Second Report of the

Senate Interim Committee on Medicaid

Accountability and Taxpayer Protection

November 29, 2021

November 17, 2021
The Honorable Dave Schatz, President Pro Tempore
State Capitol Building
Jefferson City, Missouri 65101

Dear President Pro Tempore Dave Schatz:

Following the conclusion of its first report on September 23, 2021, the Senate Interim Committee on Medicaid Accountability and Taxpayer Protection, acting according with its charge, has met, taken testimony, deliberated, and concluded its study on issues relating to Missouri's MO HealthNet program and issues relating to transparency and services. The committee now presents to the Missouri Senate a second report of the committee's activities and actions to date.

Senator Bill White, Chair

Senator Karla Eslinger, Vice-Chair

Senator Mike Bernskoetter

Senator Justin Brown

Senator Mike Cierpiot

Senator Bill Eigel

Senator Elaine Gannon

Senator Lauren Arthur

Senator Karla May

Senator Jill Schup

Pursuant to Senate Rule 31, President Pro Tempore Dave Schatz established the Senate Interim Committee on Medicaid Accountability and Taxpayer Protection on June 30, 2021. The duties of the committee were to conduct in-depth studies and make appropriate recommendations concerning the MO HealthNet program, the protection of unborn human life, and ensuring Missouri tax dollars are spent in accordance with the values of Missourians. The President authorized the committee to solicit input and information necessary to fulfil its obligations from the appropriate state departments and agencies. The committee produced a first report on September 23, 2021, relating to the MO HealthNet program and the protection of unborn life. This second and final report will summarize the activities of the committee to date concerning transparency of the MO HealthNet program and reforms concerning select services.

The committee held two public hearings relating to MO HealthNet transparency and proposed reforms. The first hearing was held on October 7, 2021, at the State Capitol Building in Senate Committee Room #2. The committee members heard testimony from members of the MO Healthnet Division and the Department of Social Services, including Kirk Matthews, Chief Transformation Officer of the MO HealthNet Division, Justin Cutter, Joshua Moore, and Sharie Hahn, General Counsel of the Department of Social Services, who presented on various Medicaid transformation initiatives (see attached) and demonstrated the Transformation Office's "Tableau Dashboard", which tracks completed, in-progress, and future transformation initiatives. Some of the transformation projects discussed included modifications in pharmacy rebate agreements to better capture potential savings in the MO HealthNet Pharmacy program, managed care compliance and quality reporting tool updates, a new hospital outpatient simplified fee schedule, out-of-state patient reimbursement payments, human-centered application redesigns, and rural hospital health hubs designed to address social determinants of health in underserved rural populations.

Committee members brought up concerns about the lack of transparency in publicly-available information related to many aspects of MO HealthNet, but particularly relating to how the various MO HealthNet managed care companies have fared in meeting specific patient quality and care criteria. Members urged the Division to consider a public dashboard that would provide members of the public with information concerning the various health plans and how they meet quality and care metrics, as well as network adequacy and case management. The committee discussed the Division's need for additional appropriations to implement a systems upgrade for the Division's claims processing and payment system, the Medicaid Management Information System (MMIS). Additionally, the committee members discussed the challenges facing some MO HealthNet recipients who receive services through managed care in finding and accessing services through the provider of their choice, especially if such service is highly specialized. Chairman White brought to the committee's attention several suggested reforms concerning the Medicaid Fraud Control Unit within the Office of the Attorney General and health care patient abuse statutes that lack an adequate definition of "neglect". Finally, the committee discussed the challenges facing rural communities in the wake of hospital closures and provider shortages and sought recommendations from the Division concerning plans to support rural hospitals in underserved populations.

The second hearing was held on October 20, 2021, at the State Capitol in Senate Committee Room #2, for the purpose of receiving invited testimony from various individuals and organizations on proposed MO HealthNet transparency and reform initiatives. The committee members heard testimony from: Alexandra Rankin of the Missouri Foundation for Health, Sidney Watson from St. Louis University School of Law, Jewell Patek of the Missouri Health Care Association, Daniel Landon of the Missouri Hospital Association, Todd Richardson from the Missouri Department of Social Services, Sara Schlemeier of the American College of Obstetricians and Gynecologists, Heidi Geisbuhler Sutherland of the Missouri State Medical Association, and Samuel Lee of Campaign Life Missouri. The testimony from the invited

witnesses ranged from strengthening managed care Healthcare Effectiveness Data and Information Set (HEDIS) measures and network adequacy measures, patient care coordination and primary care health homes, value-based payment systems and updated MMIS technologies, interoperability between the state's various social programs, and expanding the state's MO HealthNet postpartum care services from the current sixty days to one year.

Recommendations

After review and consideration of the testimony presented by the MO HealthNet Division, the Department of Social Services, and invited testimony, the committee recommends the following statutory and budgetary changes relating to MO HealthNet transparency and program reforms:

I. **MMIS budget request for updated technologies.** MO HealthNet's hardware and digital infrastructure is a collection of systems serving as data warehouses, claims processing and payment, and core systems. While some systems are currently in the process of upgrading, the core MMIS is growing outdated, having been established in the 1970s on a COBOL platform. The Division is increasingly finding it difficult to maintain and support the aging system and programmers knowledgeable in COBOL are growing scarce. Replacing the core claims processing system would represent a significant investment of time and resources, but the end result would be a platform that can be maintained into the future, as well as one that will be more flexible when adapting to newer health care service delivery and payment models. The committee recommends consideration by the House Budget and Senate Appropriations committees of appropriate and adequate funding to begin the process of replacing the MMIS so that the millions of provider claims processed by the Division may continue to be processed and paid in a timely manner.

II. **Public facing dashboard for transparency measures**. A lack of transparency in ongoing and planned changes to the MO HealthNet program and a need for a centralized location for information about MO HealthNet services, including managed care health plans, was a common concern shared by committee members. Accordingly, the committee recommends that the MO HealthNet Division develop and implement a publicly accessible dashboard or portal in order to provide the public, including current and prospective MO HealthNet recipients, policymakers, and researchers, with information on:

a. MO HealthNet services and programs for various eligible populations;

b. Managed care health plans and how each plan reports on HEDIS measures and the extent of each plan's network adequacy;

c. Current and completed transformation projects, waivers, and state plan amendments, with information regularly updated to show projected and realized efficiencies, quality of care and access to services, and savings to the state;

d. Any studies conducted by or on behalf of the state examining the functionality of the MO HealthNet program and proposed reforms; and

e. Other measures designed to increase and improve transparency into the services provided through the MO HealthNet program, measures of quality of care and patient access to services, and the potential and realized benefits provided through various projects, waivers, and other changes to the program.

