilization of this program.

During this discussion it was also noted that DMS continues to work with DPH on the project to create "linkage" with the vital records data (project supported by CMS & CDC). This work will augment ability to continue understanding the opportunities around postpartum & newborn readmission.

➤ **Misc. items**

▪ **Naloxone**

There was continued discussion of work around getting Naloxone into communities. Emily Whalen Parento, Executive Director Office of Health Policy, just returned from a national-level discussion at Georgetown University

sponsored by the Clinton Foundation and some high-level summary points were given:

- Naloxone access is critical to stemming drug overdose deaths, which is an explicit goal from Governor Beshear in kyhealthnow.
- One strategy for that is increasing access to naloxone. It is anticipated that SB5 will come out of the legislature and open up prescribing authority to basically anyone rather than just patients/families.
- With that, DMS is looking to develop strategies to increase access. The Northern Kentucky groups are heavily involved in this effort, and Van Ingram (Office of Drug Control Policy) has a pilot ready to go between NKY and SW Ohio, supported by both governors. The goal is to get naloxone in hands of every patient doing medication-assisted substance use treatment and in 50% of police cars. Estimated cost to fund = \$1.3 million or so.
- The Clinton Foundation is also very interested in this, including President Clinton due to family friend who died of drug overdose at age 28. The Foundation is actively seeking to facilitate strategies in motivated states like Kentucky to move the needle on this question.
- A primary question for MCOs is: what is paid for, and with what levels of barriers? The drug (Naloxone) is already covered, however not the atomizer/'kit' which is not yet FDA approved. It was noted that a newly FDA approved epipen-like device is coming on the market, however little information is currently available.
- There was active request that the respective MCO's give feedback regarding their current level of thought and programmatic support. What does their data show? Should we give naloxone with every new opioid prescription? What are their thoughts on what the 'model' looks like? Is it similar to the defibrillator model (i.e., airports, workplaces, public buildings, etc.)?
- We will plan to continue the dialog.

➤ **Next Meeting: Scheduled May 20, 1-3pm (Location: Anthem BCBS)**