THE MISSOURI SENATE INTERIM COMMITTEE ON MEDICAID TRANSFORMATION AND REFORM

REPORT

December 15, 2013

Prepared by
Senate Staff

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The Honorable Tom Dempsey, President Pro Tempore
State Capitol, Room 326, Jefferson City, Missouri 65101

Dear Mr. President:

The Senate Interim Committee on Medicaid Transformation and Reform, acting pursuant to Senate Rule 31 of the Missouri Senate, has met, taken testimony, deliberated, and concluded its study on the various issues facing Medicaid in Missouri as it relates to reforming Medicaid by improving system efficiency, financial stability and delivery of care. The committee now presents to the General Assembly a report of information and proposed recommendations of actions to address this issue.

Senator Gary Romine, Chair

Senator David Sater, Vice-Chair

Senator Dan Brown

Senator Doug Libla

Senator Rob Schaaf

Senator Wayne Wallingford

Senator Jay Wasson

Senator Joseph Keaveny

Senator Paul LeVota

Senator Jamilah Nasheed

I. OVERVIEW

At the end of the First Regular Session of the 97th General Assembly, President Pro Tempore Tom Dempsey tasked senators with studying the Medicaid Program in the State of Missouri, issue a report and make recommendations to the General Assembly for legislative action no later than December 15, 2013. To that end, Senator Gary Romine, chair of the committee, asked committee members to develop an innovative health care paradigm that provides high quality, cost effective care to Missourians while keeping those services affordable and accountable to the taxpayers who fund such services.

The membership of the committee consisted of the following Senate members: Senator Gary Romine, Senator David Sater, Senator Dan Brown, Senator Doug Libla, Senator Rob Schaaf, Senator Wayne Wallingford, Senator Jay Wasson, Senator Joseph Keaveny, Senator Paul LeVota, and Senator Jamilah Nasheed.

The committee held public hearings and solicited testimony regarding a wide range of issues related to Medicaid in Missouri with an eye toward setting goals and recommendations for the coming legislative session. Hearings were held on the following:

July 8-9, 2013
August 14, 2013
September 11, 2013
October 2, 2013
November 13, 2013

Oral and written testimony was provided on such topics as:

I. Update from the Departments of Social Services, Mental Health and Health and Senior Services on the progress of previous recommendations from the Medicaid Reform Commission in 2005
II. Public Testimony and Access to care
III. Supply-Side of Health Care- exploration of potential reforms and alternative approaches for the financing, payment and delivery of health care
IV. Open discussion from invited presenters
V. Demand-Side of Health Care: Altering Consumer Utilization

II. MEDICAID IN MISSOURI

History of Medicaid

Medicaid was created by Congress, through Title XIX of the Social Security Act in 1965, as a program to provide medical assistance for individuals and families with low incomes and limited resources. Unlike Medicare, the federal and state government jointly funds Medicaid. Missouri began offering health coverage to low-income individuals in 1959 through a limited medical assistance program that covered a portion of inpatient hospital care. This program was expanded in 1963 to include limited coverage for prescription drugs and dental care. Missouri's Medicaid program under Title XIX of the Social Security Act began in 1967, and coverage initially included physician's services, outpatient hospital care, and nursing home care. Eligibility was expanded to include the permanently and totally disabled and blind populations as well as expanding services to families receiving Aid to Families with Dependent Children. In 2007, Missouri's Medicaid program was named "MO HealthNet."(1)

Medicaid Today

Today, the Medicaid program includes a general match rate of 60% of federal funds to 40% state funds. In fiscal year 1968, Medicaid expenditures totaled $26 million dollars ($8 million state general revenue). In contrast, in fiscal year 2012, Medicaid expenditures exceeded $8.2 billion dollars ($1.7 billion state general revenue). (2)

As of May 2013, there are 873,466 Medicaid participants, with the majority of the Medicaid population consisting of 532,100 children. The majority of spending goes toward the elderly and disabled population, consisting of 236,837 participants.

Eligibility is determined based on annual income rates of participants as a percentage of the federal poverty level (FPL). For example, a family of four at 18% FPL has an annual income of $4,239; 100% FPL is $23,550; 138% FPL is $30, 657; 300% FPL is $70,650.

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1 MO HealthNet Division History, Missouri Department of Social Services, http://www.dss.mo.gov/mhd/general/pages/history.htm , viewed on November 25, 2013.

2 "Medicaid 101", Senate Staff, presented to Interim Committee on Medicaid Transformation and Reform, July 8, 2013, Also in Appendix B

Below is a sample of MO HealthNet coverage compared to federally-mandated eligibility levels for some populations:

Pregnant women- Missouri 185% FPL/Federal 133%
School-Age Children- Missouri 300% (premiums required at 150%)/Federal 100%

Seniors/Disabled- Missouri 85%/ Federal 74%
Custodial Parents- Missouri 19%/ Federal 19% (3)

The Affordable Care Act (ACA) was signed into law in March 2010. It allows for an increase of eligibility for individuals under the age of 65 with incomes up to 138% of the federal poverty level. Such increase in eligibility would be federally funded for the first three fiscal years of 2014 o 2016. After that, then the state share would go up in phases up to 10% in 2020.

3 "Medicaid 101", Senate Staff, presented to Interim Committee on Medicaid Transformation and Reform, July 8, 2013, Also in Appendix B

III. SYNTHESIS OF INFORMATION AND TESTIMONY RECEIVED

In the course of the examination and public hearings on the issue of transformation and reform of Missouri's Medicaid program, the committee gathered information from witnesses and reports to assist the committee in making recommendations.

A. Medicaid 101 and Updates from the Departments on Medicaid Reform Commission 2005 Recommendations, July 8, 2013

The committee was presented with the basics of Medicaid in Missouri which included such topics as:

(1) Services and service delivery systems; (2) Provider reimbursement levels; (3) Financing and budget; (4) Hospital reimbursement; (5) Provider taxes; and (6) ACA and Federal Health Reform and Transformation considerations.

(To see the information in detail please see Appendix B)

The committee then received oral and written testimony from the Departments of Social Services, Mental Health and Health and Senior Services providing an in-depth update on the implementation progress of the recommendations from the 2005 Medicaid Reform Commission. The committee was pleased to learn that of the 80 recommendations from the Commission, progress has been made in more than half, 51, of such recommendations. There was "attempted and some progress" made in 18 of the recommendations and "little or no progress" made in just three of the recommendations. (Although the department reported no progress in establishing a new Disabled Employee's Health Assistance Program, in fact the recommendation was achieved when the general assembly passed the Ticket to Work Health Assurance Program in 2007. The program was extended this year to 2019).

The departments noted that there were six main themes in the 2005 recommendations. Below are some of the examples of progress achieved:

(1) *Modernizing technologies*- progress with electronic health records, telemedicine and CyberAccess;
(2) *Broadening and deepening care coordination strategies*- More than 35,000 medically needy

participants receive comprehensive care management through health homes and the DM 3700 initiative, managed care was expanded;
(3) *Improving program operations*- Managed care contracts have been aggressively managed, use of evidence-based prior authorization enhancement;
(4) *Ensuring program integrity*- The newly organized Missouri Medicaid Audit and Compliance (MMAC) formed to consolidate and coordinate integrity efforts across departments;
(5) *Promoting consumer information and responsibility*-Health home programs for chronically ill, smoking cessation and drug therapies implemented; and
(6) *Expanding provider networks and services*- Community mental health centers and federally qualified health centers were merged in two communities to promote behavioral health/primary care integration, various demonstration projects and partnerships formed in the St. Louis, Kansas City and Columbia areas. (Please see Appendix C for more detailed information)

B. Public Testimony and Access to Care, July 9, 2013

The committee invited the public to speak and heard from 25 people ranging from Medicaid participants, providers such as physicians and mental health counselors, consumer advocates, and representatives from religious organizations and legal services on the issue of "Access to Care for all Missourians." (See Appendix A for a list of witnesses.)

Core themes from Public Testimony

A majority of the witnesses urged the committee to consider Medicaid expansion under the Affordable Care Act, arguing that expansion would provide health coverage for numerous persons with mental illness and substance abuse problems rather than crowding prisons, jails and emergency rooms. Erin Brower from the Partnership for Children argued that expansion would bring about coverage to the approximately 100,000 children who are currently eligible for Medicaid but who are not enrolled. She noted that if parents have coverage then the children will be enrolled as well.

Todd Richardson from the Missouri Association for Community Action commented that if the state increased access to preventive care for all Missourians, the end result would be lower costs across all sectors. Richardson stated that "expanding insurance coverage to more adults would decrease the amount of cost that hospitals must absorb in uncompensated care."

A number of witnesses urged the committee to not only extend Medicaid coverage for those covered under the ACA, such as working adults, but to consider first expanding eligibility for seniors and persons with disabilities. The Missouri Developmental Disabilities Council noted how the asset limits in Missouri Medicaid are one of the lowest in the nation. Joannie Gillam, of the Disabled Citizen Alliance for Independence pointed out how Missouri's asset limits are so low, that many of the Medicaid recipients who are disabled are just one home or car emergency repair from complete impoverishment due to the small amount of money such recipients are allowed to have in their bank accounts in order to maintain eligibility.

Lee Parks a physician with Crider Center, stated that savings could be gained in the long run in the Medicaid program by offering dental, physical therapy and increased mental health and screening services. These areas would curb costs in the emergency room in the areas of diabetes, heart disease, and back pain/narcotics abuse. Dr. Parks also argued for higher provider reimbursement. Another witness argued for Chiropractic physician services to be added into the Medicaid health care plan.

Anita Parran of AARP Missouri stated that Medicaid expansion is important for those persons who are over age 50 but not yet eligible for Medicare as this particular demographic has been hit the hardest during the economic downturn by having to compete with younger people for jobs. She testified that the "majority of Missouri residents age 45+ believe in the importance of Medicaid and support expansion in their state."

Joel Ferber from Legal Services of Eastern Missouri presented testimony before the committee on issues regarding the need for Medicaid expansion as well as giving examples and offering advice on reform possibilities for Medicaid in Missouri. Mr. Ferber offered many arguments for Medicaid expansion under the ACA, noting that "part of reforming health care is providing health coverage to people before they get sick, and helping them get the preventative care that they need to stay healthy." As to reform, he argued for improved care coordination such as the current MO HealthNet Primary Care Health Home Program, reducing churning through continuous Medicaid eligibility such as the longstanding state option to continuously enroll children in Medicaid for 12 months, coordinated fee-for service programs rather than state wide managed care for all populations. If Missouri were to extend managed care statewide, he proposed maintaining certain carve outs for pharmacy, transplant, community psychiatric rehabilitation and comprehensive drug and alcohol treatment services. He urged caution as to incentives for health behavior and asked for the

state to further consider addressing provider participation by increasing reimbursement rates for providers. In the end, he noted that any reforms must meet existing legal requirements even within the parameters of a waiver from the federal government.

C. Supply-Side of Health Care- August 14, 2013

Presentations were given on the issues of exploration of potential reforms and alternative approaches for the financing, payment and delivery of health care.

Core themes from provider testimony

A common theme that emerged centered on changing the incentives for providers from a Fee-for Service model to another payment model such as a capitation or risk capitation model. Team or integrated care, population health management, medical management, and medical homes were all topics that were mentioned. Many of the witnesses provided information regarding how many of these delivery models are already in place or being put in place. There was also a common theme about the usefulness of health information technology and telehealth when incorporating the new delivery models. There was also testimony regarding the need to manage the super utilizers as well as those who abuse the process by inappropriate use of the emergency room.

Tom Hale testified at the hearing that Mercy Health is moving toward a new model of care delivery that focuses on population management, coordinated care and a wellness/prevention model. This model is premised on the belief that care should be served in the local community as the very concept of a "health care home" should be where the patient resides and has social and family support. Mercy is therefore looking for tools that will serve the participant in the community. Such tools include telehealth and recognizing the unique needs of the Medicaid population to be served. Such considerations that are necessary include: identification, access to care, coordination of care and cultural disparity. Dr. Hale suggested that the committee look into changing the payment methodology for primary care and structuring payments around population management; establish a regulatory environment that will support the primary care shortage by including other providers and simplifying the licensing process for telehealth physicians.

Cerner, a health care information technology corporation, recommended a "move toward a system of care focused on the health status of a population, with an aligned payment model." The state should support quality improvement efforts similar to the shared savings program in Medicare, medical homes and accountable care organizations (ACOs). These models can incorporate personal health records to manage chronic conditions, measure compliance and wellness achievements and offer a means to allow recipients to communicate with providers and complete e-visits. The Medicaid program could pursue financial and quality transparency regarding providers and services so that consumers can make the best choices regarding health care.

Christian Jensrud of Wellpoint, a health benefit and managed care company, talked about the need for getting a handle on the dual eligible population by encouraging collaboration between coordinated long-term care programs and Medicaid managed care organizations. He argued that such collaborations can result in both health improvement and significant savings. Wellpoint has seen improvements in quality care by implementing provider quality incentive programs, holistic disease management practices and telehealth for specialty care in rural and underserved areas.

Dr. Charles Willey of Innovare Health Advocates argued against Medicaid expansion, stating that doing so would "perpetuate a vicious cycle of more government funding, bringing more destructive regulation, necessitating greater bureaucracy, causing higher costs that directly decreases access which worsens health . . ." He stated that since 1992, his business model has been prepaid for population health management, one person at a time. He has observed that good patient health lowers health care costs, which in turn opens access to quality care, which in turn increases patient health, thereby creating a cycle of health. His recommendations for reform include: provider and beneficiary accountability as well as an accountable benefit design.

Dr. Jeffery Kerr testified about the problems he has seen as a Medicaid provider for the past 27 years. He noted the need for dental health coverage as the emergency room is filled with patients with dental pain and abscesses. He has observed unnecessary laboratory re-testing and believes it could be managed better through technology. He recommended that more providers would participate in the much needed chronic care management if such providers were better reimbursed to do so.

Dr. Katie Lichtenburg from the Missouri Academy of Family Physicians talked about the need for coordinated care and specifically mentioned patient-centered medical

homes. She suggested identifying the top spenders in the Medicaid program and assigning them a personal care coordinator to work directly with a physician and create a "Hot Spotter" list. She also commented on the problem with access to see the family physicians, particularly for those who have to schedule five days in advance for Medicaid transportation. It is in situations such as these that the patient then goes to the emergency room for "after-hours" or more immediate care.

Dr Robert Atkins from Aetna, a managed health care company, recommended that Missouri implement fully integrated managed care for all populations; partner with providers to create integrated systems of care, and focus the use of resources where they are most likely to make a difference. There was also testimony from the Community Mental Health Centers regarding the Health Homes and Primary Care Health Home initiatives underway in Missouri and how such programs provide a health home for individuals with serious mental illness and another chronic condition.

D. Open Discussion from Invited Presenters- September 11, 2013

Invited presenters discussed such topics as over-utilization and under-utilization, cost sharing provisions, premium assistance as a Medicaid expansion option and medical homes or coordinated care, wellness incentives, Section 1115 Medicaid Waivers and the need for Medicaid expansion.

Dennis Smith from McKenna, Long and Aldridge argued that the problem with Medicaid is not the cost of health care but rather, it is excess cost driven by both over-utilization and under-utilization in the wrong areas. He states that efficiencies could be found in five main functions of Medicaid: eligibility, benefits, payment, service delivery and administration. He offered advice on how to manage the dual eligible population, noting that to be successful, "dual demonstrations must save money for the state, save money for the federal government (in Medicare as well as in Medicaid), be better for the individual, and must be a viable business model to attract sufficient community partners."

Sydney Watson, a Saint Louis University Law School professor offered advice in the areas of Medicaid expansion, premium assistance programs being advanced in other states and wellness incentives. She presented testimony regarding the health benefits of extending health coverage to a previously uninsured population. She described the differences between implementing a premium assistance program for the expansion population through either a state option or through a Medicaid waiver. Finally,

Professor Watson explained some of the growing body of literature suggesting that "financial incentives can be effective at achieving behavior change that requires a single activity like getting a flu vaccination or checkup" rather than for ongoing behaviors such as smoking cessation. She noted that there isn't evidence to show rewards or penalties lead to meaningful changes in health behaviors and outcomes.

Christie Herrera from the Foundation for Government Accountability made the case for patient-centered Medicaid reform. She noted how "Old Medicaid" focused on the government as consumer with complex programs, government controls, centralized planning/purchasing, and a blank check which led to unsustainable growth. Whereas, the "New Medicaid" focused on patients as consumers, consistent policies, more consumer choice, marketplace decision-making and defined investments which in turn leads to predictable growth. She then explained the reform efforts in Florida, Louisiana, Kansas and North Carolina. These efforts have been successful because all benefits and populations were carved into the reform efforts, there was smarter plan structure and funding, there were different plans to offer more competition, there were customized benefits, specialty plans and health incentives and participants were provided with independent choice counseling.

E. Demand-Side of Health Care- Altering Consumer Utilization, October 2, 2013

Invited presenters discussed such topics as the efficacy of preventive medicine, disease management, and electronic medical records. Such witnesses generally recommended medical homes, performance metrics and commercial rates.

Ed Weisbart from the Consumers Council of Missouri argued that the commonly praised strategies of preventive care, electronic records and pay for provider performance do not reduce cost. Instead, Mr. Weisbart recommends the state create financial incentives for providers to work in underserved areas by reimbursing physicians at 120 percent of Medicare rates.

The St. Louis business Coalition supported expansion. The coalition argued that there is a huge opportunity to align across state sectors and to align the message across payers. There can be quality improvement such as the case with infection control in hospitals.

Lauren Tanner, from Ranken Jordan Pediatric Specialty Hospital, recommended

implementation of an efficient care coordinated model. Craig Henning, Executive Director of the Disability Resource Association, noted the problems with geographic access to care. He urged the state to consider health care homes and pilot projects for managed care but he has found mixed effectiveness with Accountable Care Organizations.

Timothy McBride from the MO HealthNet Oversight Committee and a health economist with Washington University, discussed insurance benefit designs, improving population health and transformation. He believes that to improve the system, it is necessary to have health homes and programs like Money Follows the Person as well as improvements to health information technology.

Jeanette Mott Oxford, with the Missouri Association for Social Welfare, brought in 1,700 witness forms all urging Medicaid Expansion. She argued that expansion will keep hospitals open. She also noted that when looking at the population in Medicaid and designing incentives or penalties for participants, it is important to note that it is not just a culture of missing appointments but it is about the population living in the "chaos of poverty" that creates misuse of services.

Sergeant Mike Krohn from the Boone County Sheriff's Department explained to the committee how the sheriffs and law enforcement officers are used as mental health professionals. They are forced to triage emergency situations. He stated that 25 to 30% of inmates in the Boone County jail are receiving mental health services. When asked how this problem could be fixed, he stated that they simply needed more money for mental health beds and for training.