III. **Payment reforms and network adequacy.** Committee members heard testimony from members of the MO HealthNet Division relating to changes to the hospital outpatient fee schedule designed to create a simplified and uniform provider payment system similar to Medicare. The committee recommends the development of a similar unified fee schedule for the provision of services through managed care, with the desired result being a renewed focus on quality of care and case management as opposed to negotiating lower provider payments. In addition, the committee recommends greater emphasis on broad networks of providers under each health plan so recipients are able to see the provider they need with minimal obstacles to accessing patient care.

IV. **Abuse and neglect statutory changes.** The Medicaid Fraud Control Unit within the Office of the Attorney General investigates and prosecutes, among other things, allegations of abuse and neglect of MO HealthNet recipients by providers or in MO HealthNet facilities. Current

statutes utilized in these cases focus primarily on abuse. The committee recommends statutory changes to Section 191.905.6 (abuse of a health care recipient) to include a prohibition on "neglect", focusing on the intentional failure to provide care, as well as consideration of Sections 565.184 and 630.155 to ensure those provisions adequately protect our vulnerable Missouri residents.

V. **Postpartum extension.** Currently, Missouri provides MO Healthnet coverage through MO HealthNet for Pregnant Women for certain low-income pregnant women. Services include sixty days of postpartum coverage following the birth of the child or the end of the pregnancy. Similarly, women receiving assistance through the Show-Me Healthy Babies Program, part of the state's Children's Health Insurance Program (CHIP), are also eligible for postpartum coverage for sixty days. Changes in federal law made in the American Rescue Plan passed by Congress this year allow states to expand the postpartum coverage from sixty days to twelve months beginning April 1, 2022, and extending for a period of at least five years. The committee recommends changes to Sections 208.151 and 208.662 to extend the period of postpartum coverage to twelve months, with an emergency clause to avoid delays in implementation. Additionally, the committee recommends that the General Assembly appropriate adequate funds to cover the extended coverage for postpartum women.

Appendix A *** The following is the product of the MO HealthNet Division as presented to the Committee

McKinsey Recommendation	Description	Project Status	Timeline
Projects COMPLETED			
Reduce grandfathering	Missouri could consider only targeted use of grandfathering for specific drug classes (e.g., antipsychotics) based on an review of clinical need. Operationally, some requirements would include proper notification to participants and providers to ensure that all stakeholders are aware of pending changes and to avoid any impact on access.	MHD has completed this project	7/1/2019
Extend 'Money Follows the Person' (MFP) through a new grant waiver	On average, MFP in Missouri has helped 206 individuals each year to transition back to their communities. The quality of life of individuals living at home may be much higher than it may be for those living in an institution; in addition, the cost of a year of nursing home care is $45,000, versus $8,300 for home-based care.	MHD has completed this project	1/1/2021
Implement additional waivers (e.g., waiver for children with developmental disabilities who do not require habilitative services) or expand current waivers	Implementing such a waiver would allow children who are ineligible for Medicaid because of their parents' income to receive Medicaid services without hospitalization. This would not only allow children to receive care from the comfort of their homes, if they do not require more intensive care, but would also potentially reduce the cost of care.	Implement additional waivers/expand current waivers MHD works to implement additional waivers as funding is provided. Funding was granted in the SFY2022 budget for the Structured Family Caregiving Waiver.	Continuous
Implement medical necessity guidelines and prior authorization in drug classes that do not have such policies	The state could implement new medical necessity policies for oncology, hemophilia, IVIG, and other select high-cost physician-administered therapies. This could not only bring Missouri in line with other states and MCOs but could also require that participants are receiving care based on accepted clinical guidelines in the proper clinical sequence.	MHD implemented clinical edits on Growth Hormones and IVIG and selective PAs on certain oncology items.	GH: 2/18/2021 IVIG: 9/17/2020
Require NDC submission on claims for non-J-code HCPCS drugs	This initiative could ensure that rebates are captured on all physician administered drugs. Operationally, some requirements would include provider notification and modest MMIS system edits.	MHD has completed this project	8/30/2021
Expand day one managed care eligibility and passive enrollment to additional populations	Day one MCO eligibility and passive enrollment could be expanded beyond foster children to additional populations. Passive enrollment, while still allowing participants to choose or switch MCOs as required by federal regulations, can streamline participant transitions, increase access to care management for participants by requiring it at the time of Medicaid enrollment, and reduce the burden on the FFS system.	Day One Enrollment MHD has implemented day one enrollment.	7/1/2020
Improve TPL identification	Missouri could begin to utilize additional sources (e.g., pharmacy claims data) to increase TPL identification rate. To do this, the state could contract with a vendor that would add additional sources of data.	Improve Third Party Liability (TPL) Identification MHD reviewed the services and providers that HMS seeks recoveries for on our behalf and recoveries have increased substantially as a result	11/30/2020
Apply for CMMI grant funding through the Maternal Opioid Misuse (MOM) and Integrated Care for Kids (InCK) Models	The models provide states with federal funds to help the state fund programs to combat OUD in pregnant and postpartum Medicaid participants and improve behavioral health care for children up to 21 years. MOM provides up to $64.5 million nationally for implementation, transition, and milestone funding distributed across up to 12 states; InCK provides $16 million. The state could consider applying for these grants, which could be (but need not be) seen as two sides of the same coin. The Notices of Funding Opportunity (NOFO) for both programs are expected in early 2019; applications for funding are likely to be due early in 2019 and funds awarded in late 2019.	MHD applied and received acceptance for the MOM grant, however, it was discontinued at MHD's request. MHD has instead shifted focus to all things related to maternal health which includes opioid misuse.	Ongoing
Develop process guides for staff member efficiency improvement and error reduction	Currently, a limited number of job guides exist to guide staff member on best practices for repetitive tasks. The creation of such guides could drive improved efficiency, reduce errors, and greatly shorten time to ramp up new staff members on core manual processes. Specifically, the enrollment process has many potential tasks that could benefit from the creation of a guide, such as incarcerated disenrollment and error reconciliation. Guides that provide step-by-step instructions on how to complete these tasks could be readily created and may be greatly beneficial.	MHD has implemented desk manuals for all staff and they are regularly reviewed and updated.	Complete
Develop job aides for high-volume tasks	High-volume tasks that are currently performed through experience and on-the-job learning have the potential to be standardized and expedited through the creation of job aids. (Job aids are basic decision trees, checklists, planning tools that support work and activity by guiding or directing tasks at hand.) For example, within claims operations, the team could create job aids who provide algorithmic guides specifically for top edits and manual adjudications.	MHD has implemented desk manuals for all staff and they are regularly reviewed and updated.	Complete

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Projects COMPLETED			
Implement workforce management	In contact centers, for example, shifting staff members across tiers and optimizing staffing in each tier could achieve reduced wait time on the phone (i.e., average speed of answer of less than 60 seconds against current average of over 10 minutes). To achieve this reduction in wait time, potential solutions include moving agents from Tiers 3, 4, and 5 to Tier 1 and ensuring the right shrinkage factors (e.g., absenteeism) are factored into the staffing model. Workforce management principles could also improve efficiencies within claims processing by further aligning staff members to specializations by skill level and claim type. This could improve processing times and staff productivity.	MHD consistently focuses on cross-training staff to ensure there is an adequate knowledge base for our program.	Ongoing
Adopt performance management practices	In contact centers, the state could coach toward behaviors that drive high talk-time and quality and reduce variability in average handle time across each tier to achieve a ~10% to 12% reduction in average handle time in each tier and improve customer experience. The state could adopt best-in-class performance management practices, including defining clear agent goals and KPIs and increasing structured coaching and uniform meeting cadence. To help define clear goals and a holistic set of KPIs, scorecards could be updated with realistic goals against important KPIs. With clearer scorecards and KPIs, coaching could become more structured and efficient, driving better customer experience and lower wait time through reduction in average handle time. KPIs and dashboarding could be equally essential in participant enrollment and claims processing. In the claims tracking process, for example, organizational leadership could increase its effectiveness if it could have access to critical KPIs such as auto-adjudication rate, adjustment rate, percentage of claims paid as billed, rate of denial by denial reason code and denials overturn rate.	DSS as a whole continuously reviews and improves staff goals and expectations to ensure all customers receive the best service possible.	Ongoing
Implement issue and project tracking system	Currently, issue and request management is done through email. The state could consider transitioning to a ticket-based management system that provides real time tracking, escalation paths and pan-organizational transparency.	The Transformation Office has developed an internal Tableau dashboard to track projects. Additionally, automated risk and issue logs are utilized on all projects through the SP repository. MHD also posts WSR electronically. MHD also utilizes Change Control Boards to control scope and change management processes.	Tableau Dashboard: 6/1/2021 Others in place prior to McKinsey report
Further specify contract provisions regarding key operational processes and timelines	Contract requirements laying out the process and required decision timelines for prior authorization, provider payment, and resolution of grievances and appeals could be clarified and strengthened. In addition, program integrity language can be further elaborated to set expectations and clarify roles between the state and MCOs for eliminating overpayments due to fraud, waste, and abuse. These improvements to the MCO contract could remove ambiguity and improve MCO performance and the state's ability to monitor and manage MCO performance against these requirements	In response to the McKinsey report, MHD has implemented various workgroups to improve the specifications of existing contract requirements for these topics. MHD also introduced an Overpayments Due to Fraud, Waste, and Abuse that is reported to CMS on a regular basis. These initiatives will continue to be ongoing to ensure an open and transparency communication stream between the MCOs and MHD.	Ongoing
Optimize insourcing vs outsourcing	Increasingly, Medicaid leaders across the country are confronted with the need to make informed decisions about what MMIS activities to keep in-house and what to outsource. This decision is particularly critical given that most agencies are making greater use of managed care, implementing value-based purchasing at scale, and/or replacing the business information system platforms they use for eligibility determinations, claims processing, and provider management. All these changes have significant impact on the component's required functionalities. CMS guidance would suggest that a best practice is to keep policy and infrastructure-related decisions in house, allowing for additional oversight and agility. Other activities, such as handling participant interactions may be more efficiently outsourced or delivered through a hybrid model. To make this determination, the state could evaluate factors such as strategic priorities, existing talent, and vendor availability.	MHD has a Project Management Office (PMO) embedded into all MMIS activities. This office strategically makes decisions on how to best utilize existing resources or if outside contractors are more feasible. Decisions can often times be based on available funding, existing workloads, and current priorities.	Ongoing

McKinsey Recommendation	Description	Project Status	Timeline
Projects IN FLIGHT			
Expand Prior Authorization (PA) to additional outpatient procedures	PA policies are likewise used by commercial and other payers. This initiative could add select categories to the current PA list, and it could potentially make changes to the approach used in the existing outpatient PA process. This may require additional system edits and updates to current vendor contracts.	Expand Prior Authorization (PA) and Editing Workgroup is actively reviewing all PA requirements.	7/1/2022
Adjust outpatient base rate methodology	Missouri could consider further anchoring outpatient base rate payments to a percentage of Medicare fee schedule rather than a percentage of charges across all outpatient services. This could allow Missouri to improve alignment between payments and services provided, increase predictability of outpatient expenditures, and be better able to compare rates both within the state and with other states. In addition, the Medicare fee schedule evolves with changes in the science and practice of medicine, thus ensuring the appropriateness of the payment methodology over time.	Outpatient Simplified Fee Schedule FFS went live 7/20/2021. Managed Care is pending litigation.	FFS: 7/20/2021 MC: Pending
Adjust MCO hospital payments	The state could cap MCO hospital payments at a fixed percentage of Medicaid FFS payments. This initiative would require a modification of MCO contracts.	Outpatient Simplified Fee Schedule FFS went live 7/20/2021. Managed Care is pending litigation. Hospital Rate Rebase MHD is developing a workplan with Myers & Stauffer to rebase hospital Rates	OSFS FFS: 7/20/2021 MC: Pending Hospital Rebase 7/1/2022
Adjust inpatient base rate per diem methodology	The state could cap MCO hospital payments at a fixed percentage of Medicaid FFS payments. This initiative would require a modification of MCO contracts.	Rebase the Hospital Inpatient Base Rate and Eliminate the Estimated Days Calculation Project has begun. Myers & Stauffer consulting with an expected completion date of 7/1/2022.	7/1/2022
Reevaluate add-on payments for out-of-state (non-MO) residents	Missouri could reduce or eliminate the reimbursements it makes to hospitals for treating out-of-state patients. Out-of-state payments are concentrated in a limited set of hospitals.	Out of State Payment Reform Being conducted with the Hospital Rebase project.	7/1/2022
Apply UPL caps to individual hospitals	The state could consider applying hospital specific outpatient and inpatient UPL caps. Currently, consistent with federal regulations, the state applies UPL caps to the total of payments made within the applicable service category, but it does not apply individual hospital's UPL caps. As the UPL in Missouri is significantly impacted by the OOS payments, reducing them would affect the UPLs of the recipients of OOS payments.	Out of State Payment Reform UPL caps are being considered with this project.	7/1/2022
Improve physician and behavioral health reimbursement	For physicians, not only has the methodology for establishing rates (e.g., as a percentage of Medicare) not been updated, but once set, the rates do not change. As a result, physician reimbursement is low. It is likely that increasing reimbursement could help reduce provider shortage. Likewise, there is a shortage of behavioral health providers. The state could consider integrating this initiative in an overall VBP program	Improve Physician and Behavioral Health Reimbursement An initial state comparable analysis completed. MHD is awaiting outcomes of other projects and determining the financial impact on the program.	SFY 2024
Transition to value-based payments	In line with the healthcare industry trend led by other states, Medicare, and commercial plans, Missouri could consider moving from its current FFS payment methods to value-based payment (Alternative Payment Models, or APMs).	MHD is transitioning to VBP through a phase-in process. A rebase of nursing facility and hospital rates will establish the path towards VBP. MHD is also looking at maternal health populations.	Phase 1: 7/1/2022 Phase 2: SFY2023 and beyond
Create transparency for outcomes of care	Providing transparency of outcomes for (sub)populations and key conditions/procedures is a prerequisite of any health care system oriented towards value. Juxtaposing these outcomes to the risk adjusted costs of care shines light on the performance of the healthcare delivery system and provides the information providers, payers, participants, and policymakers require to make informed choices and focus improvement efforts.	Managed Care Public Facing Dashboard MHD is in the process of developing a public dashboard for Managed Care based on quality metrics and access to care.	Phase 1: 1/1/2022
Include MCO's in a VBP program to maximize impact and align incentives for providers across the Medicaid population	The majority of Medicaid program participants are enrolled in MCOs. To create the volume for providers to be sufficiently incentivized to participate, both FFS and managed care participants may need to be included, and the APMs across MCOs and Medicaid FFS may need to be adequately aligned. If some MCOs implement bundles and others carve out ACO subpopulations in different ways, providers cannot (and will not be motivated to) make the investments to change their business models. In addition, without alignment between APM definitions, the measurement of outcomes and financial performance will likely not be statistically feasible. Following the example of an increasing number of states, Missouri could consider working with its MCOs to facilitate this alignment and change MCO contracts accordingly.	Managed Care Contract Reprocurement New contracts will include VBP methodology.	7/1/2022 and beyond