The committee also heard from senate staff regarding a cost avoidance analysis of having Medicaid managed care statewide versus a fee-for service model, payment reductions to hospitals across the state as a result of federal sequestration and Medicare cuts, and the new federal rules regarding permissible requirements with respect to cost sharing from Medicaid participants. States will also be allowed to charge $8 copays for non-emergency use of the emergency department for those with incomes equal to or less than 150% of the federal poverty level. These participants are currently exempt from such cost sharing. For participants with incomes higher that 150%, there is no limit on the maximum cost sharing for non-emergency use of the emergency department.

IV. RECOMMENDATIONS

After review of all information received during the hearings regarding areas of improvement for the current Medicaid program, the committee believes that before the state can consider expanding eligibility and increasing the number of participants to the program, transformation of the entire Medicaid program must occur. As noted recently by the Kaiser Commission on Medicaid and the Uninsured, "[n]early all states are developing and implementing payment and delivery system reforms designed to improve quality, manage costs and better balance the delivery of long-term services and supports across institutional and community-based settings."(4)

Using the goals of attaining quality, managing costs and improving delivery of care for all participants including the super utilizers, the committee puts forth the following recommendations:

1. **The current MO HealthNet Managed Care program should be extended statewide for all populations currently in managed care, which would primarily include low-income custodial parents, pregnant women, and children. Every Medicaid participant in managed care shall designate a primary care provider.**

   Specifically, any coordinated care contract for Missouri should include the following measures:

   A.----Maximizing and implementing allowable cost-sharing, premiums and deductibles for non-preventive services.
   B.---Adopting Incentives for Participants to seek preventive services, encourage healthy behavior and to participate in his or her health care.
   C.---Encouraging health savings accounts that can be used for deductibles and copays

The committee believes it necessary to have as many Medicaid participants in a coordinated or managed care delivery system such that the participants can benefit from improved quality outcomes and the state can be better stewards of taxpayer funds. By extending managed care statewide with current population groups it is

4 "Medicaid in a Historic Time of Transformation: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2013 and 2014", The Kaiser Commission on Medicaid and the Uninsured, prepared by Vernon K. Smith, Robin Rudowitz and Laura Snyder, October 2013, Page 5

believed that the state can achieve such goals. There was testimony presented that when comparing similar population groups, the cost avoidance as a result of managed care was approximately 3% savings or $38 million annually ($14 to $15 million in the state share).(5) The MO HealthNet Division has reported quality improvements since 2005 with respect to managed care participants such as 29% increase in timely prenatal care, 15% increase in postpartum care, 11% increase in annual dental visits, and 9% increase in adolescent well-child visits. (6)

When awarding contracts for such managed care populations the state must require that the MCOs guarantee, at a minimum, the following:

Improve health outcomes with comprehensive care coordination
Increase usage of preventive services and reduce unnecessary ER visits
Promote personal responsibility of enrollees
Improve state budget predictability and taxpayer savings
Increase efficiencies and transparency
Reduce fraud, waste and abuse of the system. (7).

Specifically, any coordinated care contract for Missouri should include the following measures.

A.----Maximizing and implementing allowable cost-sharing, premiums and deductibles for non-preventive services.

Keeping in mind the barriers that can be faced by cost sharing requirements on the lowest income participants, the committee believes that the state should take advantage of higher rates of cost sharing that have been approved by the federal Centers for Medicare and Medicaid Services (CMS) recently and how requiring cost sharing could bring about change by the participants. Examples that were given to the committee include cost sharing for inappropriate use of the emergency room.

Under the new CMS rules, states will be allowed to charge $8 copays for non-emergency use of the emergency department for those with incomes equal to or less than 150% of the federal poverty level. These participants are currently exempt from

5 "Medicaid Managed Care versus Fee-For-Service Cost Avoidance Analysis", Testimony before The Missouri Senate Interim Committee on Medicaid Transformation and Reform , Adam Koenigsfeld-Senate Staff, p. 3, October 2013 and "Missouri Medicaid and Reform" Home State Health Plan, Shannon Begley, August 14, 2013, p. 2
6 "Missouri Medicaid and Reform" Id. at p. 2
7 "Missouri Medicaid Reform", Id at p 3

such cost sharing. For participants with incomes higher that 150%, there is no limit on the maximum cost sharing for non-emergency use of the emergency department.

B.---Adopting Incentives for Participants to seek preventive services, encourage healthy behavior and to participate in his or her health care and monitor effectiveness of such incentives.

The committee believes that crucial to any reform of the Medicaid system is the need to engage the participant in his or her health care. Not only will this goal work toward better health outcomes but it will also curb the rising cost of care.

The committee heard from witnesses that incentives must be well designed and flexible. Flexibility is needed to accommodate for changes as programs develop and lessons are learned. Not only must the incentives be well designed, but they must also be accompanied by a comprehensive education/outreach to the targeted population. The rewards must be simple and clearly linked to the specific behavioral problem to be addressed. When implementing an incentive program it is crucial to understand not only the literacy level of the participants involved but to also take into account the barriers Medicaid participants face such as transportation and access.

Other witnesses stressed that a Medicaid transformation embracing care coordination through the use of health navigators, peer counselors, home visiting and other patient supports will help ensure success in any incentive initiatives.

Finally, it is also essential that the MO HealthNet Division obtain from the managed care entities a means to track the efficacy of the incentives to continually improve or discontinue ineffective or cost prohibitive incentives.

C.---Encouraging health savings accounts that can be used for deductibles and copays

The committee received information regarding models of care that incorporate health savings accounts. Some examples can be found in Florida, Idaho and Indiana.

In 2010, Indiana passed legislation which added a requirement for enrollees to make a minimum contribution to their POWER account of $160 annually (but no more than 5% of their income) and allowed both non-profits and managed care entities to pay a portion of members' required POWER account contribution to incentivize positive health habits.

Evaluations of the program are promising. Missouri needs to focus on how such a program would work taking into account financing, utilization patterns and healthier patient outcomes.

2 **All other populations, excluding participants in skilled nursing facilities, that are currently in the fee-for-service program should be transitioned to regionally-based Accountable Care Organizations serving as "single points of accountability" for quality, cost, and access to coordinated care. The new delivery model will encompass all aspects of care, except pharmacy services, including physical and behavioral health. All members must be linked with a primary care provider of their choice in an ACO.**

Although in the Kaiser survey of fifty states managed care continues to be the main avenue for implementing reforms, "significant reforms are also occurring through health homes, patient-centered medical homes, ACO's, and other initiatives that coordinate acute and primary care with behavioral health care and with long-term care."(8) The committee believes that many of the recommendations listed below and other suggestions made throughout the committee process will bear fruit under both a managed care and Regional Accountable Care Organization structure.

Although generally an ACO consists of a group of health care providers that agree to share responsibility for the delivery of care and the health outcomes of a defined group and the cost of care, many states have adapted the ACO concept to be broken out across a state regionally. Such states include Oregon, Colorado, and Alabama.

As was noted by the Center for Health Care Strategies:

> "[s]tates can use their regulatory powers, managed care contracting, and direct ACO contracting to craft programs with maximum flexibility and incentives for innovation. The market-leader role may be a big shift for some states. Given the relative nascence of the ACO model, Medicaid may want to engage a range of community stakeholders to design an approach that functions well to meet a variety of needs. Medicaid can assist in the development of robust ACO models by leading efforts to integrate financing for physical health, mental

8 "Medicaid in a Historic Time of Transformation", Id. at p. 63.

health, behavioral health, and long-term supports and services, and by fostering collaborations with state and local agencies responsible for funding critical social services. At the implementation level, Medicaid can facilitate alignment across MCOs, ease administrative burdens for ACOs, and either lead key technical support activities, such as data aggregation and data feeds, or leverage their MCO contracts for these supports." (9)

Regional Accountable Care Organizations (ACOs) in Missouri will evolve out of the state's existing managed care organization (MCO) infrastructure, replacing fee-for service. However, if such a model were to be pursued in Missouri, a state statute, Section 208.950.4, RSMo, will have to be modified to allow the elderly, blind and disabled to be enrolled in any coordinated care model.

The Regional ACOs can be corporate entities or contractually-linked provider networks formed through the collaboration of MCOs, hospital systems, community-based organizations, and other entities. Depending on the given area, Regional ACOs will initially be either existing MCOs or newly merged MCOs with local community based mental health centers and county government agencies. (10)

This new model for Missouri would also grow and expand the current Department of Mental Health DM 3700 and Health Home programs to coordinate care, particularly as the elderly, blind and disabled have not previously been served under coordinated care in Missouri.

It is crucial that Regional ACOs have a strong community focus, with community health care stakeholders and community organizations represented within a Regional ACO governance structure. Other states have required that Regional or community-based ACOs form a Community Advisory Council, including community and government representatives to meet regularly to ensure that local health care needs are being met.

The Regional ACOs will be full-risk-bearing entities reimbursed through a global payment methodology developed by the State.

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9 "Accountable Care Organizations in Medicaid: Emerging Practices to Guide Program Design", Center for Health Care Strategies, Inc, by Tricia McGinnis and David Marc Small, February 2012, a p. 4

10 "Accountable Care Organizations in Medicaid, Id. at p. 16

The committee heard from numerous witnesses who argued that if some form of coordinated care is advanced in Missouri for state-wide and all populations, it is crucial that there be vigorous management and oversight by the MO HealthNet Division in order to ensure accountability and quality measures are met. Therefore, when developing the ACOs, at a minimum, the following goals should be kept in mind:

- Develop statewide uniform data and analytics integration.
- Require the contracts to adopt mandatory medical loss ratios.
- The reforms should include risk-sharing arrangements between ACOs and payers.
- Sponsor a variety of community collaboration initiatives to promote cost-saving and health improvement activities at the local level.
- Use the lessons and infrastructure from the DMH 3700 project and DSS medical home initiative to determine standards for funding under an ACO initiative.
- Ensure that there is an adequate provider network through the ACO agreements.

3. Manage super utilizers beyond current care management programs by building on the DMH 3700 and health homes.

The committee heard from numerous witnesses about the success of the innovative models initiated in Missouri with respect to behavioral care, health homes and primary case management. It has also been made clear by witnesses that it is the super utilizers who have not really been managed well in the past and coincidentally are the group of participants who are also the costliest. Now is the time to develop models that will facilitate the coordination and integration of care across the continuum of services, particularly as these groups transition in and out of various long-term care support services and home-and community based services. States have "expressed growing awareness that lack of communication and information-sharing between providers hinders good quality care and increases the risk of duplication, unnecessary care, and higher costs." (11). These issues could be improved under a Regional ACO model.

11 "Medicaid in Historic Time of Transformation", Id. at page 37.

4. **DSS shall explore and develop options for transitioning dual eligible individuals to integrate Medicaid and Medicare services. Such change requires the development of a shared savings model with Medicare for dual eligible participants.**

Dual eligibles are those persons who meet eligibility requirements for both Medicare and Medicaid and have been enrolled in both programs. The duals tend to be the poorest and ones with multiple chronic conditions or severe mental disorders. This is why the Affordable Care Act created an office, the Federal Coordinated Health Care Office within the Centers for Medicare and Medicaid Services, to coordinate such care for the dual eligibles. There are 26 states advancing demonstration projects for coordinating care for the dual eligibles. Some policy makers have proposed enrolling duals in state-designed care coordination entities or (CCEs). Under one example of a shared savings plan, there are three entities, the federal government, the state government and a CCE who share any savings from coordinating the care for the duals. Some plans also include the dual eligible in the savings as well. For example, a share of the expected savings is set aside into an account for each dually eligible person enrolled in a CCE. The money in the account is then directed by the patient and can be used to buy additional services and supports including personal assistance services, transportation etc. (12) This is just one example of how one particular Regional ACO could explore the great task of managing the dual eligible population.

5. **Continue to promote the use of technology to enhance both telehealth and transparency in Medicaid.**

Telehealth should be an important part of any Medicaid program. Numerous witnesses testified before the committee on opportunities that could be used by telehealth to help alleviate the problem of both primary care and specialty care provider shortage. Telehealth will allow for the smaller communities to keep the care and patients within their communities. This will stabilize the small hospitals and at the same time keep the patient within the social/family support system of their neighborhood.

The technology is already available and has successfully been implemented in Missouri for numerous years now. The use of such technology just needs to be enhanced and the parameters around the use of telehealth streamlined. Clear definitions of what

12 "Using Shared Savings to Foster Coordinated Care for Dual Eligibles", The New England Journal of Medicine, Richard G. Frank, January 31, 2013.

sort of services necessitate live face-to-face contact with a health care provider are necessary. For example, Medicare reimburses for telemedicine or telehealth services in three areas:

-Remote patient face-to-face services seen via live video conferencing
-Non face-to-face services that can be conducted either through live video conferencing or via store and forward telecommunication services
-Home telehealth services.

Transparency in Medicaid is essential to the program as well. It promotes transforming the Medicaid participant into a smart consumer of services as well as providing integrity to the program. The state should insist on transparency of pricing and quality data in hospitals. These tools would give consumers the necessary information to make informed decisions on how and where they choose to seek services. Also, the state should allow for legislative audits of public spending in order to monitor the flow of taxpayer dollars to facilities. All of this would increase public access to financing in order to ensure dollars are spent properly.

The Department of Social Services should also be provided with sufficient information from all Medicaid contractors in order to study, develop and implement quality and efficiency measures to run a better program on an ongoing basis. Although current managed care contracts are capable of providing such information and have done so, as Missouri embarks upon a transformation of how Medicaid is delivered, the department needs to be consistently provided trended or aggregate level data in order to look at what the taxpayers are paying for and to monitor all coordinated care programs and contracts. The department does not need federal or state protected personal health information, but it does need enough on-point information to make value-based decisions on the health care services being provided by the state.

6. **Evaluate and analyze ways to decrease emergency room over-utilization.**

Countless witnesses, from emergency room physicians to academics testified about the need to curb the tide of emergency room over utilization. This problem is not new. The committee heard about huge strides made in this area through current coordinated care programs and emergency room diversion demonstration projects.

Missouri was the first state to have approved state plan amendments for both a behavioral health and primary care health home programs. According to the Department of Mental Health, preliminary data supports the hypothesis that through the enhanced care coordination and care management there will be a reduction in avoidable emergency room visits. (13)

In 2008, the MO HealthNet Division entered into an agreement with the St. Louis integrated Health Network for a CMS Medicaid Emergency Room Diversion Grant. The purpose of the grant was to establish non-emergency room services. The program incorporated Community Referral Coordinators in emergency departments throughout St. Louis to connect patients in need of non-emergent and follow-up care to an area health center. The program then seeks to find a primary care provider and establish a medical home. Eight CRCs work in seven hospitals to coordinate care.

The committee recommends that such programs be integrated statewide taking into account variations that may be required for different areas and populations. Apparently what was essential to the success of the program was having such CRCs available 24 hours a day. The point of contact had to be made while the patient was in the emergency room.

A similar success story with the ReDiscover program can be found in the Kansas City region. In 2010, through a grant from the Health Care Foundation of Greater Kansas City, safety net providers agreed to divert persons with psychiatric and addiction disorders from hospitals to alternative services. The collaboration consisted of area Community Mental Health Centers, area hospitals, ancillary providers, policy makers, Department of Mental Health and several county funders as well. From 2010 to 2011 over 350 high utilizers were referred and successfully connected with treatment. There were much less emergency room visits once the patient was referred to community care. Only 23% of the patients returned to the hospital. Estimated cost savings during the grant period was $13,700,000 for 19 months of service.(14) The program was such a success that it is in the process of further expansion.

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13 "2005 Medicaid Reform Commission Recommendations: A Progress Report", Presentation to The Missouri Senate Interim Committee on Medicaid Transformation and Reform, Departments of Social Services, Health and Senior Services, Mental Health, July 2013, page 4 of Top Medicaid Executables

14 " A Community-Based Approach Using Intensive Outreach and Engagement to Reduce Hospital Costs Associated with High Utilizers", presented by Lauren Moyer, Special Projects Manager

7. **Continue to enforce participant and provider abuse investigations and mine Medicaid data to guide further policy changes.**

The committee was charged with developing methods to prevent fraud and abuse in the MO HealthNet system. There was testimony regarding participants hopping from emergency room to emergency room and obtaining narcotics. Not only is such use costly to the state, but a CMS report noted that increased abuse of controlled prescription drugs " has led to elevated numbers of deaths related to prescription opiods, which increased 98 percent from 2002 to 2006." (15)

As was noted in recommendation #6, it is thought that proper emergency room diversion programs will help curb narcotics abuse. However, the committee also recommends exploring policy or legislative changes that could be made within the rules governing physician practice that would alleviate the dilemma of feeling compelled to prescribe narcotics for a patient claiming pain symptoms and not having a claim against him or her for failing to properly treat a patient. For example, could a physician (when appropriate in his or her medical opinion) offer something less than a controlled substance when at the emergency room and then suggest follow up care to determine whether a prescription for a controlled substance is necessary for long-term pain management?

The committee understands that what can really curb participant fraud is to ensure that there are accurate eligibility determinations. To that end, the Family Support Division is forging ahead with implementation of the new Modified Adjusted Gross Income determination provisions found in the ACA.

Not only is there fraud and abuse by participants, but a great deal can be found on the provider side as well. The committee heard testimony from the Missouri Attorney General's office regarding efforts and the amount of fraud taking place.

8. **Increase the asset limit to $2,000 for a single person and $4,000 for a couple.**

The state of Missouri has one of the lowest asset limits for the Medicaid elderly and disabled individuals in the country. The current asset limit is less than $1000 for a

15 "Drug Diversion in the Medicaid Program-State Strategies for Reducing Prescription Drug Diversion in Medicaid", Centers for Medicare and Medicaid, January 2012, at p. 1

single person and $2,000 for a couple. A recommendation of the committee could be to include an asset limit to $2,000 for a single person and $4,000 for a couple. The funds allowed under the current asset limits could be used by the individual for any item or purchase. Such action of creating these additional funds through the increase of the asset limit would empower the individual or couple to exert more control over their health care decisions and increase the financial stability for these individuals.

9. Encourage funding coverage for dental services for adults and disabled populations.

As discussed in recommendation # 6, a great deal of emergency room visits is preventable and many times could be avoided by less costly preventive care. There were numerous witnesses testifying about the need to provide dental services not only to encourage a better quality of life, but as a means of curbing health care costs.

The committee believes that dental care for adults and the disabled would achieve the goals of both improving quality of care and cost savings. Of the top ten causes of Medicaid emergency department visits, dental problems is one that could be reduced by offering preventive care. (16)

Currently, MO HealthNet provides dental services to pregnant women, children, the blind and nursing facility residents. Under Missouri statute, Section 208.152.1(21), coverage for prescribed medically necessary dental services is subject to appropriations and is available for all other populations. Such services should be funded and the MO HealthNet Division should require funding for such dental services in any future coordinated care contracts.

10. Reinvest future transformation savings into technology and provider payments.

The committee also heard from a number of witnesses concerned about the low number of providers, more specifically physicians and dentists, willing to except Medicaid participants. It was also noted that there will be fewer health care providers in general as a result of retirement and due to the fact of a smaller number of individuals pursuing this career. It is the recommendation of the committee to use

16 "Data Book: Missouri Health and Health Care", Missouri Hospital Association, July 2013, at p 58

savings generated from the transformation of the current Medicaid program to increase provider rates to encourage more providers to accept Medicaid participants. The state should provide additional funding for the Primary Care Resource Initiative for Missouri (PRIMO) loan program to increase the number of primary medical, dental, and behavioral health care professionals willing to work in a rural or underserved area of the state.

11. Ensure hospital health and sustain the Federal Reimbursement Allowance program.

"Hospital health", especially the health of small, rural hospitals is essential for quality health care and can be a life-and-death matter in emergency situations. Rural hospitals are often the biggest employers in the community. It is essential that steps be taken so that small rural hospitals can remain profitable, up-to-date, and in business. The closure of hospitals in rural communities can result in certain services being so far away that people may not be able to get treatment. (17)

Hospital revenue streams are substantially changing as a result of federally mandated reductions. The Missouri Hospital Association (MHA) estimates payment reductions in excess of $4 billion from 2013-2019. The Patient Protection and Affordable Care Act of 2010 (ACA) mandates aggregate DSH reductions to state DSH allotments beginning in FY 2014. In addition to the Medicaid reductions imposed by the ACA, hospitals are having payments reduced as a result of Medicare rate cuts, sequestration and other federal government restrictive actions ($3.3 billion of the $4 billion).

Medicaid disproportionate share hospital (DSH) payments are paid to hospitals to help offset costs of uncompensated care for Medicaid and uninsured patients. DSH will be reduced 5% for the first three years; 15% for the next year; and 50% thereafter. Beginning October 1, 2013, Missouri's state-specific DSH allotment was reduced by $25.9 million (5.14%). DSH payments are subject to hospital specific limits and state-wide DSH allotments. Annual DSH payments in Missouri are in excess of $700 million.

MO HealthNet currently pays hospitals based on a complicated out-dated reimbursement methodology that isn't used by other third party payers. Hospitals are paid a daily rate (per diem) for each day a patient is in the hospital. The daily rate is

17 Testimony to The Missouri Senate Interim Committee on Medicaid Transformation and Reform, Barbara Davis of the League of Women Voters, July 9, 2013.

based on 1995 costs inflated to 2001. Supplemental payments are then added to align payments with current costs. Even though inpatient stays are subject to precertification by MO HealthNet, the current methodology provides little incentive to manage ancillary tests and services for a patient while in the hospital or manage a patient's condition following discharge.

The Committee believes that payment reforms must be explored to promote consistency among payers, quality and value in hospital inpatient and outpatient settings. MO HealthNet should use a hospital payment methodology similar to how hospitals are paid by Medicare. Most commercial payers pay based on episodes of care specific to a diagnosis or condition. The committee recommends exploring new methodologies and/or managed care contract requirements that sustain and support rural hospitals while promoting access to care.

12. Enact tort reform legislation to cap the amount of damages physicians pay when sued for malpractice.

The committee believes that defensive medicine contributes to a great percentage of the cost of health care. Without caps on damages physicians can be ordered to pay, the cost of medical malpractice premiums remains high in order to provide coverage for such claims. Tort reform would reduce the number of malpractice claims, thereby decreasing the cost of medical malpractice premiums and eliminating the need for physicians to leave Missouri for other states with more favorable tort reform laws.

13. Put transparency into the health care market by making prices more available to patients.

The committee believes, as with other recommendations in the report regarding encouraging patients to have more information and to be more involved in his or her health care, it is important for patients and potential patients to be informed of the true cost for a health care service and to use such information when making informed health care decisions. Such information could be achieved if certain contractual provisions were disallowed. Examples of such provisions include those that restrict any party to a contract from disclosing to a patient or potential patient the contractual payment amount for a health care service if such payment amount is less than the health care provider's usual charge for the health care service; or if such contractual provision prevents a patient from determining the potential out-of-pocket cost for the health care service.

14. **Consolidate departments responsible for providing Medicaid services into one agency responsible for the administration and transformation of the Medicaid program when it makes sense to do so. Efficiencies gained should be reinvested into transformation efforts. Either a newly formed Joint Committee on Medicaid and Medicaid Transformation or a reinvigorated Joint Committee on MO HealthNet should study issues regarding such consolidation and efficiencies.**

State agencies with Medicaid administration responsibilities include the Departments of Social Services (DSS), Health and Senior Services (DHSS), Mental Health (DMH), and Department of Elementary and Secondary Education (DESE). Federal law requires each state to designate a single state agency to administer or supervise the administration of its Medicaid program. DSS is the designated single state agency in Missouri and has ultimate responsibility for the Medicaid program, but lacks authority over several components of the program including long-term care services administered by DHSS and mental health services administered by DMH. Even though senior leadership from each department work collaboratively on Medicaid initiatives, it is difficult to manage the program and carry out initiatives at the staff level when multiple department leaders and division heads are involved in the program's administration.

MO HealthNet operates in silos where a decision in one silo can have catastrophic actions that increase costs in another silo. (18) Effective management of the Medicaid program requires the balancing of program and financial priorities for a diverse and vulnerable set of populations. Missouri's decentralized Medicaid program leads to knowledge gaps and lacks a structure where there is a clear line of accountability. (19) A centralized Medicaid program integrates staff expertise and enables existing resources to be efficiently used across departmental silos.

Medicaid appropriations for FY 2014 are close to $9 billion, the largest program in state government. Medicaid is the second largest user of state General Revenue. Implementing transformation recommendations will require refocusing efforts of existing staff to lead federal waiver and demonstration submissions, analyze care data,

18 Testimony to The Missouri Senate Interim Committee on Medicaid Transformation and Reform, Jeffery Kerr, D.O, August 14, 2013

19 "MO HealthNet Comprehensive Review Final Report, Final Version", The Lewin Group, April 30, 2010.

and strengthen contracts. Efficiently transforming Missouri Medicaid without jeopardizing our current financing structure (provider taxes) will take the efforts of all staff under central cabinet-level leadership.

The committee also believes that if we are to reform all aspects of the Medicaid program, it would also be wise to repeal the MO HealthNet Oversight Committee and revise the current Joint Committee on MO HealthNet to become the Joint Committee on Medicaid and Medicaid Transformation. The Joint on Committee on MO HealthNet has never been fully appointed or met. Now that the state is embarking on Medicaid Transformation, it would be wise to have a joint committee overseeing such changes and implementation of reform measure that has the ability to truly monitor, vote and take action through the legislative process. A joint committee would be a better fit. In addition, either a newly formed Joint Committee on Medicaid and Medicaid Transformation or a reinvigorated Joint Committee on MO HealthNet should study issues regarding such consolidation of Medicaid duties and efficiencies that could be gained and give a recommendation to the General Assembly on when such changes should take place.

APPENDICES:

Appendix A- List of Witnesses Who Testified at Hearings

Appendix B- MEDICAID 101 Powerpoint Presentation

Appendix C- Medicaid Reform Commission 2005 Progress Report from the Departments of Social Services, Mental Health and Health and Senior Services

Appendix D- Letter from Senator Schaaf

Appendix E- Letter from the Minority members of the committee

Appendix A- List of Witnesses Who Testified at Hearings

July 8, 2013- Medicaid 101 and the Medicaid Reform Commission 2005 Update

1. Senate Staff- Adam Koenigsfeld, Adriane Crouse and Marga Hoelscher
2. Missouri Departments of Social Services, Mental Health and Health and Senior Services

July 9, 2013- Public Testimony and Access to care

1. John Orear- National Alliance on Mental Illness (NAMI) and parent
2. Erin Bower- Partnership for Children
3. Sarah Gentry- National Multiple Sclerosis Society
4. Todd Richardson- Missouri Association for Community Action
5. Joanie Gilliam- Disabled Citizens Alliance for Independence
6. Chuck Hollister- Missouri Psychological Association
7. Dr. Mark Bradford- Ozark Psychological Association
8. Andrea Routh- Missouri Health Advocacy Alliance
9. Joel Ferber, Legal Services of Eastern Missouri
10. Sherri Keller- Self
11. Mike Keller- Missouri Council for the Blind
12. Richard MCCullough- Missouri State Chiropractors Association
13. Brent Gilstrap- Missouri Mental Health Counselors Association
14. Barbara Davis- League of Women Voters
15. Sayra Gordillo- Self/Student
16. Dawn Martin- self
17. Joe Hardy- Missouri Rural Crisis Center
18. James King-Adapt of Missouri
19. Wyndi Chambers- Self/ Foster and Adoptive parent
20. April Neiswender –Self
21. Deborah Minton- Self
22. Wayne Lee-Advocate for disabled
23. Jackie Lukitsch- NAMI/ National Alliance on Mental Illness of St. Louis
24. Michelle Scott-Huffman- Missouri Faith Voices
25. Anita Parron- AARP

August 14, 2013 Supply-Side of Health Care- exploration of potential reforms and alternative approaches for the financing, payment and delivery of health care

1. Dr. Tom Hale, Executive Director- Mercy Telehealth Services
2. Carrie Sherer, Director of Government Affairs- Cerner
3. Dr. Heidi Miller, Internal Medicine- Primary Care Association
4. David Smith, -Blue Cross Blue Shield

5. Christian Jensrud, Vice President for Business Development- Wellpoint
6. Daniel Landon, Senior Vice President of Governmental Affairs- Missouri Hospital Association
7. Dr. Charles Willey, Internal Medicine- Missouri State Medical Association- Innovative Health Advocates
8. Dr. Jeffrey Kerr- Missouri Association of Osteopathic Physicians and Surgeons
9. Steve Halper- Healthcare Fraud Control Unit
10. Joan Gummels- Missouri Attorney General's Office
11. John Kopp- Missouri Attorney General's Office- Medicaid Fraud Control Unit
12. Pam Victor- HealthCare USA/Aetna
13. Dr. Bob Adkins- HealthCare USA/ Aetna
14. Dr. Larry Lewis- Missouri College of Emergency Physicians
15. John Marshall, Communications Officer- Signature Medical Group
16. Dr. Katie Lichtenburg- Missouri Academy of Family Physicians
17. Jason White, Missouri Ambulance Association
18. Steve Goldberg-WellCare Health Plans, Inc
19. Alaina Macia- Medical Transport Management
20. Shannon Begley- Home State Health Plan
21. Bob Reid- Page Minder
22. Kim Yeagle- Burrell Behavioral Health
23. Christy Henley- Clark Community Mental Health Center
24. Brent McGinty- Missouri Coalition of Community Mental Health Centers
25. Mary Schantz- Missouri Alliance for Home Care

September 11, 2013 Open discussion from invited presenters

1. Sidney Watson, Professor- St. Louis University School of Law
2. Christie Herrera- Foundation for Government Accountability
3. Dennis Smith- Mckenna, Long and Aldridge LLP
4. Margarida Jorge- Healthcare for America Now

October 2, 2013 Demand-Side of Health Care: Altering Consumer Utilization

1. Dr. Ed Weisbart, Vice President- Missouri Consumer Council
2. Louise Probst, Executive Director- St. Louis Area Business Health Coalition
3. Lauren Tanner, President and CEO- Ranken Jordan Pediatric Specialty Hospital
4. Dr. Timothy McBride, Professor, Washington University's Brown School of Social Work
5. Sergeant Mike Krohn- Boone County Sheriff's Department
6. Jeannette Mott Oxford, Executive Director- Missouri Association for Social Welfare
7. Craig Henning, Executive Director- Disability Resource Association
8. Senate Staff- Adam Koenigsfeld, Adriane Crouse and Marga Hoerchler

2005 MEDICAID REFORM COMMISSION RECOMMENDATIONS: A PROGRESS REPORT
JULY 2013

The report of the 2005 Medicaid Reform Commission included more than 80 recommendations for improving the state's Medicaid program. The Departments of Social Services, Mental Health and Heath and Senior Services have reviewed these recommendations and the progress that has been made since the report was issued.

In reviewing the Reform Commission's recommendations, six general themes are noted. These themes are listed below along with several examples of the progress made in each

Modernizing Technologies

- MMIS is in the final stages of modernization and enhancement
- CyberAccess has developed into a significant clinical support tool for the Medicaid program and providers
- Significant investments have been made in promoting electronic health records and health information exchange
- Telemedicine policy and reimbursements have been implemented

Broadening and Deepening Care Coordination Strategies

- More than 35,000 medically needy Medicaid participants receive comprehensive care management and care coordination through health homes and the DM 3700 initiative. This effort grows upon earlier ASO and "CCIP" initiatives which were developed shortly after the Commission's report was issued
- Managed care was expanded to 17 additional counties in 2008
- Diversion grant in St. Louis to connect patients to non-ER services using Community Referral Coordinators

Improving Program Operations

- Expanded use of sophisticated and evidence-based prior authorization and pre-certification processes have been implemented for pharmacy, imaging, durable medical equipment
- Managed care contracts have been aggressively managed. Rates consider the following efficiencies: 1) expectation that health plans manage a portion of low acuity Emergency Room (ER) visits in a less acute setting; 2) expectation that a certain portion of inpatient admissions could have been avoided or reduced in duration through alternative services and high-quality care management; and 3) address differences in claim levels among health plans within a region after adjusting for the underlying risk level of their enrolled population. Rates have been held at the bottom of actuarial ranges and cost containment expectations have been factored into rates.
- Reimbursement review and reform has been implemented for durable medical equipment, radiology services, and pharmaceutical drugs. Hospital reimbursement under review
- Balancing Incentives Program (BIP) promotes a "no wrong door" and standardized assessment to promote appropriate use of in-home care for elders and the disabled

Ensuring Program Integrity

- MMAC was formed to consolidate and coordinate the Medicaid audit and program integrity efforts of DSS, DMH and DHSS
- TPL contracts now focus on cost avoidance actions; MMAC has contracted for RAC audit services
- MMAC implementing modern provider enrollment and case management automated systems
- Telephony pilot for DHSS home and community based services underway

Promoting Consumer Information and Responsibility

- Implemented smoking cessation drug therapies and counseling
- DMH Screening, Brief Intervention and Referral to Treatment (SBIRT) and Mental Health First Aid initiatives
- Health home programs for chronically ill promote self-management plans of care, including counseling on the importance of immunizations and screenings, lifestyle choices, physical activity, obesity reduction, improving social networks, etc.
- Partnership for Hope now serves over 2,400 individuals with developmental disabilities and their families

Expanding Provider Networks and Services

- CMHC/FQHC mergers in two communities promote behavioral health/primary care integration
- Transferred underfunded state-operated acute psychiatric beds to Truman Medical Center (Kansas City) and University of Missouri Health Center (Columbia)
- Partnered with SSM and BJC health systems in St. Louis to create the Psychiatric Stabilization Center (PSC) following closure of state-operated acute psychiatric beds in St. Louis
- CMS approved a Section 1115 Demonstration Projects for DSS to partner with the St. Louis Regional Health Commission (SLRHC) to increase access to health care for people who are medically uninsured and underinsured

Progress Reports Included in this Update

Recommendation Scorecards

This summary provides an overview of those recommendations specific to the Medicaid program, and a general assessment of whether significant, some or little progress has been made on each recommendation.

Progress Report by Recommendation

This summary provides description of specific actions that have been taken or are operational with regard to the Reform Commission's specific recommendations. As with the scorecard, only those recommendations that pertain to the state's Medicaid program are discussed.