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Projects IN FLIGHT			
Explore multi-payer VBP alignment	To further increase the potential impact of value based payment, the state could consider collaborating with non-Medicaid payers in the state to align APMs and set collective goals. To significantly increase impact (see previous initiative), multi-payer models are becoming increasingly widespread: CMS' Comprehensive Primary Care models (CPC and CPC+) are an example. Two options the state could explore are, first, alignment with the other main state government payer, the Missouri Consolidated Health Care Plan MCHCP).104 Second, the state could consider engaging with CMS to facilitate mutual alignment between the existing and forthcoming Medicare APMs and the Missouri VBP strategy.	Managed Care Contract Reprocurement New contracts will include VBP methodology.	7/1/2022 and beyond
Include an acuity adjustment in the nursing home reimbursement methodology	Missouri could consider adding an acuity adjustment to the current per diem methodology. By using an acuity adjustment such as a resource utilization group (RUG)-based grouper, Missouri could categorize patients based on need and reimburse nursing facilities accordingly, using a stratified set of per diem rates.	Nursing Facility Value-Based Rate Setting MHD is consulting with Myers & Stauffer to include an acuity adjustment within the nursing home rates.	7/1/2022
Rationalize rates for similar HCBS services provided through different programs and funding authorities	For services provided through multiple waivers or through a combination of State Plan and one or more waivers (e.g., personal care services), Missouri could consider standardizing rates independent of the funding source for the service. Without standardization, providers may be reimbursed different amounts for care provided to patients with similar needs and acuity levels, which may encourage them to participate selectively in certain programs while not participating in others. This may result in access issues in certain programs and/or geographic areas, eroding patient experience and outcomes.	Rationalize Rates for similar HCBS provided through different programs and funding sources DSS received funding in SFY2022 to rationalize rates for personal care services for programs administered by DHSS and DMH. Funding was also provided for the BH Program and DMH waivers.	Ongoing
Complete and expand upon revisions currently underway to assessment algorithm and process	The state recently announced changes to DHSS' algorithm to assign points using the interRAI HC assessment instrument, which represent the first major changes since 1982. These revisions could improve the accuracy of the level of care assessment process. The state could also consider further streamlining and strengthening the assessment process across populations, programs, and departments (e.g., improving capture of personal care data with review on a per-reviewer and per-physician basis, especially in the consumer-directed program).	Home and Community Based Services Assessment Algorithm This is a multi-phased approach. DHSS is still in the implementation phase of the level of care. Next phase will include this.	Ongoing
Create transparency of the outcomes of care	Providing transparency of outcomes for (sub)populations is a prerequisite of any healthcare system oriented towards value. Juxtaposing these outcomes to the risk-adjusted costs of care shines light on the performance of the healthcare delivery system and provides the information providers, payers, participants, and policymakers require to make informed choices and focused improvement efforts. As the collection point of all Medicaid claims and assessment data, the state could publish such information on the total costs and outcomes of care per county per provider, or per group of providers.	Managed Care Public Facing Dashboard MHD is in the process of developing a public dashboard based on quality metrics and access to care. The public and participants will be able to make an informed choice when selecting a health plan to enroll with.	Phase 1: 1/1/2022
Clarify and strengthen incentive programs and programs intended to encourage adoption of value-based payment	The state could engage in a focused effort to collaborate with and manage MCOs in designing and rolling out member incentives, provider incentives, and LCCCP programs. Depending on the choices the state makes in its approach to value-based payment, it could incentivize or require MCOs to align or integrate their efforts with the state's strategy and include definitions for Alternative Payment Models in MCO contracts and/or performance management.	Managed Care Performance Withhold Program Re-Procurement of the Managed Care Contracts	Performance Withhold Program: 7/1/2019 Reprocurement: 7/1/2022
Deploy additional levers to incentivize MCO performance on key metrics	In addition to the revisions to the withhold program currently underway, the state can consider additional levers such as MCO prioritization in the auto-assignment algorithm based on performance, pooled rewards, bonuses, or public report cards. Expanding the levers in use can enable the state to incentivize performance across a broader set of metrics covering operational performance, quality, and healthcare value (e.g., encounter data submission, member/provider incentive program participation, LCCP or VBP program participation, care management). If the state were to prioritize improving data submission, it would need to ensure that remaining obstacles in the state's encounter data intake process are resolved.	Public Facing Dashboard Managed Care Withhold Program Managed Care Contract Compliance Tool	Dashboard Phase 1: 1/1/2022 Performance Withhold Program: 7/1/2019 Compliance Tool: 12/2022
Optimize financial penalties to better regulate MCO performance on key metrics	The state could revisit the structure and magnitude of the sanctions and liquidated damages set forth in the contract to ensure their efficacy. The state could also more clearly communicate to MCOs which areas of performance will be most closely monitored in a given time period.	Managed Care Performance Withhold Program Re-Procurement of the Managed Care Contracts Managed Care Contract Compliance Tool	Withhold: 7/1/2019 Reprocurement: 7/1/2022 Compliance Tool: 12/2022