TIMELINE FOR REFORM
TOP TEN RECOMMENDATIONS - MEDICAID RELATED RECOMMENDATIONS

		Progress Made	Attempted / Some Progress	Little or No Progress
MEDICAID				
1	Expand the MC+ coordinated care program to Northwest Missouri			
2	Implement a Chronic Care Improvement Program		[redacted]	
3	Implemet/expand the MedStat program to reduce waste, fraud and abuse		[redacted]	
4	Upgrade the Medicaid Management Information System program		[redacted]	
5	Pilot program for e-prescribing to reduce prior authorization concerns			
6	Evaluate and analyze ways to decrease ER over utilization		[redacted]	
7	Require the Division of Medical Services to participate in the Missouri Quality Award process		[redacted]	
8	Implement technoloy that will link the provider to Pharmacy Claim data		[redacted]	

SHORT TERM RECOMMENDATIONS

		Progress Made	Attempted / Some Progress	Little or No Progress
1	A program that emphasizes personal responsibility, health literacy, and creates a structure to guide participants to become better consumers of healthcare	[redacted]		
2	A program that encourages preventive care through health maintenance, evidence based health promotion and education programs	[redacted]		
3	A program that provides basic level of services for each individual, . including annual physical and preventive screenings (those identified as evidence based, cost-effective by age, etc.)			
4	Develop and create nurse information and triage lines			
5	Establish and expand use of preventive services and evidence-based practice with chronically ill participants. This would include use of tools such as chronic care management, paying for care according to established standards of care and paying for tobacco cessation counseling	[redacted]		
7	Explore a system whereby emergency room physicians are allowed to screen patients and refer them to the appropriate level of care	[redacted]		
8	Explore mechanisms to prevent fraudulent providers from doing business in Missouri	[redacted]		
9	Implement provider performance and technological advancements			
10	Through the use of technology improve the prior authorization and claims payment process	[redacted]		
11	Expand coordinated care into other geographic areas around the suburban rings	[redacted]		
12	Implement medical loss ratios into any new contract and require the contract to include customer protections and high levels of customer satisfaction	[redacted]		
13	Increase reimbursements to providers that implement EMRs, CHRs, Personal Health Records and E-Prescribing			
14	Encourage providers to invest in telemonitoring and telemedicine	[redacted]		
15	Offer technical assistance for implementation of EMRs, CHRs, Personal Health Records, telemonitoring and telemedicine	[redacted]		
16	Evaluate the mental health responsibilities and resources across state agencies to identify additional resources and efficiencies that can be gained	[redacted]		
17	Develop provider profiling that gives consumers adequate mental health information			[redacted]

SHORT TERM RECOMMENDATIONS

		Progress Made	Attempted / Some Progress	Little or No Progress
18	Continue to promote local investment in services and supports by county developmental disabilities mill tax boards	[redacted]		
19	Continued collaboration among departments to assure that evidence based practices are used in behavioral health programs and that care management technologies are used to promotes efficiency and consumer choice without inappropriate restricting of availability	[redacted]		
20	Support a public health approach that emphasizes prevention, early intervention and integration of primary care with basic behavioral health services	[redacted]		
21	Ensure that DMH is responsible for establishing appropriate standards of care	[redacted]		
22	Support approaches to strengthen the linkages between federally qualified health centers and community mental health centers	[redacted]		
23	Increase education and outreach efforts to encourage the purchase of long-term care insurance, particularly for younger consumers	[redacted]		
24	Examine opportunities to participate in the federal long-term care partnership pilot project	[redacted]		
25	Examine new community-based options and expand the PACE model to other sites in the state and encourage cooperative agreements between all long-term care providers to encourage and promote appropriate options for consumers			
26	Examine the use of division of assets for home and community based services for individuals under the age of 63			[redacted]
27	Review licensure and oversight requirements for all types of long-term care providers	[redacted]		
28	Explore and implement quality control indicators and oversight for licensed Home and Community Based Care provider			
30	Continue and enhance the collaborative efforts of the Division of Medical Services and the Department of Mental Health through their common partner Comprehensive NeuroScience	[redacted]		
31	Continue to expand and update preferred drug and supplemental rebate opportunities	[redacted]		
32	Enhance current and develop additional clinical and fiscal on-line edits	[redacted]		
33	Improve and expand step therapies as supported by best practice and current medical evidence	[redacted]		
34	Update and expand MAC pricing of generically available products	[redacted]		

SHORT TERM RECOMMENDATIONS

		Progress Made	Attempted / Some Progress	Little or No Progress
35	Expand cost avoidance through required third party billing	[redacted]		
36	Support targeted prior authorization with as much transparency as possible	[redacted]		
37	Continue maximizing other processes already in place that ensure maximum cost containment and appropriate drug usage based on best practices and current medical evidence	[redacted]		
38	Assist communities in starting or expanding FQHCs through technical assistance for the grant process	[redacted]		
39	Explore a dental care carve-out program from the coordinated care program			
41	Require the Division of Medical Services to participate in the Missouri Quality Award process	[redacted]		
42	Maintain flexibility to allow for the appropriate use of state funds to meet the healthcare needs of Missourians			
43	Establish a new Disabled Employee's Health Assistance Program (DEHAP)			[redacted]

LONG TERM RECOMMENDATIONS

		Progress Made	Attempted / Some Progress	Little or No Progress
1	Create data and automation systems that provide critical information about the population served, financial issues, critical management information and health outcomes to support decision making by factual information			
2	Implement technology that provides central point of entry for all state services			
3	Integrate prevention into the use of technology through electronic medical records to empower individual and community level health decision and integrations/coordination of care by providers			
4	Explore mechanisms to prevent provider fraud		[redacted]	
5	Restructure provider reimbursement rates		[redacted]	
6	Explore a tiered level of co-pays to assist with patient compliance and empowerment			
7	Centralize and integrate claims systems as to prevent provider fraud		[redacted]	
8	Expand coordinated care to the ABD population through a pilot program		[redacted]	
9	Establish an administrative services organization (ASO) to run the coordinated care for the ABD population through a pilot program in existing coordinated care areas		[redacted]	
10	All Medicaid providers should have E-Prescribing capabilities in their offices within five years			
11	All Medicaid providers should have Electronic Medical Records within ten years		[redacted]	
12	Seek Medicaid waivers to assure that an appropriate array of services and supports are available for individuals with developmental disabilities and (2) serious mental illnesses or emotional disorders who are eligible through the PTD category		[redacted]	
13	Implement a pilot coordinated care program by DMH for individuals with serious mental illnesses		[redacted]	
14	Support local investment in mental health services and supports, and to develop mechanisms that reduce fragmentation at the local level and appropriately balance state and local control		[redacted]	
15	Promote the use of new technologies, such as telemedicine and electronic medical records		[redacted]	
17	Create a mechanism that educates and informs consumers about all of their options for receiving long-term care		[redacted]	

LONG TERM RECOMMENDATIONS

		Progress Made	Attempted / Some Progress	Little or No Progress
18	Examine the pathway to safety issue to encourage safety and the placement in the least restrictive environment			
19	Establish a single point of entry that includes a statewide-standardized assessment, evaluates the needs of the individuals and provides information about all long-term care options that are available			
20	Utilize technology to better manage information about long-term care consumers and plan for future needs			
21	Revise the Medicaid nursing home reimbursement system to take into account the acuity of the residents in the facility			
22	Support the inclusion of new technology as it becomes available especially in the areas of electronic prescribing and electronic medical records			
23	Ensure that all Medicaid participants have availability to a Medical Home where a primary care case manager will be available to assist in their healthcare decisions			
24	Fund and/or facilitate public-private partnerships to promote the availability of healthcare, such as the examples stated above			
29	Establish a tiered benefit package based on the healthcare needs and category of the participant			

Recommendations from the Medicaid Reform Commission

Top Medicaid Executables

1. Expand the MC+ coordinated care program to Northwest Missouri.

   - *In September 2008, Missouri Care Inc. was awarded a contract to implement an Administrative Service Organization (ASO) in Northwest Missouri.*

   - *This program was in the initial stages when budget constraints ended the initiative in FY 2010 (July 2009).*

2. Implement a Chronic Care Improvement Program.

   - *A contract was awarded to APS Healthcare in April 2006 to manage the Chronic Care Improvement Program (CCIP), a voluntary, opt-out case management program that incorporated the principles of disease management, care coordination and case management to serve fee-for-service participants.*

     - *The goals of the CCIP were to improve health status and decrease complications for participants with chronic illness, thereby reducing costs for emergency care and inpatient hospitalization.*

     - *The program focused on participants with chronic conditions including asthma, Chronic Obstructive Pulmonary Disease (COPD), diabetes, cardiovascular disease, sickle cell disease, and Gastroesophageal Reflux Disease (GERD).*

     - *In June 2008, a contract amendment was awarded to APS Healthcare to expand services to include an Administrative Service Organization (ASO) model for all fee-for-service participants (a result of SB 577), except in the northwest and southwest regions of the state.*

     - *The ASO model established a care management program to include wellness and prevention counseling, care coordination, disease management, and intensive care management.*

     - *Due to cost exceeding the benefits of this program, it was scaled back and then eliminated in 2009.*

     - *The program has been replaced with the more performance based Health Homes and Disease Management (DM) 3700 projects described in the responses to #6 on page 4 and # 16 under Short-term Implementation, Mental Health.*

Recommendations from the Medicaid Reform Commission

3. Implement and expand the MedStat program to reduce waste, fraud and abuse.

   - *The MedStat contract was in place until FY 2012. The MedStat data mining approach did not provide the geographical mapping required for Missouri Medicaid Audit and Compliance (MMAC) to fulfill 42 CFR 455.23 where "credible allegations of fraud" instead of suspected were required. MMAC has hired several investigators to aid in the determination of fraud, waste and abuse in the Medicaid program.*

   - *In FY 2012, the Department of Social Services (DSS) drafted a Request for Proposal (RFP) for a new provider enrollment system to help stop fraud on the front-end. The RFP has been through the evaluation phase and awaits CMS approval before finalizing. We anticipate CMS approval within the next 60 days. In FY 2013, MMAC drafted a RFP for a new Fraud and Abuse Detection System to include a predictive modeling approach to data mining. This RFP will be ready for submission to CMS for approval in the next 60 days.*

4. Upgrade the Medicaid Management Information System (MMIS) program.

   - *During FY 2010, the following upgrades were completed:*

     - *Web-based Prior Authorizations - The current Prior Authorization process was streamlined and automated where possible. Expanded comment lines and enhanced searching, selection, and viewing were also added.*

     - *Imaging and Work Flow – The MO HealthNet Division (MHD) implemented the Electronic Document Management System (EDMS) to better manage business processes related to all correspondence and documents.*

     - *Improved eMMIS application - The existing Customer Information Control System (CICS) screens were replaced with browser based functionality to create a more user-friendly, functionality enhanced, electronic MMIS (eMMIS) enterprise application. The new eMMIS browser-based user interface allows for an intuitive Graphic User Interface (GUI) to shorten the learning curve for new users and improve business functionality.*

     - *Improved Audit Trails - MHD implemented a DB2 database that automatically logs any change of information within the DB2 tables. The logs are stored in real-time and made available for auditing, reporting, and ad-hoc purposes.*

   - *During FY 2011, the following upgrades were completed:*

     - *Data Modeling and Conversion - This changed the existing MMIS data structure into a relational database format. The new structure reduces storage*

requirements, processing time and redundancy while improving the flexibility of adding and using the data.

- *Phase One of the Business Rules Engine - The business rules engine optimized the State's need for flexibility and rapid solutions to healthcare changes. The rules encompassed within the engine reflect nearly two thirds of the MMIS claim adjudication process and includes validation, provider and participant editing*

- *Enterprise Service Bus (ESB) - ESB reduces the point-to-point interfaces between various applications within MMIS; provides a new standardized data interface using ESB, and increases reusability so multiple applications will communicate with business service producers. The enhancement platform supports interoperability, security management, and standards based data exchange*

- *Update Web Applications - Updates were applied to the architecture and the applications to take advantage of upgrades and technological advances. These advances included launching a provider survey tool and connecting other enhancements to the web.*

- *Data Warehouse - The move of data from the VSAM file structure to a relational database structure provides the advantage of gathering and normalizing data. The user friendly access to near real-time data provides the ability to manage, query, and report data.*

- *Enterprise Surveillance Utilization Reporting (ESUR) - The ESUR System and Program Integrity application provides effective, easy-to-use, fraud and abuse detection tools for DSS. ESUR is a powerful combination of integrated, web-based tools that address Missouri's fraud and surveillance needs.*

➢ *During FY 2012 and FY 2013, the following upgrades were completed:*

- *implemented the Health Insurance Portability and Accountability Act (HIPAA) Electronic Data Interchange (EDI) transactions and Committee on Operating Rules for Information Exchange (CORE) operating rules Phase I & II to ensure compliancy with the federally mandated 5010 and National Council for Prescription Drug Programs (NCPDP) D.0 transaction standards and to improve the electronic exchange of information.*

Recommendations from the Medicaid Reform Commission

5. Begin a pilot program for e-prescribing to reduce prior authorization concerns.
8. Implement technological tools that will link the provider to Pharmacy Claim data.

The response below is applicable to the above two recommendations.

Cyber Access℠

- *More than 17,600 prescribers and other health care providers located at 5,700 provider sites use the Cyber Access℠ web-based portal to access electronic health records for MO HealthNet patients.*

- *Treating providers can view a patient's medical history including diagnoses, procedures and prescribed medications. Providers can electronically submit prescriptions (e-prescribe) and request pre-certification for imaging procedures, durable medical equipment, inpatient hospital stays and optical services.*

- *CyberAccess℠ improves efficiency of health care delivery by using a rules-based engine to determine if a requested drug or service meets the appropriate clinical criteria. All of this is done in a secure environment and the entire system is HIPAA compliant.*

- *The tool now includes lab and clinical trait data imported from provider medical records, as well as increased functionality to allow physicians to input notes.*

- *The tool supports the prior authorization of services provided to participants to ensure appropriate utilization and efficient use of funds.*

- *A health home program was recently implemented to provide case management services for participants with chronic behavioral or medical conditions. The CyberAccess tool provides the care management service providers with claims information and clinical tools to support the delivery of the care management services and coordination of care for the participants.*

EHR and E-Prescribing

- *Electronic Health Record (EHR) systems used by providers participating in the EHR incentive program require e-prescribing functionality. Over time providers must show that increasing percentages of their patients are given prescriptions through systems that check formularies electronically and submit prescriptions electronically.*

6. Evaluate and analyze ways to decrease ER over utilization.

Health Homes Initiative

- *Missouri is the first state to have approved state plan amendments for both a behavioral health and a primary care health home program. This program offers health home services for Medicaid recipients with certain chronic conditions and risk*

factors. Missouri's behavioral health home initiative is coordinated through community mental health centers. The primary care health home initiative is coordinated through federally qualified health centers, rural health clinics and other hospital-based clinics.

- *One of the goals of Missouri's health home initiative is to improve the health status of individuals with asthma/chronic obstructive pulmonary disease, developmental disabilities, diabetes, heart disease, serious and persistent mental illness, and who use tobacco and have a BMI greater than 25 - factors that put them at risk for these conditions. Another is to show cost savings through the reduction of avoidable emergency department (ED) visits, hospitalizations, and readmissions through intensive care coordination and management.*

- *Through the enhanced care coordination and care management across primary care and behavioral health, we anticipate a reduction in both avoidable ED visits and in-patient admissions. Preliminary data supports this hypothesis.*

- *Health homes work toward achieving these goals through providing the following services to their participants:*

  - ***Comprehensive care management** includes identification of high-risk individuals and use of client information to determine the level of participation in care management service and treatment plan development. This includes client goals, preferences and optimal clinical outcome, and monitoring of individual and population health status and service use to determine adherence to or variance from treatment guidelines.*

  - ***Care coordination** implements the individualized treatment plan (with active client involvement) through appropriate linkages, referrals, coordination and follow-up to needed services and supports, including referral and linkages to long term services and supports.*

  - ***Health promotion** provides health education specific to an individual's chronic conditions, development of self-management plans with the individual, education regarding the importance of immunizations and screenings, child physical and emotional development, support for improving social networks and health promoting lifestyle interventions, including substance use prevention, smoking prevention and cessation, nutritional counseling, obesity reduction and prevention and increasing physical activity.*

  - ***Comprehensive transitional care** includes appropriate inpatient and ED follow-up.*

- ***Individual and family support services*** *include advocating for individuals and families and assisting with obtaining and adhering to medications and other prescribed treatments. In addition, health team members are responsible for identifying resources for individuals to support them in attaining their highest level of health and functioning in their families and in the community, including transportation to medically necessary services.*

- ***Referral to and coordination with community and support services*** *provides for example, assistance for clients to obtain and maintain eligibility for healthcare including long term services and supports, disability benefits, housing, personal need and legal services.*

Community Referral Coordinators

- *In April 2008, the MHD entered into an agreement with the St. Louis Integrated Health Network for a CMS Medicaid Emergency Room Diversion Grant. The purpose of the grant was for the establishment of alternate non-emergency room services for Medicaid and Medicare clients. The grant was extended through June 2011.*

- *The program utilizes Community Referral Coordinator (CRCs) in emergency departments throughout St. Louis to connect patients in need of non-emergent and follow-up medical care to an area health center. Ultimately, the program intends to help patients find a primary care provider (PCP) and establish a medical home. Eight CRCs work in seven hospitals to coordinate care with local health centers.*

- *The CRC program had four main goals:*

  - *Increasing access to PCPs and other health resources for uninsured and under-insured patients;*

  - *Reducing non-emergent use of EDs;*

  - *Increasing continuity of care; and*

  - *Strengthening and facilitating communication among safety net providers.*

- *Factors that contributed to the success of the CRC program included the appointment scheduling process, buy-in from hospital staff, physical location of the CRC, patient hand off from the medical professional to the CRC, serving patients after-hours, and access to medical records by the CRC.*

- *In addition to patient education on the different types of care and linking patients with PCPs, the CRC program has assisted in improving communication between*

hospitals and health centers, prompted a health information exchange initiative which brought systemic inconsistencies to the forefront.

LANE Analysis

- *The State of Missouri contracted with Mercer Government Human Services Consulting, a division of Mercer Health & Benefits LLC (Mercer) to perform a Low-Acuity Non-Emergent (LANE) analysis to determine an appropriate adjustment to apply to health plan experience during the FY 2011 rate development. The LANE analysis identified instances when Medicaid eligibles would not have needed to make a trip to the emergency room if they had received effective outreach, care coordination and access to preventive care. The LANE analysis is an effective cost-containment strategy that reduced the effect of health care inefficiencies in the emergency room setting and supported the State's desire for a more value-focused purchasing strategy. The LANE adjustment reflects the expectation that health plans should manage a portion of low acuity emergency room visits in a less acute setting.*

- *This process generated a list of primary diagnosis codes representing a high percentage of ED visits that could be avoided. For all visits that were identified as LANE visits, Managed Care assumptions representing the percentage of LANE emergency room visits that could be prevented in an efficient, well-run Managed Care Program were applied to calculate an initial estimate of reduced emergency room expenditures. Additional costs of services that would have been incurred in other medical settings to avoid the unnecessary emergency room utilization were subsequently built into the adjustment.*

- *The overall results of the analysis provided an adjustment percentage of -0.4% to -0.5% of total regional medical expenditures which were incorporated into the FY 2011 Managed Care rate ranges. The 60% targeted efficiency level recognized that the health plans may need time to continue to incorporate additional best practices to mitigate the incidence of avoidable emergency room expenditures in the future and accounts for the limited alternatives to emergency room services.*

7. Require the Division of Medical Services to participate in the Missouri Quality Award process.

- *MHD, in partnership with Department of Mental Health (DMH) and the Coalition of Community Mental Health Centers, won a **2012 Governor's Award for Quality and Productivity** for the DM 3700 Project, which focused on reducing costs by improving the quality of care of MHD participants with serious mental illness and multiple chronic health conditions. The project won the Pinnacle Award, which "is awarded to a project that clearly encompasses multiple award categories in a manner that exemplifies the spirit of the Governor's Award, or exceeds all other nominations."*

Recommendations from the Medicaid Reform Commission

Short-term Implementation (Less than 2 years)

Wellness, Prevention and Responsibility

1. A program that emphasizes personal responsibility, health literacy, and creates a structure to guide participants to become better consumers of healthcare.
2. A program that encourages preventive care through health maintenance, evidence based health promotion and education programs.
3. A program that provides basic level of services for each individual, including annual physical and preventive screenings (those identified as evidence based, cost-effective by age, etc.).

The response below is applicable to the above three recommendations.

Health Homes Project

- *Section 2703 of the Affordable Care Act passed in 2010 allowed states to amend their Medicaid State Plans to offer health home services for Medicaid recipients with certain chronic conditions and risk factors.*

- *Missouri submitted two such amendments that were approved - one to develop a behavioral health home initiative through community mental health centers, and the other to develop a primary care health home initiative using federally qualified health centers, rural health clinics and other hospital-based clinics.*

- *The Missouri Health Home Initiative reengineers the healthcare delivery system for complex and costly chronic medical and behavioral health conditions. This joint initiative of MHD and DMH promotes personal responsibility, health literacy and informed consumption of health care, and encourages and provides preventive care.*

- *See response to #6 under Top Medicaid Executables for more information on the Health Homes project*

Managed Care Plan Improvements

- *The Managed Care contract contains a provision identifying eight (8) guiding principles for the MO HealthNet Program as follows:*
  - *All members must be linked with a primary care provider, of their choice;*
  - *Attention to wellness of the individual (i.e. education);*
  - *Chronic care management;*
  - *Case management – (resources focused towards people receiving the services they need, not necessarily because the service is available);*
  - *Appropriate setting at the right cost;*
  - *Emphasis on the individual person;*

- *Evidenced based guidelines for improved quality care and use of resources;*
- *Encourage responsibility and investment on the part of the member to ensure wellness.*

- *The Managed Care health plans are required to have and implement written policies and procedures for ensuring that the health plan's members are assigned to a primary care provider; provide for the linking of every member to a primary care provider; the monitoring of primary care providers to ensure they are performing the duties described below and are operating in compliance with health plan policies and procedures described herein; the use of specialists as primary care provider; and notifying primary care providers of their assigned member(s) prior to the member's effective date with the primary care provider.*

- *The primary care provider serves as the member's initial and most important contact. As such, primary care provider responsibilities include at a minimum:*
  - *Maintaining continuity of each member's health care;*
  - *Making referrals for specialty care and other medically necessary services to both in-network and out-of-network providers;*
  - *Working with health plan case managers in developing plans of care for members receiving case management services;*
  - *Conducting a behavioral health screen to determine whether the member needs behavioral health services, and*
  - *Maintaining a comprehensive, current medical record for the member, including documentation of all services provided to the member by the primary care provider, as well as any specialty or referral services, diagnostic reports, physical and behavioral health screens, etc*

- *Case Management - The health plans are required to provide case management to selected members focusing on enhancing and coordinating a member's care across an episode or continuum of care; negotiating, procuring, and coordinating services and resources needed by members/families with complex issues; ensuring and facilitating the achievement of quality, clinical, and cost outcomes; intervening at key points for individual members; addressing and resolving patterns of issues that have negative quality cost impact; and creating opportunities and systems to enhance outcomes. The health plan may use designated health home providers to perform case management functions if the health home practice is a member of the health plan network. In this event, the health plan shall have processes in place to monitor service delivery and ensure that all requirements, as described herein, are adequately performed.*

- *The contracts with the MO HealthNet Managed Care health plans allow the health plans to provide incentive programs for their members to encourage healthy behaviors and personal health care responsibility.*

4. Develop and create nurse information and triage lines.

   (Please also refer to #2 under Top Medicaid Executables.)

   - *The MO HealthNet Managed Care health plans provide a Nurse Advice Line to members twenty-four hours per day, seven days per week. Calls to the Nurse Advice Line are answered by a Registered Nurse who directs Managed Care members to receive care within the health plans' network. The Nurse Advice Line offers Managed Care members the assistance they need to prevent them from incurring unnecessary emergency room visits.*

5. Establish and expand use of preventive services and evidence-based practice with chronically ill participants. This would include use of tools such as chronic care management, paying for care according to established standards of care and paying for tobacco cessation counseling.

   (Please also refer to the responses to #6 under Top Medicaid Executables and #1–3 under Short-term Implementation, Wellness, Prevention and Responsibility for information on the Missouri Health Home Initiative.)

   - *MHD implemented a smoking cessation program in 2 phases beginning with coverage for pregnant women starting October 2010, followed by coverage for all smoking participants in February 2011.*

   - *Medicaid enrollees have nearly twice the smoking rates (37%) of the general adult population (21%), and smoking related medical costs are responsible for 11% of Medicaid expenditures.*

   - *The smoking rate for Missouri's pregnant women has remained consistently high at around 18% for the last 10 years.*

   - *A report from the CDC (2009) recommends smoking cessation coverage of all pharmacotherapy combinations as well as individual and group counseling for all Medicaid enrollees to achieve a higher rate of success for the program.*

   - *A 2008 Public Health Service guidelines recommend 4 combination therapies (2 tobacco-dependence medications taken simultaneously – nicotine patch and nicotine gum; nicotine patch and nicotine nasal spray, nicotine patch and nicotine inhaler, or nicotine patch and bupropion SR – combined with individual or group counseling to encourage behavior modification).*

- *Evidenced based guidelines for improved quality care and use of resources;*
- *Encourage responsibility and investment on the part of the member to ensure wellness.*

- *The Managed Care health plans are required to have and implement written policies and procedures for ensuring that the health plan's members are assigned to a primary care provider; provide for the linking of every member to a primary care provider; the monitoring of primary care providers to ensure they are performing the duties described below and are operating in compliance with health plan policies and procedures described herein; the use of specialists as primary care provider; and notifying primary care providers of their assigned member(s) prior to the member's effective date with the primary care provider.*

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Recommendations from the Medicaid Reform Commission

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- *In addition to tobacco cessation behavioral interventions (available for 1 visit weekly for 12 weeks up to 2 quit attempts per lifetime), the MO HealthNet Program covers the following pharmacotherapy smoking cessation agents (in any combination):*

Brand Name	Generic Name
Nicorette Gum	Nicotine Gum
Nicotrol Inhaler	Nicotine Inhaler
Nicorette Lozenge	Nicotine Lozenge
Nicotrol NS	Nicotine Nasal Spray
Nicoderm	Nicotine Patch
Chantix	Varenicline
Zyban/Wellbutrin	Bupropion SR

- *MHD currently reimburses all Behavioral Health professionals for smoking cessation counseling. MHD covers 12 sessions in a 12 week period with a maximum of 24 sessions per lifetime. Participants in Managed Care receive these benefits through fee-for-service and not the Managed Care health plan*

Provider Participation and Satisfaction

7. Explore a system whereby emergency room physicians are allowed to screen patients and refer them to the appropriate level of care.

- *The Managed Care contracts contain a provision allowing attending emergency physicians, or the provider(s) actually treating the member, the responsibility for screening the Managed Care members and determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the health plan.*

- *Please also refer to the response to #7 under Top Medicaid Executables.*

8. Explore mechanisms to prevent fraudulent providers from doing business in Missouri.

- *Missouri has consolidated its Medicaid audit and compliance functions in one agency. The Missouri Medicaid Audit and Compliance Unit (MMAC) is a unit located within the Missouri Department of Social Services. MMAC is responsible for the oversight and auditing of compliance of Missouri Medicaid providers and participants and is charged with detecting, investigating and preventing fraud, waste and abuse*

of the Missouri Medicaid program. MMAC is also charged with enrolling, screening and terminating potential and existing Missouri Medicaid providers. MMAC was created in 2012 through an Executive Order submitted to the General Assembly.

- *Detecting and preventing waste, fraud and abuse in the Missouri Medicaid program is initiated from a number of sources. MMAC receives hotline tips from outside agencies, consumers and healthcare providers; actively data mines claims submitted by providers; utilizes desk-audits; and performs on-site audits. Focus has shifted from desk-audits to on-site audit because of their effectiveness. Also, interviewing provider staff and Medicaid participants is a key component of on-site reviews as is the use of investigators to assist in these efforts.*

- *MMAC is also tasked with terminating and excluding providers. Missouri Medicaid providers can be terminated for a number of reasons, such as loss of licensure or findings relating to health-care fraud. Also, providers must be excluded if the provider has committed health-care fraud, is excluded by Medicare as a Medicare provider, or is excluded from another state's Medicaid program due to health-care fraud.*

- *The state is making a commitment to invest in new technologies to more efficiently review potential Missouri Medicaid providers. The new technology will aid with identifying potential fraud on the front end prior to enrollment. Also, a new Fraud and Abuse Detection System is being procured and will include a predictive modeling approach to data mining.*

- *With the consolidation of audit and compliance functions, the state has increased its recoveries. Recoveries for FY 2011- $8.4 million; FY 2012 - $16.2 million; and FY 2013 - $32.8 million.*

9. Implement provider performance and technological advancements.

Health Home Pay For Performance

- *As part of the Health Home initiative, MHD and health homes are tracking both clinical outcomes and utilization and cost outcomes. MHD is exploring a shared savings methodology with CMS by which MHD would share a portion of potential savings with the health homes. The amount of shared savings to the health homes, or incentive payment, would be determined by performance on key measures and savings in aggregate. As a framework for the primary care health home program and this potential shared savings process, MHD with its partners established a central data warehouse that facilitates a standardized collection and assessment of clinical data. MHD shares reports with the health homes on their clinical measures and benchmarking of the health homes on those clinical measures. Likewise, the primary care clinics participating in the health home program all have electronic*

medical records and can run their own reports on process, trends, and outcomes so that they can gauge their own performance. Similarly, MHD established a framework for looking at utilization and cost for the health home population based on its existing claims-based system.

Managed Care Performance Incentives

- *As MHD enhances its quality assessment and performance improvement process for the managed care plans, patient assignment could be driven by quality benchmarking and performance on key measures.*

- *Managed Care Health Plan Performance Based on HCY/EPSDT Participant Ratio - In accordance with CMS guidelines, the state agency requires eighty percent (80%) of eligible Managed Care members to have HCY/EPSDT well child visits, and accordingly, has included an eighty percent (80%) participant ratio in the rates paid to the health plan. In accordance with CMS 416 reporting methodology, the state agency measures the health plan's performance regarding the percentage of eligible members having HCY/EPSDT well child visits (participant ratio). The state agency applies State specific criteria to the CMS methodology to reflect the MO HealthNet Managed Care Program. The State specific criteria reflects performance by Category of Aid and rate cell, and recognition of a month to be greater than twenty-seven (27) days. The participant ratio is defined as the number of total eligible members receiving at least one initial or periodic well child visit divided by the number of total eligibles who should receive at least one initial or periodic well child visit.*

- *Automatic Assignment of Managed Care Members into Managed Care Health Plans - The state agency employs an algorithm to assign to the health plan, on a prorated basis, any MO HealthNet Managed Care eligibles who do not make a voluntary selection of a health plan during the open enrollment period. The algorithm is based on the following:*

  - *If the MO HealthNet Managed Care eligible's case head is enrolled with a health plan, the MO HealthNet Managed Care eligible is assigned to that health plan. If not, the next step in the algorithm will be followed.*
  - *If the MO HealthNet Managed Care eligible is included in a MO HealthNet eligibility case where another member is enrolled with a health plan, the MO HealthNet Managed Care eligible is assigned to that health plan. If not, the MO HealthNet Managed Care eligible will be assigned randomly.*
  - *Within each region, the health plans share equally forty percent (40%) of the random auto assignments.*
  - *The remaining sixty percent (60%) of the random auto assignments in each region are based on the total performance score for each health plan for that*

region. The performance score for each region is calculated on the following measures:

1) *The total evaluation score determined by the State of Missouri;*
2) *The health plan's Missouri regional score on the HEDIS measure of annual dental visits;*
3) *The health plan's Missouri regional score on the HEDIS measure of adolescent well care visits;*
4) *The health plan's Missouri regional score on the HEDIS measure of mental health utilization;*
5) *The number of FQHCs, RHCs, and CMHCs the health plan has in its network (beyond the minimum of one (1) in the region); and*
6) *The inclusion of an acute care safety net hospital, (as defined in 13 CSR 70-15.010 of the Code of State Regulations, as amended) in its network.*

- *The health plan receives a total number of points based on these six (6) measures; the total of these points is the performance score earned by the health plan. The performance score translates into a percent of the performance auto assignment. For the first year of the contract, health plans that are new to the MO HealthNet Managed Care Program or new to a region will receive the average score of all health plans in the awarded region for its proxy HEDIS measures.*

- *The state agency conducts meetings with stakeholders and the health plans to solicit input on appropriate measures to be used during the second and third years of the contract. The state agency informs the health plans of the measures to be used at least six (6) months prior to the implementation of the changed performance auto assignment algorithm*

<u>*CCIP Pay for Performance*</u>

- *The Chronic Care Improvement Program (CCIP) began roll-out to participants and providers in late 2006. The CCIP contract was developed based on the premise that rewarding achievement is crucial to engaging all sectors of the provider community in continuous quality improvement.*

- *A Quality Improvement Council was established and began meeting in October 2006. The Council, which consists of key representatives of the provider community, was tasked with developing metrics and expectations for providers and participants to improve health care quality.*

- *MHD participated as one of seven state Medicaid programs accepted into the Center for Health Care Strategies (CHCS) P4P Purchasing Institute to share information and develop best practices that supported providers and reinforced positive outcomes on*

a national level. Our application indicated that the first P4P payments for CCIP would initiate in October 2007.

- *The preliminary work on the CCIP program paved the way for the SB 577 requirements for P4P for overall MO HealthNet health improvement plans. The CCIP metrics were requested for review by the MO HealthNet Oversight Committee.*

- *The premise was that sharing best practices information and reinforcing improved provider practices would help ensure that Missouri continued to be successful in obtaining buy-in from its providers and other health care partners as MO HealthNet continued to evolve.*

- *In addition, it was believed that provider access would improve as MO HealthNet demonstrated the desire to compensate providers for quality healthcare. Patients would be more likely to comply with their healthcare improvement plan if access to their primary care physician (PCP) was maintained, or if additional providers were more geographically accessible.*

- *MO HealthNet would have a more positive impact on improving quality of care and containing costs if the majority of PCPs participate in health improvement plan training, educational activities and quality improvement initiatives.*

- *The initial P4P cost output was considered minimal as provider enrollment in CCIP was still being developed. A maximum of 200 providers were included in the first payment.*

- *Only a couple of P4P payments were made before funding became a issue and the payments were discontinued. Inconclusive results also contributed to the termination of the program.*

10. Through the use of technology improve the prior authorization and claims payment process

- *MHD continues to enhance the prior authorization/pre-certification process. The pre-certification process added Durable Medical Equipment (DME) in 2007, optical services in 2009, and a provider inpatient certification reporting tool and pre certification request application in 2010. Within the established framework, MHD continues to develop and launch additional product edits to increase efficiency and automation in the precertification and claim adjudication process.*

- ***Smart PA***

  - *Smart PA™ is a clinical rules engine which uses a decision tree (algorithm) comprised of criteria derived from best practices and evidence-based medical information to allow transparent approval of service and product requests.*

- *The tool is used for adjudication of Clinical and Preferred Drug List edits. These edits are designed to enhance patient care and optimize the use of program funds through therapeutically prudent use of pharmaceuticals. Point-of-sale (POS) pharmacy claims are routed through an automated computer system to apply edits specifically designed to ensure effective and appropriate drug utilization. In most cases, these edits will be transparent to providers and recipients. The goal of these edits is to encourage cost effective therapy within the selected drug class.*

- *The Smart PA™ rules engine also alerts providers of areas of concern to be addressed by action or intervention to achieve better outcomes.*

- *Smart PA™ allows each claim to be referenced against the recipient's pharmacy claims history, medical claims history (including ICD-9 codes), and procedural data (CPT codes) transparently. For those patients that meet any of the approval criteria, the claim will be paid automatically. In the rare instances when a phone call is necessary, our responsive hotline call center is available seven day a week, Monday through Friday 8am to 9pm, Saturday and Sunday 8am to 6pm at 800-392-8030.*

➢ ***Precertification Module***

- *Precertification is a web-based program within CyberAccess that was created to comply with Senate Bill 577 passed by the 94th General Assembly, which directs MO HealthNet to utilize an electronic web-based system to authorize Durable Medical Equipment using best medical evidence and care and treatment guidelines, consistent with national standards to verify medical need.*

- *Currently there are 38 edits for Durable Medical Equipment as well as the Optical program in the Precertification Program* (MHD)

Coordinated Care

11. Expand coordinated care into other geographic areas around the suburban rings.

➢ *Western Region - On January 1, 2008, the State of Missouri introduced the MO HealthNet Managed Care Program in Bates, Cedar, Polk, and Vernon counties in the Western Region. Today, approximately 134,000 individuals are enrolled in the MO HealthNet Managed Care Western Region.*

➢ *Eastern Region - On December 1, 2000, the counties of Lincoln, St. Francois, Ste. Genevieve, Warren, and Washington were included in the Eastern Region. On January 1, 2008, the Managed Care Program expanded to Madison, Perry, and Pike*

counties in the Eastern Region. Today, approximately 208,000 individuals are enrolled in the MO HealthNet Managed Care Eastern Region.

- *Central Region - On January 1, 2008, the State of Missouri introduced the MO HealthNet Managed Care Program in Benton, Laclede, Linn, Macon, Maries, Marion, Pheips, Pulaski, Ralls and Shelby counties in the Central Region. Today, approximately 81,000 individuals are enrolled in the MO HealthNet Managed Care Central Region.*

- *Also, Missouri's Health Home Initiative provides a statewide infrastructure for coordinated care beyond the suburban ring. See responses to #6 under Top Medicaid Executables and #1-3 under Short-term implementation, Wellness, Prevention and Responsibility for more information.*

12. **Implement medical loss ratios into any new contract and require the contract to include customer protections and high levels of customer satisfaction.**

- *The MO HealthNet Managed Care contract does not include any medical loss ratio provisions. However, Mercer Government Human Services Consulting incorporated an assumption for medical loss ratios in the FY 2012 rate setting process.*

- *The health plans are required to ensure that all contracts between the health plans and providers include a provision that the provider complies with the consumer protection provisions outlined in the MO HealthNet Managed Care marketing guidelines. The health plans and their subcontractors are prohibited from developing marketing materials that are inaccurate or mislead, confuse, defraud, or deceive MO HealthNet Managed Care eligibles, or otherwise violate Federal or State consumer protection laws or regulations.*

- *Starting in SFY-2011, the managed care rates were adjusted for effective cost-containment to reduce health care inefficiencies and support value-based purchasing. Successful management of managed care organizations can reduce overall health care costs and improve patients' quality of medical care. The managed care efficiency adjustments are:*

    - *Low-Acuity Non-Emergency (LANE) - LANE adjustment reflects expectation that health plans should manage a portion of low acuity Emergency Room (ER) visits in a less acute setting. Encounter data is examined for ER visits with diagnosis codes indicating potential low acuity and a percentage of LANE visits preventable for each diagnosis are applied to each health plan's encounters.*

    - *Potentially Preventable Hospital Admissions (PPA) - PPA adjustment reflects expectation that a certain portion of inpatient admissions could have been*

avoided or reduced in duration through alternative services and high-quality care management. Encounter data is examined for Agency for Healthcare Research and Quality (AHRQ) guidelines for PPAs.