McKinsey Recommendation	Description	Project Status	Timeline
Projects IN FLIGHT			
Streamline MCO reporting requirements and improve accuracy and timeliness of information reported by MCOs; establish cadence for performance management dialogues	Accuracy and timeliness of information reported by MCOs could be improved to enable more informed, focused performance management discussions. This could include further streamlining of MCO reporting requirements, shifting from a focus on processes to outcomes based on collaboration between MHD and each of the MCOs. A cadence for performance management dialogues between the state and MCOs could be established along with clear priorities and expectations for the topics to be covered in each discussion.	Managed Care Contract Compliance Tool MHD is currently drafting an RFP to procure software	12/1/2022
Carve in additional services to managed care for the current managed care population	The scope of services covered under managed care for the current managed care population could be broadened to include pharmacy benefits and additional behavioral health services (e.g., those under DMH-administered programs). Including these services could enhance the MCOs' ability to manage the overall health and total cost of care for the managed care population as well as VBP programs, which could help improve quality, outcomes, and participant experience while increasing program efficiency.	BH Carve In/Single Specialty Plan for COA4 RFP is being drafted along with Master Training Plan	7/1/2022
Transition to a single-MCO model with specialized capabilities for the foster care population	The structure of the managed care program for children in foster care or in subsidized, post-adoption, or guardianship programs could be modified to place this population into a single MCO offering specialized capabilities, experience and expertise with this population, potentially procured through a more tailored procurement process. This could avoid the sometimes-fragmented nature of current services for this vulnerable population, ensure the application of focused expertise and experience within one MCO and optimally leverage its infrastructure to meet this population's needs. Relying on the expertise of one MCO may also improve the ability of the state to conform to the regulatory requirements associated with serving this population (e.g. the management of psychotropic).	BH Carve In/Single Specialty Plan for COA4 RFP is being drafted along with Master Training Plan	7/1/2022
Expanding the national correct coding initiatives (NCCI) coding edits that the state has in place	CMS developed the National Correct Coding Initiative to promote national correct coding methodologies and to control improper coding leading to inappropriate payment in claims. There are two broad classifications of NCCI edits: Procedure-to- Procedure edits, which prevent improper payment when incorrect code combinations are reported, and Medically Unlikely edits, which prevent improper payments when services are reported with incorrect units of service. Missouri has implemented some of these edits but has not implemented the full suite of edits. This initiative would require changes to the MMIS system to implement the full suite of codes, among other requirements.	Expand (NCCI) Coding Edits Workgroup has been formed and is actively working on requirements.	1/1/2022
Optimize the state's ability to identify and enroll participants who are currently and may become Medicare eligible.	The state could implement (either internally or through a vendor) new claims-based technology that would allow the state to identify participants who are currently Medicare-eligible or may become eligible. Missouri staff could then help notify participants about this benefit. This would require medium-complexity changes to the MMIS system and potentially a new vendor.	Develop Dual Eligible Strategy/Partner MHD and FSD are discussing options with a community partner to see if a partnership can be formed to pivot Medicare eligible to them so they can assist them through the Medicare enrollment process. This has been identified as a barrier.	1/1/2022
Improve alignment between IS and program	Adopt an integrated perspective across both IS and the program in both strategy development/planning and day-to-day operations. This would include having IS representation at key program meetings to advise on technical implications and feasibility of various program decisions. In this way, IS would be able to inform and advise on implications of program decisions, introduce novel ideas, provide insights in IS-driven needs as well as opportunities ahead of time. Additionally, it would allow IS to keep business informed about in-flight initiatives to take into account during program decision-making. Additionally, the state could conduct joint planning exercises to ensure that IS timelines are in accordance with program-desired outcome delivery dates of both technical and functional requirements. These exercises could also help IS explain the choices that the program may have to make and the implications of those choices. These decisions, which tend to be made by the program, will impact the delineations between modules as well as the sequencing of module implementation. Holding these planning exercises may help tighten the feedback loop for IS to explain the choices that the program may have to make and the implications thereof. Lastly, the state could consider including specific desired functional/program outcomes in procurement documents (e.g., RFPs, vendor contracts) such that vendors are operating against both technical specifications required by IS and functional specifications required to drive targeted, prioritized program outcomes. The additional specificity may help ensure that IS day-to-day tactical actions are more closely aligned.	MHD has partnered with other states to create a Master Agreement which will allow Missouri to streamline the procurement of a new MMIS system. This will be a multi-year project. Currently the implementation of a new data warehouse has taken priority. The data warehouse will enhance the capabilities of a new MMIS so it must be completed first.	Ongoing