- *Risk-Adjusted Efficiency (RAE) - Addresses differences in claim levels among health plans within a region after adjusting for the underlying risk level of their enrolled population. Risk scores are assigned for each eligible person and aggregated for each regional health plan. Risk scores and health plan experience were evaluated on a rate cell and constant case mix basis.*

Technology

13. Increase reimbursements to providers that implement EMRs, CHRs, Personal Health Records and E-Prescribing.

- *MO HeathNet launched its Medicaid Electronic Health Records (EHR) incentives program in June 2011 under the HITECH provisions of ARRA. Since the program started over 2,800 payments have been made to 2,235 participating professionals and hospitals that have implemented EHRs with specific functionality. Professionals can qualify for incentive payments for up to six years; hospitals for three. Both must meet requirements for meaningful use of their technology in each year they apply for payments. During the first two fiscal years, total incentive payments made to Missouri providers was $135.7 million.*

14. Encourage providers to invest in telemonitoring and telemedicine.

Telehealth

- *Effective August 30, 2008, MHD began reimbursing for Telehealth Services. The Missouri Code of State Regulations 13 CSR 70-3.190 Telehealth Services, establishes coverage for Telehealth Services through the MO HealthNet program.*

- *Telehealth Services are health care services provided through advanced telecommunications technology from one location to another. Medical information is exchanged in real-time communication from an Originating Site, where the participant is located, to a Distant Site, where the provider is located, allowing them to interact as if they are having a face-to-face, "hands-on" session. Telehealth offers participants, particularly those in rural areas of the state, access to health care services without having to travel extensive miles for an appointment.*

- *A Telehealth service requires the use of a two (2)-way interactive video technology. Telehealth is not a telephone conversation, email, faxed transmission between a healthcare provider and a participant, or a consultation between two healthcare*

providers. The participant must be able to see and interact with the off-site provider at the time services are provided via Telehealth.

- *Telehealth services are only covered if medically necessary. Coverage of services rendered through Telehealth at the distant site is limited to:*
  - ✓ *Consultations made to confirm a diagnosis;*
  - ✓ *Evaluation and management services;*
  - ✓ *A diagnostic, therapeutic, or interpretative service;*
  - ✓ *Individual psychiatric or substance abuse assessment diagnostic interview examinations;*
  - ✓ *Individual psychotherapy; and*
  - ✓ *Pharmacologic management.*

- *Health care providers utilizing Telehealth at either an originating site or a distant site must be enrolled as a MO HealthNet provider. Providers eligible to receive payment for Telehealth services include Physicians, Advanced Practice Nurses and Psychologists.*

- *Additional information is contained in the provider bulletin found at: http://dss.mo.gov/mhd/providers/pdf/bulletin32-08_2009aug7.pdf*

- *During fiscal years 2008 and 2009, funds were appropriated in the DSS/MO HealthNet budget to provide grants to Rural Health Clinics (RHCs) for implementing Telehealth technologies. Nearly $950,000 in grants to RHCs were made during this time.*

Telemonitoring Services

- *MHD currently has two separate contracts for Telemonitoring services with Oxford Healthcare and Integrity Healthcare.*

- *Telemonitoring is limited to patients with chronic disease who require in-home monitoring of vital signs and clinical measures (blood pressure, weight, oxygen saturation levels, pulse, etc.) to help deter use of the emergency department and/or inpatient hospitalization.*

- *The contractors must comply with the terms of the contract, including provision and training in the use of the in-home monitors, evaluation of the clinical data transmitted to their nursing station and follow-up with any potential clinical alerts shown by the data. Services are subject to annual appropriations for the program.*

Telephony for In-Home Services

- *The Department of Health and Senior Services (DHSS) through statute is required to establish telephone tracking system (telephony) pilot projects for the delivery of In-Home*

Services (IHS) and Consumer Directed Services (CDS) in collaboration with other appropriate agencies, including providers. The pilot projects are in both urban and rural areas.

- *In August 2010, IHS and CDS providers were notified that any provider wishing to participate in the pilot could do so voluntarily. The provider must be in good standing with DHSS and DSS in order to be considered part of the pilot.*

- *Participants utilize a telephone tracking system rather than paper timesheets to verify the delivery of services to clients/consumers. The telephony system must have the following capabilities:*

  - *The system must record the exact date services are delivered;*
  - *The system must record the exact time the service began and the exact time the service ended;*
  - *The system must verify the telephone number from which the services were registered and verify that the number called from was the client's home or a telephone unique to the client;*
  - *The employee placing the verification call will be identified in each case by a personal identification number unique to each employee;*
  - *The system must accommodate both rotary and touch tone telephone instruments. For clients with rotary telephones, the system must be capable of accepting voice activation to capture the required information;*
  - *The system must be capable of producing reports of services delivered, tasks performed, client identity, beginning and ending times of service and date of service in summary fashion that constitute adequate documentation of service;*
  - *All calls made from each client's telephone for the purpose of recording service delivery data must be made at no additional cost to the client.*

- *As of this date the following numbers are enrolled.*

Pilot	***In-Home Services***	***Consumer Directed Services***
Both	*4*	*2*
Rural	*3*	*4*
Urban	*4*	*3*
Total	*11*	*9*

- *Once the pilot projects are completed, a report must be submitted by December 31, 2013, detailing the outcomes of the project.*

15. Offer technical assistance for implementation of EMRs, CHRs, Personal Health Records, telemonitoring and telemedicine.

   - *Technical assistance to providers participating in MO HealthNet's EHR incentive program is available through Missouri's Regional Extension Center, operated by the MO HIT Assistance Center at the University of Missouri Columbia and funding by the Office of National Coordinator.*

Mental Health

16. Evaluate the mental health responsibilities and resources across state agencies to identify additional resources and efficiencies that can be gained

   - *Over the last eight years, DMH has actively sought opportunities to collaborate with other state agencies to save taxpayer dollars while simultaneously improving outcomes for Missouri citizens. We cite six examples that best reflect these efforts:*

     - ***DM 3700**: Disease Management 3700 is a collaboration between DMH and MHD that began in November, 2010. Medicaid eligible individuals with co-occurring chronic medical conditions and serious mental illness who are not current consumers of DMH and have minimum annual Medicaid claims of $20,000 are invited to participate. This project requires intensive outreach by Community Mental Health Centers (CMHCs). Of the Medicaid recipients who qualify for this program, 3,300 have been enrolled so far. The annual savings for persons enrolled one year or more is approximately $5 million. Outcomes for people enrolled in the program have been excellent, including reductions in emergency room visits and inpatient hospitalization.*

     - ***Health Homes:** This was patterned after the DM 3700 project. Missouri was the first state in the nation to receive federal funding to develop a comprehensive Health Homes initiative for Medicaid-eligible participants with co-occurring chronic medical and mental health conditions. Beginning in January 2012, this project enrolled 18,000 individuals with minimum prior annual Medicaid claims of $10,000 or more. While these individuals were already receiving CMHC services for their serious mental illness conditions, they were not receiving care coordination for their chronic health conditions. To date, the annual savings for all participants enrolled one year or more is $4.2 million. Outcomes include reductions in inpatient hospitalization and emergency room costs.*

     - ***Corrections/Mental Health Reentry Efforts**: Since 2007, DMH has worked closely with the Department of Corrections (DOC) on multiple initiatives targeting effective treatment of offenders with mental illness or substance use disorders, or both. These initiatives connect offenders with serious mental illness to a CMHC*

immediately upon release from prison. As a result, the rate that offenders with the most serious mental illness return to prison has dropped from 61% down to 38%.

- ***Partnership for Hope**: In 2010, DMH and MHD received approval from CMS for a groundbreaking Medicaid home and community-based waiver for Missourians with developmental disabilities now known as Partnership for Hope (PfH). PfH is funded by leveraging state resources (19%) and county mill tax board resources (19%) to draw down Federal funds (62%) to fund waiver services. The PfH waiver is available in 99 participating counties. Since approval of the PfH, more than 2,400 eligible individuals have been enrolled at an average annual cost of $8,500 per person. By comparison, that represents over 800 new individuals per year entering home and community based Developmental Disability (DD) waiver services for each of the past three years. This represents a 400% annual increase in new Medicaid-eligible individuals enrolling in Missouri's DD waiver services over any of the prior eight years.*

- ***Better Behavioral Health Pharmacy Management**: DMH and MHD have implemented a statewide Pharmacy Quality Improvement Project that identifies the highest users of the Medicaid behavioral health pharmacy benefits and reviews the prescribing practices of their physicians. The program provides feedback to physicians whose prescribing deviates from best practices guidelines, or who have patients that are being prescribed multiple same-class medications by multiple prescribers. The program eliminates duplications and unnecessary medications and has reduced Missouri's Medicaid behavioral health pharmacy spending at least $10 million annually. It has also resulted in reductions in non-behavioral health pharmacy costs, hospital usage and emergency room usage.*

- ***Emergency Room Project:** Beginning in FY 14, seven regions of the state will develop emergency room enhancement projects as part of the Strengthening Missouri's Mental Health System initiative. The key feature will be collaboration of key stakeholders --hospitals, community mental health centers, specialty substance use treatment providers, law enforcement, etc.—to target people with mental illness and substance use disorders who have multiple emergency room visits, spend hours or even days in emergency rooms because they cannot be stabilized, or spend weeks (or months) in acute psychiatric units because there is no suitable community placement.*

17. Develop provider profiling that gives consumers adequate mental health information.

- *DMH has not developed formal provider profiling because of the limited availability of service alternatives to our 170,000 clients. However, the department continues to seek ways to provide broader access to services for consumers. DMH does provide*

a variety of electronic vehicles for consumers to find the services that do exist, including:

- *A DMH website that provides information for users to access community providers in their area, and*
- *Coalition of Community Mental Health Centers (CMHCs) directories for consumers and stakeholders as a source of local information about behavioral health.*

18. Continue to promote local investment in services and supports by county developmental disabilities mill tax boards.

- *The Partnership for Hope (PfH) program described in response to #16 above is an example of leveraging local investment with state and federal resources.*
- *The DMH Division of Developmental Disabilities has also continued to expand local service coordination provided by county developmental disabilities mill tax boards (Senate Bill 40 Boards). In FY 2014, over 55% of the individuals eligible for DD services will be served by a local service coordinator. This initiative brings service coordination closer to individuals and their families.*
- *Other initiatives are in progress as DMH is making further critical changes in its working relationship with County Developmental Boards over the next three years:*
  - *Transferring greater authority for full determination of the services needs of Medicaid-eligible individuals with developmental disabilities being served through the DMH system;*
  - *Delegating fuller accountability for budget management of local, state and federal resources to selected County Boards;*
  - *Developing a risk-sharing financial management system between selected counties and the state for Medicaid-individuals with developmental disabilities needing more expensive residential services; and*
  - *Redefining the role of the state's DD Regional Offices to accomplish the three objectives above.*

19. Continued collaboration among departments to assure that evidence based practices are used in behavioral health programs and that care management technologies are used to promotes efficiency and consumer choice without inappropriate restricting of availability.

- *Pharmacy Management - See response to recommendation #16 above.*
- *In Managed Care, DMH and MHD have worked together to implement evidence-based practices and ensure choice in managed care plans through their joint efforts on the Quality and Improvement Committee. Activities included developing a common set of performance and outcome metrics for behavioral health services and managed care.*

- *Implementing a standardized level of care assessment (LOCUS) to determine adequate length of stay during psychiatric hospitalization and level of services following psychiatric hospitalization.*
- *Assuring that the Paul Wellstone/Pete Domenici Mental Health Parity Act of 2008 is fully implemented.*
- *In its own programs, DMH supports implementation of programs and practices that have proven effective in reducing the impact of behavioral health disorders on individuals and families. Missouri has implemented the following evidence-based practices in the treatment of serious mental illness (SMI) and substance use disorders (SUD).*
  - ***Integrated Treatment** for individuals with co-occurring mental illness and substance use disorders assures that care of people with complex needs is not fragmented.*
  - ***Supported Employment** for people with serious mental illness helps them find competitive jobs.*
  - ***Illness management and recovery** for people with severe mental illness gives them information about mental illness and the skills to help them manage their lives.*
  - ***Assertive Community Treatment** is a round-the-clock, comprehensive, multidisciplinary service for people with serious mental illness who need intensive support to avoid hospitalization.*
  - ***Consumer-Operated Service Programs** are peer-run service programs that are administratively controlled and operated by people with mental illness and emphasize self-help.*
  - ***Dialectical Behavior Therapy** is an approach that focuses on thoughts and behaviors to reduce symptoms for people with hard-to-treat personality disorders.*
  - ***Medication-Assisted Treatment** is the use of FDA-approved medications in treating individuals with alcohol dependence and opiate dependence.*

20. Support a public health approach that emphasizes prevention, early intervention and integration of primary care with basic behavioral health services.

- *The following initiatives are examples of DMH's efforts to move service systems toward more preventive and integrated care:*
  - ***Partnership for Hope** - See response to recommendation #16 above for details about this initiative.*
  - ***DM 3700** - See response to recommendation #16 above for details about this initiative.*

- ***Health Homes*** - *See response to recommendation #16 above for details about this initiative.*

- *SBIRT (Screening, Brief Intervention, and Referral to Treatment) is now in over 100 individual primary care clinic and hospital locations statewide, providing effective strategies to identify persons with risky levels of drinking alcohol or drug use for intervention prior to the need for specialized treatment.*

- *The **Missouri Suicide Prevention Project** (MSPP) is a joint effort between DMH and the Missouri Institute of Mental Health (MIMH) that utilizes community partnerships to provide evidence-based suicide prevention services with an emphasis on gatekeeper training.*

- ***Mental Health First Aid** (MHFA) is an evidence based, internationally recognized 8 to12 hour training provided throughout Missouri, teaching the public how to recognize the early signs of mental illness and direct individuals to help. Over 7,580 Missourians have been trained so far in MHFA, and over 310 individuals have been certified as MHFA instructors.*

- *Since 2005, DMH has implemented a statewide **behavioral health/primary care integration initiative** based on creating partnerships between local community mental health centers (CMHCs) and federally qualified health centers (FQHCs). Four of the state's 29 CMHCs are also FQHCs, and seven others are formally affiliated with their local FQHCs. This initiative has resulted in closer collaborative working relationships between CMHCs and FQHCs in the communities that are served by CMHCs and FQHCs.*

- *Beginning in FY 2014, seven regions of the state will develop **emergency room enhancement projects** as part of the Strengthening Missouri's Mental Health System initiative. The key feature will be collaboration of key stakeholders -- hospitals, community mental health centers, specialty substance use treatment providers, law enforcement, etc.—to target people with mental illness and substance use disorders who have multiple emergency room visits, spend hours or even days in emergency rooms because they cannot be stabilized, or spend weeks (or months) in acute psychiatric units because there is no suitable community placement.*

21. Ensure that DMH is responsible for establishing appropriate standards of care.

- *DMH establishes appropriate standards of care for its own programs and assists DSS through a myriad of programs previously described in responses above, including DM 3700, Health Homes, Partnership for Hope, and Pharmacy Quality Improvement.*

22. Support approaches to strengthen the linkages between federally qualified health centers and community mental health centers.

- *In 2008, DMH created a Primary/Behavioral Health Care Integration Project in collaboration with the Missouri Primary Care Association and the Missouri Coalition of Community Mental Health Centers. Seven local sites were selected across the state, pairing a community mental health center (CMHC) with a federally qualified health center (FQHC). Six of these initiatives involved a separate CMHC and an FQHC in the same city, while one initiative was with a single organization (Crider Center, St. Charles County) which is both a CMHC and FQHC. Funding was provided to co-locate primary care staff at the CMHC and behavioral health staff at the FQHC. Primary objectives in the CMHC setting included: assuring persons with serious mental illness have the same health care screenings, tests, and treatment as the general population appropriate to their age, sex, and risk factors; improving the screening, diagnosis, and treatment of diabetes, hypertension, and dyslipidemia; and promoting smoking cessation.*

Long-Term Care

23. Increase education and outreach efforts to encourage the purchase of long-term care insurance, particularly for younger consumers.

- *Under the Long-Term Care Insurance Partnership programs, individuals purchase long-term care insurance plans. When long-term care is needed, typically later in life, individuals will use the benefits afforded by the insurance plan. This will allow them to retain a certain amount of assets (assets equal to the amount of long-term care benefits paid on behalf of the individual through a long-term care partnership plan) and still qualify for MO HealthNet long-term care benefits, provided all eligibility requirements are met including resources.*

- *This type of program provides an incentive for consumers to be directly involved with health care decisions while protecting individual assets and reducing reliance on publicly funded programs.*

- *The Department of Insurance, Financial Institutions & Professional Registration issued related state policies and regulations regarding the Long-Term Care Partnership Program. Partnership policies became available for purchase August 1, 2008. Information about these partnership plans can be found on the website at http://www.completelongtermcare.com/states/missouri/.*

24. Examine opportunities to participate in the federal long-term care partnership pilot project.

- *Please refer to response for #23 above.*

25. Examine new community-based options and expand the PACE model to other sites in the state and encourage cooperative agreements between all long-term care providers to encourage and promote appropriate options for consumers.

- *The State continues to examine the possibility of expanding PACE when approached by organizations showing an interest in the program.*

26. Examine the use of division of assets for home and community based services for individuals under the age of 63.

- *In 2007, a Home and Community Based Services study was prepared for the Legislature which identified the cost of lowering the age from 63 to 50 at $10.5 million General Revenue dollars. The age limit remains at 63.*

27. Review licensure and oversight requirements for all types of long-term care providers.

- *DHSS staff has oversight of the requirements to ensure that participants are receiving the appropriate level of care for Nursing Home Long Term Care Services as well as Home and Community Based Services.*

- *Nursing Home Services - The Central Office Medical Review Unit (COMRU) is responsible for coordinating the federally mandated Preadmission Screening and Resident Review (PASRR) process. PASRR is required to assure appropriate placement of individuals who seek placement in a certified bed in a Long Term Care facility. The unit staff reviews the pre-screening forms for the individual's assessed needs that are submitted from a hospital, a nursing facility, or other entity. The individual is assigned a Level of Care point count dependant on the level of acuity needed for their care. This is known as the Level I screening process. A Level II screening process is completed for those individuals identified in the Level I process who are known or suspected to have a serious mental illness and/or mental retardation. DMH completes a Level II screening process for those individuals. After DMH completes their process, the COMRU unit notifies the hospital/facility of the determination and whether the individual is appropriate for Skilled Nursing home placement.*

- *Home and Community Based Services - The assessment process utilized to determine a nursing facility Level of Care (LOC) score is based on the information gathered during this process, a numeric score of 0, 3, 6, or 9 points is assigned to each of the nine LOC categories for current or potential participants who are entered into the MO HealthNet Division CyberAccess Home and Community Based Services Web Tool (HCBS Web Tool) system. Determination of LOC is an eligibility factor for authorization of Home and Community Based Services (HCBS). Regardless of an individual's living arrangement (i.e., their own home, Assisted Living Facility (ALF), Residential Care Facility (RCF), or living with others – temporarily or permanently), the LOC scores are determined based on the information entered in the InterRAI HC MO Version. This information documents the amount of assistance required and the participant's complexity of the care. An applicant is determined to be qualified for nursing facility LOC with an assessed cumulative score of 21 points or higher. The LOC score is determined by the*

culmination of behind the scenes calculations (algorithms) assigned to answers given during the PreScreen and Assessment process. The Assessor will utilize the InterRAI HC MO Version, and scan any attachments or documentation of any contacts that support the information entered into the InterRAI HC, which will assist in substantiating the final LOC score.

- *DSS/MMAC credentials and screens all providers including long-term care (LTC) prior to enrolling them to provide Medicaid eligible services. Once the LTC providers have been certified to participate as a MHD provider; additional forms are required before claims may be submitted.*

- *DSS/MMAC determines if the all beds are licensed for participation, as some may be Medicare only. MMAC verifies if the participant had any breaks in stays such as for inpatient hospital care or therapeutic home serve days. MMAC also verifies physicians' orders in the care plan and daily distribution of medications in participants file.*

28. Explore and implement quality control indicators and oversight for licensed Home and Community Based Care provider.

- *DSS/MMAC screens these providers by checking for prior sanctions and restrictions through such avenues as the Health Database, contract review, Office of Inspector General, Secretary of State's Office and complaints, deficiencies or sanctions reported in the ASPEN (DHSS database system) as a State of Deficiency (SOD) prior to enrollment. MMAC reviews different clients, aides and/or employees for previous citations on the Employee Disqualification List (EDL) and Family Care Safety Registry. MMAC also reviews areas such as:*

    - *Deficiencies in care plans;*
    - *Service delivery inadequacies; and*
    - *Physician orders do not match medication set-up or treatment.*

Pharmacy

30. Continue and enhance the collaborative efforts of the Division of Medical Services and the Department of Mental Health through their common partner Comprehensive NeuroScience.

- *Please see the response regarding the pharmacy quality improvement project for recommendations #16 and #19 under Mental Health above.*

Recommendations from the Medicaid Reform Commission

31. Continue to expand and update preferred drug and supplemental rebate opportunities.

- *MHD annually reviews therapeutic classes of medications for inclusion in the MO HealthNet Preferred Drug List (PDL). The PDL review process utilizes information from various clinical sources, including the UMKC Drug Information Center, the Oregon Evidence-Based Drug Research Consortium, MHD clinical contractors, and MHD's clinical research team.*

- *The clinical information is paired with a fiscal evaluation (supplemental rebate bids), then developed into a therapeutic class recommendation. The PDL process incorporates clinical edits, including step therapies, into the prescription drug program.*

- *MHD aggressively solicits and collects supplemental rebates associated with the PDL. Our clinical rules engine allows ongoing review and implementation of therapeutic classes for PDL inclusion; giving the MO HealthNet pharmacy program one of the largest Preferred Drug Lists in the nation, with over 100 classes represented.*

32. Enhance current and develop additional clinical and fiscal on-line edits.

- *Clinical and fiscal edits are designed to enhance patient care and optimize the use of program funds through therapeutically prudent use of pharmaceuticals. Point-of-sale (POS) pharmacy claims are routed through an automated rules engine to apply edits specifically designed to ensure effective and appropriate drug utilization. In most cases, these edits will be transparent to providers and recipients. The goal of these edits is to encourage cost effective therapy within the selected drug class*

- *Smart PA™ is a clinical rules engine which uses a decision tree (algorithm) comprised of criteria derived from best practices and evidence-based medical information to allow transparent approval of service and product requests. It streamlines the prior authorization process for all stakeholders – physicians, allied health professionals and participants - as it adjudicates prior authorizations in real time.*

- *The Smart PA™ rules engine also alerts providers of areas of concern to be addressed by action or intervention to achieve better outcomes.*

- *Smart MedPA™ processes precertifications for durable medical equipment, radiology and optical services. MHD has begun rolling out behavioral health services into the rules engine to ensure appropriate utilization and efficient use of funds.*

- *MO HealthNet's improved POS computer system allows each claim to be referenced against the participant's pharmacy claims history, medical claims history (including ICD-9 codes), and procedural data (CPT codes) transparently. For those patients that meet the approval criteria, the claim will be paid automatically. In the rare instances when a phone call is necessary, our responsive hotline call center is available seven days a*

week. Monday through Friday 8am to 9pm. Saturday and Sunday 8am to 6pm at 800-392-8030.

33. Improve and expand step therapies as supported by best practice and current medical evidence.

- *Please refer to response for #31 under Pharmacy*

34. Update and expand MAC pricing of generically available products.

- *The State Maximum Allowable Cost (MAC) is defined as the maximum per unit price the state agency will pay for multi-source drugs that are of the same chemical content, dosage and form. Since the early 2000's MO HealthNet has been an industry leader, building an aggressive MAC program. These MAC prices are set based on an analysis and clinical review of the state agency's pharmacy claims history to determine and recommend to the state agency a list of generic drugs to apply a MAC program. The prices are updated quarterly.*

35. Expand cost avoidance through required third party billing.

- *MO HealthNet began editing pharmacy claims for those participants who have primary third party coverage in September 2005. MO HealthNet denies payment if the active third party pharmacy insurance on file for the participant is not billed prior to submitting the claim to MO HealthNet. If the provider learns of new insurance information or of a change in the third party liability (TPL) information, the system allows submission of the primary insurance information to the MO HealthNet agency to be verified and updated on the participant's eligibility file.*

- *In July 2011, the State contracted with Health Management Systems as the TPL Fund Recovery vendor. The contract was shifted from a cost recovery to a cost avoidance focus. MO HealthNet is the payor of last resort. Cost avoidance occurs when providers' claims are submitted to the primary payor before being considered for payment by MO HealthNet. Cost avoidance is more cost effective than cost recovery. Cost recovery is also known as pay and chase. This method requires the State or its contracted vendor to pursue recovery from any liable third party resource for MO HealthNet payments made for participants' medical expenses.*

36. Support targeted prior authorization with as much transparency as possible.

- *Please refer to response for #10 under Provider Participation and Satisfaction and response for #32 under Pharmacy.*

37. Continue maximizing other processes already in place that ensure maximum cost containment and appropriate drug usage based on best practices and current medical evidence.

- *Please refer to responses for #31 and #32 under Pharmacy.*

Improving Availability of Quality Care

38. Assist communities in starting or expanding FQHCs through technical assistance for the grant process.

- *MHD supports the efforts of the Missouri Primary Care Association (MPCA), the state's FQHC association. MPCA meets with community leaders to assess area health needs that FQHCs can provide; assists with building support for potential FQHC sites; and identifies available federal, state, and local resources for establishing an FQHC in the community.*

- *Through the FQHC Distribution appropriation, DSS contracts with MPCA to provide FQHCs with expansion and oral health grants for $2.7 million. The grants provide equipment for FQHC infrastructure and personnel to expand access by: 1) Supporting nontraditional hours of operation (weekend and special evening hours). FQHCs recognize that many Missourians do not have the luxury of accessing care during normal business hours; 2) Defraying the costs of caring for the uninsured. FQHCs are required to accept uninsured patients as they do insured patients; and 3) Funding staff and infrastructure to provide services not usually accessible to FQHC patients such as dental services.*

39. Explore a dental care carve-out program from the coordinated care program

- *During the 2013 Legislative Session, Senate Bill 127 provided the MO HealthNet Division the opportunity to pursue a statewide dental delivery system to ensure participant access to providers of dental services under MO HealthNet.*

- *Under the current Managed Care delivery system, the Managed Care health plans contract with a health benefit manager for dental services.*

41. Require the Division of Medical Services to participate in the Missouri Quality Award process.

- *MHD, in partnership with DMH and the Coalition of Community Mental Health Centers, won a **2012 Governor's Award for Quality and Productivity** for the DM 3700 Project, which focused on reducing costs by improving the quality of care of MHD participants with serious mental illness and multiple chronic health conditions. The project won the Pinnacle Award, which "is awarded to a project that clearly encompasses multiple award*

categories in a manner that exemplifies the spirit of the Governor's Award, or exceeds all other nominations." MHD has also recently submitted the health home program for consideration for the 2013 Governor's Award for Quality and Productivity.

Eligibility

42. Maintain flexibility to allow for the appropriate use of state funds to meet the healthcare needs of Missourians.

   - *Flexibility has been tempered in the last few budget cycles with the removal of Estimated "E"s on some appropriation sections.*

43. Establish a new Disabled Employee's Health Assistance Program (DEHAP).

   - *The Department of Mental Health has taken no action on this item.*

Recommendations from the Medicaid Reform Commission

Long-term implementation (more than 2 years)

Wellness, Prevention and Responsibility

1. Create data and automation systems that provide critical information about the population served, financial issues, critical management information and health outcomes to support decision making by factual information.

   - *MHD is in the process of evaluating mechanisms by which to transform the claims and encounter data that it receives into a format that is more applicable to assessment of clinical patient status and outcomes on an individual, group, and population level. Several data bases have been developed, for example for managed care and the health home programs, with work also underway to align fee for service benchmarks and measures with managed care benchmarks and measures. This will also involve linkages with other existing state databases, for example those coordinated by DHSS. In addition, the quality grant that MHD received will facilitate the ongoing development of MHD's quality and analytical infrastructure. With this enhanced infrastructure, MHD can perform heightened continuous surveillance and quality improvement of the system, including analysis of population health characteristics, MHD program performance, leading MHD expenditures, and leading diagnoses and conditions to facilitate evidence-based decision making.*

3. Integrate prevention into the use of technology through electronic medical records to empower individual and community level health decision and integrations/coordination of care by providers.

   - *To promote participation in the statewide and nationwide exchange of health information, the DSS applied for and received a HITECH grant from ONC to establish a statewide Health Information Network (HIN) for Missouri. The MO-HITECH Board created the Missouri Health Connection (MHC) to create and administer the Missouri Health Information Network. Medicaid participation in the statewide HIN is considered to be a key factor in the HIN's overall success. This participation includes the sharing of Medicaid claims data through a patient query function with the providers participating in the statewide HIN. To promote the use of electronic health records by healthcare service providers for prevention and quality improvement, the State of Missouri has elected to participate in the Medicaid Electronic Health Record (EHR) Incentive program funded through HITECH. MO HealthNet recognizes that provider adoption and utilization of EHRs is an initial step toward meaningful statewide Health Information Exchange (HIE) in Missouri. Eligible Professionals (EPs) and Eligible Hospitals (EHs) must meaningfully use certified EHRs and participate in health information exchange to be eligible for incentive payments. EPs and EHs participating must demonstrate that they have adopted, implemented or upgraded a certified EHR or demonstrated meaningful use. Incentive payments may also be disbursed to providers who demonstrate meaningful use for an additional five years culminating in 2021.*

Recommendations from the Medicaid Reform Commission

- *MO HealthNet has developed five year goals and objectives for the Medicaid program. MO HealthNet's vision and ultimate goals for the State of Missouri are to improve population health outcomes and quality of healthcare for Missourians' using clinical information obtained through adoption, implementation, or upgrade of certified EHR technology, while ensuring provider and member access to health information through MHC's HIN*

  - *Share Medicaid claims data with any participants in the statewide Health Information Network allowing them to view and/or consume this data into their EHRs.*

  - *Administer the Missouri Medicaid EHR Incentive Program to promote and encourage provider adoption of EHR technology and achieve meaningful use.*

  - *Encourage and promote provider participation with MHC to ensure care coordination and use this means for achieving meaningful use.*

  - *Ensure options are available to all Missouri Medicaid health care service providers for participation with MHC for sharing and viewing/consuming clinical data ("No Provider Left Behind"). There are two solutions planned through MHC: 1) A portal for providers to query and view data from website; and 2) MHC will form a qualified HIE to allow provider EHRs to view and consume data directly through the statewide HIN functionality.*

  - *Participate with MHC in the design and development of a statewide Provider Registry and identify opportunities to leverage the registry to support the Missouri Medicaid Program.*

  - *Engage in collaborative partnerships with organizations such as the MHC, Missouri HIT Assistance Center (the AC), Missouri Primary Care Association, Missouri State Medical Association, Missouri Hospital Association, and others to promote EHR adoption and utilization and provider participation with MHC.*

- *MO HealthNet will leverage the products and services offered by MHC's HIN to improve the efficiency and effectiveness of the Missouri Medicaid Program and maximize the value of the MHC. MO HealthNet will share Medicaid claims data, making it available to healthcare providers for viewing and consumption into their EHRs to improve prevention and care coordination among providers. MO HealthNet and state agencies, including DHSS and DMH. MO HealthNet is working closely with its partners in the Missouri Medicaid Enterprise (MME) to identify opportunities to improve program administration through the exchange of health information within the MME and with Medicaid providers. These opportunities include the deployment of Direct Secure Messaging (Direct) for MME staff, the creation of an HIN within the MME to facilitate exchange of health*

information between partners and to manage the flow of Medicaid data through the statewide HIN, and the development of HIN functionality to support key Medicaid business functions including prior authorization and pre-certification of participant services.

- *Through the health home program, MHD is evaluating primary and secondary preventive measures, including childhood immunization, weight assessment, diabetes, and cardiovascular disease indicators. The primary care health homes are required to have electronic medical records (EMR) and to maintain this data in their EMR's. As the primary care health home program continues to evolve, it will most likely incorporate additional evidence-based preventive measures. In addition, MHD has established goals for performance on these benchmarks for the health homes. MHD has been educating the health homes on population health management principles via webinars, and the health homes are making the transition from thinking in terms of individual health to community and population health. As this transition continues, the health homes' capability to bring to bear the data in their EMR's and its analysis and application to affect community health grows.*

Provider Participation and Satisfaction

4. Explore mechanisms to prevent provider fraud.

   - *Please refer to response for #8 under Short term Implementation, Provider Participation and Satisfaction section*

5. Restructure provider reimbursement rates.

   - *Section 208.152.1(24) of the Revised Statues of Missouri requires the MO HealthNet Division (MHD) to annually report the status of MO HealthNet provider reimbursement rates as compared to one hundred percent of the Medicare reimbursement rates and compared to the average dental reimbursement rates paid by third-party payors licensed by the state. The MHD has submitted rate studies each year since January 1, 2008.*

   - **Provider Rate Reimbursement**

     - *Durable Medical Equipment (DME) Program Reductions - Due to significant revenue shortages, in calendar year 2010 reductions were made to the DME Program fee schedule. The first reduction was effective April 15, 2010 for a projected savings of $5.8 million. The reductions included the following:*

       - ✓ *Reduce any code over 100% of the Medicare fee schedule to 100% of the Medicare fee schedule;*
       - ✓ *Reduce reimbursement for 3 highly utilized wheelchair codes;*
       - ✓ *Reduce certain manually priced items by 5%;*

- ✓ *Implement policy changes to reduce nursing home wheelchair utilization.*

- *The second round of fee schedule reductions was effective August 15, 2010 for a projected savings of $3.9 million. The reductions included the following:*

  - ✓ *Oxygen payment restructure;*
  - ✓ *Further reductions in nursing home wheelchair utilization;*
  - ✓ *Reduction to 96.5% of the Medicare fee schedule (excluding complex rehab);*
  - ✓ *Change payment structure for hospital beds to rent-to-purchase;*
  - ✓ *Eliminate back-up wheelchairs for patients with manual wheelchairs;*
  - ✓ *Eliminate authorization of safety equipment.*

- *Physician Program Adjustments - In July 2007, physicians were given a rate increase by the Legislature. In 2007, all procedure codes billed by physicians not at 55% of Medicare's rate were increased to 55%. The plan at the time was to achieve 100% of Medicare's rate in four years.*

- *In July 2008, physicians were given a rate increase by the Legislature. All procedure codes billed by physicians not at 62.5% of Medicare's rates were increased to 62.5%.*

- *In January 2010, all procedure codes reimbursed at greater than 90% of the Medicare fee schedule were reduced to 90% of the Medicare fee schedule.*

- *On April 18, 2013, CMS approved Missouri's State Plan Amendment adding language to increase payments to certain physician specialties for primary care evaluation and management healthcare common procedure system codes as required by Section 1202 of the Affordable Care Act. The law defines covered services as those evaluation and management codes and immunization services that are covered by Medicare, as well as primary care codes that Medicare does not currently cover but for which it publishes and sets relative value units. The law provides 100% federal funding for the incremental cost of meeting this requirement. The 100% federal funding of the incremental cost is calculated based on the Medicaid rate as of July 1, 2009. The MO HealthNet Division began making the enhanced payments to eligible providers in May 2013.*

- *Dental Program Reimbursement - The Dental Program fee schedule is currently at 38.5% of the 50th percentile of the usual and customary rates published in the 2008 National Dental Advisory Service Comprehensive Fee Report. This is after fee schedule rate increases effective July 1, 2008 and July 1, 2009.*

- *Effective July 1, 2013, MHD is making the following changes in the Dental Program:*

  - ✓ *Adding coverage of a procedure to facilitate eruption of an impacted tooth;*

- ✓ *Reducing reimbursement of porcelain/ceramic substrate crowns to maintain budget neutrality while expanding coverage to include posterior teeth as well as anterior teeth;*
- ✓ *Removing restrictions regarding restoration of an occlusal surface after placement of a sealant.*

- *Hospital Program Reimbursement - MHD is reviewing hospital inpatient and outpatient reimbursement systems with the assistance of independent consultants. MHD is still in the process of evaluating the inpatient reimbursement to determine if or what type of changes would be best for Missouri. MHD is also currently reviewing the outpatient reimbursement system to evaluate a grouper type of reimbursement methodology compared to the current percentage-of-charge method.*

- *On October 1, 2011, MHD changed reimbursement for non-cardiac catheter radiology services from a percentage-of-charge method to a fee schedule.*

- *Nursing Facility Program Reimbursement – In FY 2010, MHD filed amendments to the nursing facility regulations to implement a change in the reimbursement of Medicare/Medicaid crossover claims for Medicare Part A and Medicare Advantage/Part C inpatient skilled nursing facility benefits. Effective for dates of service beginning April 1, 2010, MHD no longer automatically reimburses the coinsurance or cost sharing amount determined by Medicare or the Medicare Advantage Plan for inpatient nursing facility services. MHD determines the MO HealthNet reimbursement for the coinsurance or cost sharing amount of crossover claims which is limited to the FFS amount that would be paid by MHD for those services. For FY 2010, the estimated savings was $6.7 million and the estimated cost savings annually thereafter was $40 million.*

6. **Explore a tiered level of co-pays to assist with patient compliance and empowerment.**

- *MO HealthNet continues to review the level of cost-sharing by participants to maintain compliance with state and federal laws and regulations. The federal government has long allowed states to impose cost sharing on certain Medicaid beneficiaries as long as it was "nominal". The Deficit Reduction Act of 2005 gave the states the ability to apply additional, "alternative" premiums and cost sharing for certain higher income beneficiaries. On January 14, 2013, CMS issued a proposed rule intended to simplify what cost sharing limits states may impose.*

- ***Current Cost Sharing** - Under current law Missouri does impose co-payments for Medicaid services provided. The current co-pays provided for in the Missouri regulation are capped at $3 for most services and $2 for pharmacy services. Total cost sharing may not exceed an aggregate limit of 5% of a family's income. For a family of three at 100% of the federal poverty level (FPL) this would be $954.50. Co-payments for*

hospital inpatient services are charged at the rate of $10 per hospitalization, applicable to the first day of the Medicaid-covered hospital stay.