McKinsey Recommendation	Description	Project Status	Timeline
	Projects IN FLIGHT		
Evaluate the current modular replacement strategy and define an updated strategy informed by clear strategic direction from the program and reflecting better alignment to the market, other states, and CMS	First, Missouri could reevaluate the structure of modules used in the current replacement plan, realign it closer to the modules recommended by CMS and those utilized in other states further along in their MMIS modernizations, and map to solutions offered in marketplace. Additionally, finalized modules may be aligned to program priorities (e.g., the decision to carve pharmacy in or out of managed care would alter the future Pharmacy module). To create an illustrative example of a potential module alternative, several interviews were conducted with experts both in Medicaid and in the MMIS industry to understand the common module structures and market offerings. In Exhibit 46, a sample alternative module option is displayed, along with Missouri's current module structure as well as the common marketplace modules.	MHD has partnered with other states to create a Master Agreement which will allow Missouri to streamline the procurement of a new MMIS system. This will be a multi-year project. Currently the implementation of a new data warehouse has taken priority. The data warehouse will enhance the capabilities of a new MMIS so it must be completed first.	Ongoing
Strengthen IS capabilities through hiring, partnering for talent, and retraining/upskilling	DSS could consider prioritizing upskilling IS to complement the currently available skill sets with capabilities focused on technology, data, contract management and vendor management and accountability. Training, hiring, or outsourcing individual expertise are all possible routes towards this goal.	MHD has added a new Medicaid Data Manager and introduced a Data Governance Council to ensure clear and concise data elements within our operations. Data Stewards have been incorporated into our Medicaid program to ensure data knowledge is passed on and incorporated into our new data warehouse.	Ongoing
Within the participant enrollment flow, integrate mailer and correspondence process with FSD	The state could implement process change to integrate correspondence of premium notices with FSD eligibility notices to drive improved response rate. This could require a simple process change to implement the inclusion of the first premium notice in the same envelope as the eligibility notice. This may significantly reduce non-responses to premium notices.	Civilla Project MHD and FSD are collaborating with Civilla to redesign enrollment and eligibility notifications to be easier to understand and improve response rates. Although this project does not include a mechanism that combines premium notices with eligibility notices, MHD does anticipate better responses due to the redesign.	10/1/2021
Assess prior authorization (PA) list for high pass rate codes and optimize through quarterly refreshes	State staff could conduct analysis to identify drivers of manual Pas and ensure quarterly list refreshes. This could minimize manual PAs for high pass rate codes.	Expand Prior Authorization (PA) and Editing Workgroup is actively reviewing all PA requirements.	7/1/2022
Implement macros and automation to replace repetitive manual tasks	The state could identify repetitive manual tasks and build simple macros/automation to reduce manual intervention. Batch enrollment corrects or incarcerated participants disenrollment could be executed automatically, for example. Implementation would require both macro development and inbound data manipulation. Creating macros or process automation routines that utilize database queries and pre-set algorithms to perform defined tasks such as participant information updates or error reconciliation could significantly reduce the manual intervention required. Engaging vendors to identify and build use cases for automation could drive efficiency gains: in some quick-win cases, technologies like optical character recognition (OCR) could be implemented within 6 to 12 months, while more complex implementations (e.g., machine learning to improve auto adjudication rates) could take 12 to 24 months.	MHD is collaborating with DOC to automate disenrollment actions for incarcerated participants. An MOU was recently put into place. MHD is not pursuing optical character recognition (OCR) technology at this time. The volume of documents that could be processed through it does not warrant the need. This might be more feasible for FSD.	Ongoing
The state could engage inbound data stream owners to align on data feed formats	Currently, data from various other state agencies is primarily received via email. Convening leaders to align on unified and simple data exchange formats (some best-in-class payers use pipe-delimited files) could allow for easy and automated intake into ITSD systems. This could reduce manual workarounds and potential for error.	MHD is implementing a new data warehouse which will automate many of these state agencies data feeds. This is a multi-phased project.	Ongoing
Evaluate engaging additional vendors	The state could consider engaging a vendor for improved participant address management. Significant correspondence challenges stem from dead or out-of-date addresses. Engaging vendors to conduct address reconciliation and quality improvement is a best-in-class payer practice and can help better engage participants. Ensuring mail is sent to correct participant addresses could also drive cost savings by reducing rework and through postage and printing cost reduction. In addition, the state could consider engaging vendors to maximize value added work performed by the department's participant enrollment team. MHD could consider the potential to outsource enrollment correction processes and assess the current reliance on participant enrollment team to solve routine and complex enrollment issues.	FSD has recently contracted with Lexis Nexis to improve deceased and out-of-state address investigations. Additional conversations are occurring to improve incarcerated participant data. In managed care, MCOs are now able to feed demographic data back to Wipro who will update the latest available address.	Ongoing

McKinsey Recommendation	Description	Project Status	Timeline
Projects IN FLIGHT			
Redesign root-cause drivers (e.g., participant communication & notification) to reduce call volume to contact centers	The state could institute ongoing processes to address root-cause drivers currently leading to increased call volumes. There are several near-term initiatives that could lead to the reduction of call volume. For example, the state could consider redesigning forms and letters to guide to digital channels and highlight additional communication resources available. This communication could provide clear and updated guidelines on when to call the contact center after application submission. In the case of interviews, the state could consider asking the applicants to wait 24 hours to allow for the appropriate processing time before calling.	Civilla Project MHD and FSD are collaborating with Civilla to redesign enrollment and eligibility notifications to be easier to understand and improve response rates.	10/1/2021
Implement stop-loss provision and combine small rate cells	The current rate structure contains several small but high-cost, potentially volatile rate cells (e.g., a rate cell for participants in neonatal intensive care units). The state could consider implementing a stop loss provision and combining smaller, more volatile rate cells with larger, more stable ones. This could increase the predictability of state outlays for managed care capitation payments and simplify administration of the rate structure.	We have initiated analysis of NICU payments as part of a broad look at payment policies that may be transitioned to a value basis in order to improve maternal and infant health.	Ongoing
Modify Direct Medicaid payments methodology	The Direct Medicaid payments (one component of the add-on payments) attempt to bridge the gap between base rate payments and the hospitals' costs to serve the Medicaid population. The state could consider limiting the reliance on cost reports so that reduced utilization or reductions in payments due to other initiatives are not compensated by increased Direct Medicaid payments.	We are finalizing the FMP methodology on the Managed Care side and are taking initial steps to reduce the size of the gap between base rate payments and hospitals' costs.	Phase 1: 7/1/2022 Phase 2: SFY2023-24
Re-examine payment levels for financially vulnerable rural and safety net providers	To the extent that other initiatives are undertaken that could reduce revenue to hospitals generally, the state could consider re-examining the effects of the initiatives on financially vulnerable rural and safety net providers in particular to determine whether adjustments in payment levels, value-based payment structures, or other changes are necessary to mitigate the potential for erosion of access to care.	We are developing a value-based model that targets rural and safety net hospitals, but it is still in the design phase.	Ongoing
Build digital participant engagement platform	Transitioning traditional communication channels to a digital medium for high-impact communications such as premium notices (e.g., e-pay functions), ID cards, or explanation of benefits (EOB) delivery could drive improved participant engagement. The state could consider investing to get ahead of developing participant digital preference trends and drive adoption for new enrollees over a five-year horizon. Some of these participant engagement practices could help promote self-service and reduce call volumes for the contact center and save on costs incurred due to existing communication using traditional channels, such as printed ID cards and EOBs. Given the proliferation of different modes of communication, it could also be helpful to note/flag the preferred method of communication during the enrollment process.	MHD has awarding a new contract for Beneficiary Support and Premium Collections that includes electronic messaging for invoice and enrollment. This contract also includes options for a mobile app and web portal.	Ongoing
Clarify and strengthen care management requirements	The state could enhance care management requirements by adding specificity around risk stratification and participant identification, the proportion of participants to receive care management, case load standards for care managers, and/or care management activity requirements for MCOs. The state could consider further clarifying expectations for MCOs to collaborate and/or formally delegate care management requirements to health homes or other care management entities. This could ensure clarity of roles and prevent against payment by the state for duplicative care management efforts by multiple parties (e.g., MCOs and health homes).	MHD is in the process of reprocuring managed care contracts. There are many elements that are incorporated into the new RFP that touch on this recommendation.	1-Jul-22

McKinsey Recommendation	Description	Project Status	Timeline
Projects NOT CURRENTLY BEING PURSUED			
Improve medical record matching to reduce incorrect denials in participant enrollment	Matching medical records to appropriate claims to minimize inaccurate denials could drive significant improvement in enrollment accuracy and reduce downstream rework.	MHD already does medical record reviews during annual clinical reviews. In managed care, an External Quality Review Organization conducts medical record reviews to assess quality of care. MHD does not have adequate staffing to implement this on a grander scale.	NA
Define future operating model for state contact centers to balance in-house vs outsourcing options	As part of future review of the state's contact center operation, the state could consider three options for future operating model for contact centers: • Focus on operations excellence and operate contact centers internally with only strategic outsourced vendor partners as required • Focus on contract excellence and move to a primarily outsourced model with retention or strategic contact center operations in-house	MHD does not have adequate staffing to implement this.	NA
Provide self-service options for Tier 1 calls to reduce live calls and wait times	The state could consider investing in new self-service channels for the resolution of simple issues like status of cases or food stamp eligibility through alternative channels to reduce call volume by 15% to 20% in Tier 1. This could ease the load and reduce the current peak wait time for 60 minutes significantly. The state could consider potential quick wins like website-based self-service options and SMS-based notifications and bots to provide quick answers to simple requirement questions. Likewise, Chabot's in the website could potentially answer queries on case status and document uploads	This is an FSD function	NA
Expand the analytical funnel to identify additional improper payments that can be prevented using claims edits and pre-pay changes or can result in recoveries	As an example, for given procedure codes, Missouri has set billing limits that the state only reimburses hospital observation stays for up to 24 hours. The state could ensure that the claims system is preventing payment for procedures after the allotted 24-hour period. Opportunities that take the form of edits would require feasible changes to the MMIS system.	Initiative would require significant changes to the MMIS which MHD cannot pursue at this time due to other priorities.	NA
Create an experimental, investigation, and unproven (EIU) medical procedure policy to prevent improper payments	This agency policy would identify devices or procedures that have not been proven to be medically effective. This initiative would require the state's clinical staff to identify these procedures and review the procedure on annual basis. Additionally, the initiative would require feasible changes to the MMIS system.	Initiative would require significant changes to the MMIS and clinical staff resources are limited.	NA
Consider case rate methodology for inpatient and/or outpatient services	Missouri could move away from per diems and payments for individual outpatient services toward a case rate-based reimbursement model. Such models employ a grouping mechanism that varies for inpatient and outpatient services and are in use in many other states outpatient, widely used grouper options are Enhanced Ambulatory Patient Groups (EAPG) and Ambulatory Payment Classification (APC). For inpatient, the standard is Diagnosis- Related Groups (DRG). Like the stratified per diem method above, pricing could be based on regional average costs or historical pricing with forward-looking trend factors set by the Medicaid program. Although payments are no longer determined at the individual service level, this payment methodology would still be volume-focused and hence would still limit cost containment incentives. The implementation complexity will likely be significant: in particular, the change from single inpatient per diem payments will require a thorough rebasing effort so that the transition is within the planned inpatient expenditures, remains predictable, includes the needed add-ons, and does not create financial disruptions for individual providers. In addition, the current MMIS is not currently equipped to handle case rate-based reimbursement models. Workarounds through additional DRG grouping applications exist, but these would have to handle all payments to hospitals.	MHD's current MMIS system does not allow for this type of billing mechanism. MHD's Transformation Office has several payment methodologies projects in flight and continues to explore other possibilities for DRG payments and/or value-based arrangements.	NA
Join a purchasing consortium to increase supplemental rebate capture	There are three supplemental rebate consortiums that state Medicaid programs utilize today: the National Medicaid Pooling Initiative (NMPI), the Optimal PDL Solution (TOPS) and the Sovereign States Drug Consortium (SSDC). Missouri would need to consider how these consortia fit with their current approach and PDL vendor. Additionally, the state would need to submit a State Plan Amendment to CMS.	MHD's large enrollment numbers allows for better rebates and control over our PDL program over joining a purchasing consortium.	NA
Consider whether to contract with a specialty pharmacy	The state could establish a preferred specialty pharmacy which may provide lower prices for certain specialty drugs, and potentially better care management and improved clinical outcomes for participants. Before doing this, the state would need to determine whether such an approach would be consistent with any willing provider regulations. Additionally, the state would likely have to go through the required procurement process.	MHD determined such an approach would not be consistent with any willing provider regulations and would reduce participant access.	NA

McKinsey Recommendation	Description	Project Status	Timeline
Projects NOT CURRENTLY BEING PURSUED			
Apply for a value-based contracting waiver from CMS	The state could apply for a value based contracting waiver from CMS, which would allow the state to negotiate drug prices with manufacturers based on clinical outcomes. CMS approval of a State Plan Amendment would be required, as would negotiation with manufacturers to determine the optimal drug(s), outcome(s), and pricing.		NA
Incorporate additional efficiency measures into the managed care rate-setting process	Three efficiency adjustments have been put into place in the current managed care rate-setting methodology: 1) removing claims for potentially preventable inpatient admissions, 2) removing emergency department claims that could have been avoided, and 3) conducting an overall adjustment for risk-adjusted efficiency. These efficiency adjustments can be continued. In addition, there are several other efficiency adjustments available that have not yet been employed, covering spending areas such as short-stay admissions, readmissions and maternity care (e.g., inpatient stays that could have been avoided with better outpatient care). These additional adjustments would need to be examined for potential overlap with the adjustments current in place (e.g., risk-adjusted efficiency, a more broad-based adjustment, may already capture some of the value that could be captured through new adjustments), but they have the potential to create additional cost savings for the program.	MHD is currently focused on rate-setting initiatives related to VBP, Behavioral Health Carve-In, Nursing Facility Rebase, and expansion initiatives.	NA
Improving upstream systems to help reduce manual rework	Erroneous information feeds drive significant rework within MHD processes. Engaging FSD leadership to drive changes in these upstream systems (especially MEDES) could significantly reduce rework within participant enrollment function. Improved data formats (e.g., pipe-delimited flat files rather than email-based information) could provide basis for rapid system updates, eliminating manual processes.		
Revise policy guidance on MAGI helpdesk to avoid rework	The state could review internal policies that currently prohibit outsourced MAGI helpdesk agents from completing case updates in situations when a change of coverage occurs (currently, these changes must be completed by an internal agent). Also, the state could consider updating policies to enable MHD staff members to transfer to Wipro, when applicable, to reduce downstream rework in internal case processing team		
Improve accumulator accuracy to help manage spend down errors	Spend down inaccuracy drives significant billing errors and inbound inquiries. The state could consider setting up a team to minimize spend down on out of sync scenarios, which could help minimize errors.		
Apply for the Serious Mental Illness/Severe Emotional Disturbance (SMI/SED) demonstration through a Section 1115 Waiver	The SMI/SED demonstration allows states to use federal funds to pay for treatment services in residential settings that qualify as IMDs for individuals with SMI/SED. To access the funds, Missouri would need to design a program emphasizing quality and value that meets budget neutrality requirements for a Section 1115 Waiver. Missouri would be expected to achieve a statewide average length of stay of 30 days for participants receiving care in IMDs. Additional analysis would be required to understand the net budgetary impact of funding for SMI/SED services provided in IMDs.		
Pursue a State Plan Amendment to access federal funds for SUD services provided in IMDs	Missouri may be able to leverage the Amendment to the IMD Exclusion to use federal funds to pay for treatment services in residential settings that qualify as IMDs. To access the funds, Missouri would need to design a program emphasizing quality and value. Missouri could consider working with CMS to develop a State Plan Amendment (SPA) initiating the program; this SPA could potentially be effective as early as October 1, 2019. As the services currently are not provided, this initiative would be an investment which the state could consider as part of a value-based program, for example, to reduce total cost of SUD care.		

McKinsey Recommendation	Description	Project Status	Timeline
Projects NOT CURRENTLY BEING PURSUED			
Access enhanced match by strengthening SUD focus in health homes	While Missouri has exhausted the eight quarters of enhanced match for the health home program, the SUPPORT Act allows for the creation of a new SUD-focused SPA that would cover 10 quarters of enhanced match for individuals with SUD not previously covered under a health home. There are three groups of individuals whom the state could potentially consider as part of a new SUD-focused SPA: (a) participants with SUD who meet the existing health home criteria but were never successfully engaged (e.g., no payment occurred for those participants); (b) participants with SUD who are newly eligible and meet the existing health home criteria; and (c) participants who are not eligible under the current criteria but would be eligible if the state created additional eligibility pathways for the SUD population (e.g., making receipt of MAT a qualifying factor, creating an eligibility pathway for pregnant women with OUD). The state would need to meet reporting requirements outlined in the SUPPORT Act (e.g., quality of care reporting, reporting of costs of individuals in health homes).		
Expand the scope of the managed care program to include the ABD population (in whole, in part, or on a phase-in basis)	Expanding managed care to portions of the ABD population represents one potential approach to achieving the improvements to efficiency, quality of care, and outcomes discussed in the preceding sections, among alternatives such as improved state-led care management programs or meaningful adoption of alternative payment models. Expanding managed care to this population would likely require statutory change and could take many forms given the heterogeneity of the ABD population and the services required by its various subpopulations. In general, MCO capabilities in serving the ABD population – and state experience in operating managed care programs for this population – vary widely by sub segment of the population and associated services. Managed care programs covering the core medical, behavioral, LTSS, and pharmacy benefits of non-dual eligible ABD participants are becoming increasingly common, as are managed care programs focused on covering the LTSS services for dual-eligible beneficiaries. Meanwhile, managed care programs for persons with intellectual and/or developmental disabilities (whether residing in an institutional setting or on an HCBS waiver) remain relatively rare. Any potential consideration of managed care for the ABD population may take into consideration the diverse and nuanced characteristics and needs of the various sub segments of this population. Finally, through enrolling elderly and/or dually eligible participants with disabilities in Medicaid managed care plans, the state could take advantage of the increased opportunities recently provided by CMS to improve integrated care for dually eligible populations through, for example, Dual Eligible Special Needs Plans (D-SNPs) or Medicare Advantage Medicare-Medicaid Plans (MMPs).		
Improve the consistency of the approval process for personal care services	The state could better capture personal care (PCA) PA data digitally and review it on a per reviewer and physician level to ensure consistency in implementing assessment tools and appeals processes. This would be especially important in the consumer-directed program, as different PA approvers may be inconsistent in the type and degree of services they authorize for different individuals with similar care needs.		

McKinsey Recommendation	Description	Project Status	Timeline
	Projects NOT CURRENTLY BEING PURSUED		
Invest in improvement of auto adjudication rates	The state could conduct detailed analysis to assess current drivers of manual adjudication – such as edits, medical policies, system issues – and inbound data issues, in addition to implementing improvements in the claims systems to improve auto-adjudication rates. For example, the state could consider identifying top edits that trigger manual adjudication and determining modifications to edits that could drive claims to be auto-adjudicated. For example, if an edit requires an assessment of a particular attachment or medical record and it is found that such claims are paid with a high pass rate, removing that requirement could eliminate need for manual intervention.		
Update the DME fee schedule	Missouri could update its DME rates to match those of other state Medicaid agencies and MCOs, which could potentially be supported by competitive procurements in specific categories. Operationally, this would require a change in the fee schedule, potential procurements, and efforts to ensure access.		
More directly employ assessment results in care planning process	In addition to improving the assessment process as is currently planned, Missouri could consider incorporating additional functionality into the assessment instrument. First, it could be used to determine eligibility for services. Second, it could more closely tie results of assessment to the care planning process. For example, DHSS has previously considered using a case rate-based system, using a RUG-based grouper mechanism layered on top of the current interRAI HC assessment. This could include more consistently using assessment results as a standardized basis for setting of care determinations and the types and intensity of services to be provided. Third, the assessment instrument could be used to determine payment levels for care. Fourth, the assessment results could serve as an auditing mechanism: care planners and/or providers could be flagged if they are providing a level of care that is inconsistent with the results of the assessment.		
Missouri could consider introducing Alternative Payment Models (APMs) for LTSS services	The main value opportunity for LTSS services is moving care from a nursing home or residential services to care in the participant's home where possible. The costs of this care are generally less than half the cost of intuitional care and living at home tends to be highly preferable. Improving care planning and management for this population can also be a significant source of value. An Accountable Care Organization model, specifically designed for LTSS, may be one option to incentivize providers to create this value. Yet for those providers most likely to do so – home care providers – taking on the financial responsibility for nursing home costs is a large risk and is likely not feasible for many smaller providers. Alternatively, such providers could be incentivized by tying a part of their reimbursement to the key outcomes that matter to participants, such as the extent to which they can be successful in delaying or avoiding nursing home admissions, improving selfdetermination, encouraging independence at home, etc.		
Implement an Impatient Hospital Readmissions Policy	Inpatient hospital readmission policies are used by commercial payers, MCOs, other state Medicaid programs, and CMS to not only ensure appropriate utilization of services but also to improve quality. This policy could be modeled after policies that MCOs have today and further refined by the state. This could help ensure safe and appropriate discharge of participants and would also provide important feedback to hospitals. Operationally, this initiative would require modest policy and MMIS changes.		