- ***Exemptions from Co-Payments*** *- The following populations are exempt from the Medicaid co-payment requirement:*
  - *Children under nineteen (19) years of age;*
  - *Residents of nursing facilities;*
  - *Beneficiaries with both Medicare and Medicaid coverage when Medicare pays for the service;*
  - *Pregnant women;*
  - *Blind persons; and*
  - *Foster Care Recipients.*

- *The following services are among those exempt from the Medicaid co-payment requirement:*
  - *Emergency inpatient hospital transfer;*
  - *Emergency room care when life threatening conditions present;*
  - *Therapies such as chemotherapy services;*
  - *Personal care services;*
  - *Mental health services;*
  - *Hospice care;*
  - *Managed Care Services;*
  - *Family Planning Services; and*
  - *Medicaid Waiver Services.*

- ***Proposed Federal Rule Changes*** - *Under the proposed rules, states may increase cost sharing maximums for most Medicaid services as shown in the tables below. Under the proposed rule, it is still the responsibility of the healthcare provider to collect the co-payment. The proposed rule also does not change the current cap (5% of family's income) on the total amount an individual can be required to pay.*

	Individuals with family income ≤ 100% FPL	***Individuals with family income 101-150% FPL***	***Individuals with family income > 150% FPL***
Outpatient Services	*$4 (starting in 2015, to be increased by the medical care component of the CPI-U)*	*10% of cost the agency pays*	*20% of cost the agency pays*
Inpatient stays	*50% of cost the agency pays for the first day of care*	*50% of cost the agency pays for the first day of care or 10% of total cost the agency pays for the entire stay*	*50% of the cost the agency pays for the first day of care or 20% of the total cost the agency pays for the entire stay*

	Individuals with family income ≤ 150% FPL	***Individuals with family income > 150% FPL***
Preferred Drugs	*$4*	*$4*
Non-Preferred Drugs	*$8*	*20% of cost the agency pays*
Non-emergency use of an emergency department	*$8*	*No limit*

7. Centralize and integrate claims systems as to prevent provider fraud.

- *MHD has not yet been able to centralize and integrate additional claims systems outside of the Medicaid system, but is working on the following initiatives that have or will allow MHD access to additional clinical and claims data:*

- *Participation in the statewide Health Information Network (HIN) for Missouri will allow Medicaid access to additional clinical data regarding Medicaid participants that will provide a more holistic view of the care provided. In addition to supporting care coordination and case management efforts, the additional data will support prior authorization and pre-certification functions that evaluate the necessity of the care provided prior to authorization for payment.*

- *MHD implemented new electronic claim transaction formats as required by the federal government. These new formats required providers to submit additional third party liability data regarding the claims prior to payment by Medicaid.*

- *MHD is implementing the new International Classification of Diseases diagnosis and procedure codeset version 10 (ICD-10) as required by the federal government. The ICD-10 codesets contain a significant amount of additional information over the current ICD-9 codesets that will allow the Medicaid Programs to improve detection of provider fraud.*

- *For quality improvement purposes, CMS has offered additional Medicare claims data related to Medicaid participants to the Medicaid Programs. MHD will be exploring the possibility of integrating the additional Medicare claims data into the Medicaid claims data warehouse.*

Coordinated Care

8. Expand coordinated care to the ABD population through a pilot program.

   - *Since 2008, DMH has expanded coordinated care through the DM 3700 and Health Homes projects. The majority of persons served in each are part of the ABD population. These programs are described in detail under recommendation #16 in the Short-term Implementation, Mental Health section.*

9. Establish an administrative services organization (ASO) to run the coordinated care for the ABD population through a pilot program in existing coordinated care areas.

   - *A virtual ASO is a public/private, payer/provider partnership that effectively integrates state agency and provider service delivery operations. Both the DM 3700 and Health Home initiatives are supported by a virtual ASO consisting of the following partners:*

     - *DMH and MHD - leadership, project oversight, final operational authority, project management and operational support;*

     - *Coalition of Community Mental Health Centers and Missouri Primary Care Association - technical assistance, practice coaching, training;*

- *Care Management Technologies and Xerox - health information technology support for analysis, benchmarking, and IT-based care coordination and care management tools.*
- *Missouri Institute of Mental Health - project management and operational support, outcome analysis, and project evaluation.*

Technology

10. All Medicaid providers should have E-Prescribing capabilities in their offices within five years.

    - *E-prescribing is a specific functionality required by EHR systems used by providers participating in the incentive program. Over time providers must show that increasing percentages of their patients are given prescriptions through systems that check formularies electronically and submit prescriptions electronically. In addition, MHD offers an e-prescribing function through MHD's CyberAccess provider web portal for prescriptions issued to MO HealthNet participants.*

11. All Medicaid providers should have Electronic Medical Records within ten years.

    - *At least 2,143 professionals and 91 hospitals participating in the Medicaid EHR Incentive Program are currently utilizing EMRs that meet specific functionality requirements. As the program is in the second of ten years, it is expected that more professionals and hospitals will adopt this technology over time.*

Mental Health

12. Seek Medicaid waivers to assure that an appropriate array of services and supports are available for individuals with developmental disabilities and (2) serious mental illnesses or emotional disorders who are eligible through the PTD category.

    - *The DMH Division of Developmental Disabilities sought and was approved for the Autism Waiver in 2009.*
    - *The DMH Division of Developmental Disabilities sought and was approved for the Partnership for Hope Waiver in 2010.*
    - *DMH is now exploring the possibilities for developing a new Missouri Home and Community-Based Waiver focused on Medicaid-eligible individuals with co-occurring developmental disabilities and serious mental illnesses.*
    - *The DMH Division of Developmental Disabilities operates three additional Medicaid Waivers for people with developmental disabilities: Comprehensive, Support, and Lopez.*

Recommendations from the Medicaid Reform Commission

13. Implement a pilot coordinated care program by DMH for individuals with serious mental illnesses.

- *DM 3700 was implemented in November 2010 and Health Homes was implemented in January of 2012. These coordinated care programs for persons with serious mental illness are described in detail under recommendation #16 in the Short-term Implementation, Mental Health section above.*

14. Support local investment in mental health services and supports, and to develop mechanisms that reduce fragmentation at the local level and appropriately balance state and local control

- *Partnership for Hope combines local investment (99 County Disability Boards) with state and federal funds to expand services for persons with developmental disabilities. This program is described in detail under recommendation #16 in the Short-term Implementation, Mental Health section above.*
- *The DD Division has continued to expand service coordination provided by county developmental disabilities mill tax boards. In Fiscal Year 2014 over 55% of the individuals eligible for the DD services will be served by a local service coordination provider.*
- *The Division of Behavioral Health partners with county mill tax boards that provide state match to increase the availability of Medicaid reimbursable behavioral health services. County contributions for substance use disorder treatment and mental health care total $1.6 million annually.*

15. Promote the use of new technologies, such as telemedicine and electronic medical records.

- *DMH in partnership with MHD has implemented new health information technology care coordination and care management tools that allow both community mental health centers and primary care practices to monitor and follow-up on individuals discharged from the hospital.*
- *DMH is developing an EHR system in its state psychiatric hospitals and exploring a similar system for its state-operated developmental disabilities programs.*
- *DMH has implemented statewide telepsychiatry services for deaf persons and supports telepsychiatry in Community Mental Health Centers by its regular reimbursement methods.*

16. Incentives are developed to promote expansion of employer sponsored benefit plans that include coverage of basic behavioral healthcare.

- *Incentives were created at a national level for two initiatives that DMH and the Department of Insurance, Finance and Professional Registration (DIFP) are collaborating on managing in Missouri:*
  - *The federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires parity between mental health or substance use disorder benefits and medical/surgical benefits with respect to services covered, treatment limitations, co-pays and deductibles. DMH has advised DIFP on areas of Missouri statute that are currently inconsistent with MHPAEA.*
  - *The Affordable Care Act requires that benefit plans for any newly covered populations must comply with the parity requirements of MHPAEA and that medically frail persons (including people with serious mental illness and developmental disabilities) receive the full range of specialized services required by their condition. DMH is collaborating with DIFP to assure that Missouri meets these requirements.*

Long-Term Care

17. Create a mechanism that educates and informs consumers about all of their options for receiving long-term care.
19. Establish a single point of entry that includes a statewide-standardized assessment, evaluates the needs of the individuals and provides information about all long-term care options that are available.

The response below is applicable to the above two recommendations.

- *Missouri was awarded the Balancing Incentive Program Grant on June 13, 2012. The goals of the program are: 1) Keep Missourians in their homes as long as possible by providing less costly in-home services; and 2) Shift spending from institutions to the community so at least 50% of all long-term care dollars are spent on services delivered in the community.*

- *The program requires the following:*
  - *No Wrong Door/Single Entry Point - Makes it easier for Missourians to access information and make connections to services in their community through a website, toll-free number, and at state office locations including DSS/Family Support Division offices, DMH Regional offices, and DHSS Regional offices*
  - *Core Standardized Assessment - Requires all individuals needing community long-term care services to be evaluated using the same criteria (activities of daily living, instrumental activities of daily living, medical conditions/diagnoses, cognitive*

functioning, behavioral concerns, etc.) no matter where they enter the system. A new initial screening process is being developed to quickly refer individuals to the state entity that can best meet their needs.

18. Examine the pathway to safety issue to encourage safety and the placement in the least restrictive environment.

- *CMS awarded a Money Follows the Person (MFP) Demonstration grant to Missouri in January, 2007. The demonstration grant has been renewed through September 30, 2016 with an additional four years to spend any awards.*

- *The MFP Rebalancing Demonstration grant will support state efforts to "rebalance" their long-term support systems. The five-year demonstration will support state efforts to:*

  - *Provide people the choice of where they live and receive services;*
  - *Allow people living in nursing facilities or habilitation centers to move to the community; and*
  - *Promote a system that is person centered, based on needs, and ensures high-quality services in both the community and care facilities.*

- *Through MFP, Missouri plans to transition individuals from nursing facilities or habilitation centers to the community. People who want to move into the community will receive help with the planning from transition coordinators including finding housing, applying for community supports, and setting up their new household.*

- *Participants must meet the following criteria:*

  - *Have lived in a state habilitation center or nursing facility for a period of at least six months;*
  - *Be MO HealthNet eligible in the care facility for at least one month;*
  - *Transition to a house that is leased or owned by the participant or participant's family, or move to residential housing with no more than four individuals living in the house.*

- *People who qualify will participate in the demonstration for a year. At the end of the demonstration period, they will continue to receive home and community services and supports through the regular MO HealthNet program as long as they continue to be eligible for those services.*

- *Below are the statistics on the program:*

Calendar Year	Total # MFP Transitions
2007	7
2008	59
2009	138
2010	92
2011	142
2012	226
2013	82 (as of 7/5/13)
Total	749

20. Utilize technology to better manage information about long-term care consumers and plan for future needs.

- *Some of the structural changes that are part of the Balancing Incentive Program utilize technology to make it easier for Missourians to access information and make connections to services in their community through a website that is being developed. The website will provide information on all long term care options as well as a toll-free number.*

21. Revise the Medicaid nursing home reimbursement system to take into account the acuity of the residents in the facility.

- *During the fall of 2011, the State of Missouri developed strategy teams to work on a Long Term Care Modernization Project. Several state agencies, including DSS, DHSS, and DMH, are working in conjunction with the nursing home industry, other stakeholders and contracted consultants, to undertake a large scale, multifaceted project to modernize Missouri's long term care system. One facet of the project is to review Missouri's reimbursement system to determine whether changes to the system, such as acuity adjustments and incentives, are necessary to meet the changing consumer demands by maximizing community-based, long-term care options while maintaining adequate traditional bed space. This is a long-term project and the work will continue throughout FY 2014.*

Pharmacy

22. Support the inclusion of new technology as it becomes available especially in the areas of electronic prescribing and electronic medical records.

- *Please refer to response #5 under Top Medicaid Executables.*

- *A specific EHR functionality required for providers participating in the incentive program is e-prescribing. Over time providers must show that increasing percentages of their patients are given prescriptions through systems that check formularies electronically and submit prescriptions electronically.*

Improving Availability of Quality Care

23. Ensure that all Medicaid participants have availability to a Medical Home where a primary care case manager will be available to assist in their healthcare decisions.

- *Section 2703 of the Affordable Care Act passed in 2010 allowed states to amend their Medicaid State Plans to offer health home services for Medicaid recipients with certain chronic conditions and risk factors. Missouri submitted two such amendments that were approved - one to develop a behavioral health home initiative through community mental health centers, and the other to develop a primary care health home initiative using federally qualified health centers, rural health clinics and other hospital-based clinics. See responses to #7 under Top Medicaid Executables and #1-3 under Wellness, Prevention and Responsibility in the Short-term Implementation section for more information.*

- *In the future, the scope may be broadened to include additional complex, high cost populations that require more intensive care management and coordination. Likewise, MHD will evaluate its population to identify those that would benefit from a health home approach and those that would benefit from a more traditional medical-home care management and coordination approach through enhancements in the managed care program and fee-for-service population.*

24. Fund and/or facilitate public-private partnerships to promote the availability of healthcare, such as the examples stated above.

- *As described throughout our responses above, DSS and DMH have funded and/or facilitated a number of public-private partnerships to promote the availability of both mental and physical health care. Some examples include:*

  - *Created Health Homes (described earlier) in community mental health centers for people with serious mental illness and co-occurring medical problems.*
  - *Collaborated with FQHCs to co-locate physical and behavioral health staff.*
  - *Transferred underfunded state-operated acute psychiatric beds to Truman Medical Center (Kansas City) and University of Missouri Health Center (Columbia).*
  - *Partnered with SSM and BJC health systems in St. Louis to create the Psychiatric Stabilization Center (PSC) following closure of state-operated acute psychiatric beds in St. Louis.*

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MISSOURI SENATE

Rob Schaaf
District 34

December 3, 2013

The Honorable Gary Romine
State Senator
Missouri State Capitol
Jefferson City, MO 65101

Dear Chairman Romine:

Thank you for your hard work chairing the Missouri Senate Interim Committee on Medicaid Transformation and Reform. I greatly appreciate the attention you gave to the concerns I voiced during the November hearing. While I understand that you would like all committee members to sign the report as submitted, I fear signing it would give my tacit approval to all the recommendations, both good and bad. So instead of signing the report as submitted, I am providing this letter as an appendix to the report for clarity. I like a good number of the fourteen recommendations contained in the report, but it is important to me to clearly outline the recommendations I oppose.

I strongly oppose expanding the MoHealthNet managed care program, especially for the aged, blind and disabled population. Those individuals face too great a risk when forced to fight a managed care bureaucracy. I am not convinced that managed care saves the state money at all. I believe that expanding it would cause needed care to be rationed to those most needy in our society, while enriching managed care companies. That said, I also believe if there is to be managed care, it should be provided in the setting of health savings accounts that provide the benefits outlined in the committee report.

I am not confident that accountable care organizations will provide a benefit to the state. The data on accountable care organizations are mixed and there is real danger that they could be harmful to our recipients.

I am very supportive of efforts to decrease emergency room overutilization, enforce participant abuse investigations (which we learned that the Medicaid fraud unit does not

do), increase the asset limit, fund coverage for dental care, and reform the payment methodologies for hospitals.

I also thank you for accepting my recommendations of enacting tort reform and putting transparency in the health care market. I have some mixed feelings about the rest of the recommendations, but I know the 'devil is in the details' as to whether or not I would wholeheartedly support them.

I hope this adds clarity to my general support for the document.

Sincerely,

Rob Schaaf
State Senator
District 34

MISSOURI SENATE
MINORITY CAUCUS

State Capitol, Room 318, Jefferson City, MO 65101
TEL. (573) 751-4473 FAX (573) 751-7638

December 15, 2013

The Honorable Senator Gary Romine
Missouri Capitol, Room 334
Jefferson City, Missouri 65102

Dear Senator Romine:

In accordance with your instructions pursuant to the establishment of the Senate Interim Committee on Medicaid Transformation and Reform, the minority members of the committee have conducted a thorough review of the facts and testimony. We respectfully decline to sign the report submitted by the committee. Please consider the contents of this correspondence to be our policy recommendations and observations of the work of the committee.

Please feel free to contact the undersigned members of the committee if you have any questions.

Sincerely,

Joe Keaveny Paul LeVota Jamilah Nasheed.

cc: Terry Spieler, Secretary of the Senate.

EXECUTIVE SUMMARY

The Senate Interim Committee on Medicaid Transformation and Reform has failed to fulfill its stated purpose, which, according to the committee's webpage was to improve "system efficiency, financial stability and delivery of care." The committee's report is not based on the actual testimony and information presented to the committee as it ignores those who testified regarding Medicaid expansion in Missouri.

When minority members requested the committee report contain information regarding Medicaid expansion they were told such a subject was "not under the purview of the committee's responsibility" despite the fact that 52.4% of the committee testimony related to Medicaid expansion. After rejecting the topic of Medicaid expansion, the committee added Tort Reform to the report's Recommendations section despite a complete lack of committee discussion and witness testimony on the matter.

Healthcare service delivery is far too important in terms of lives, jobs, and the economy for the minority members of this committee to be complicit in the majority's lack of seriousness in crafting meaningful healthcare policy. This letter seeks to correct the committee's oversight by providing information based on the actual testimony presented to the committee. This letter recommends that:

- Medicaid eligibility be expanded to those citizens with incomes up to 138% of Federal Poverty Level;
- A hybrid approach based on the "premium assistance" model be adopted if traditional Medicaid expansion is not politically feasible;
- Certain recommendations from the Majority Report be enacted along with Medicaid expansion, including: extending current Managed Care programs; transitioning populations currently in the fee-for-service programs into regionally-based Accountable Care Organizations; and reforming hospital payment structures; and
- Certain other recommendations from the Majority Report be enacted regardless of whether Medicaid is expanded, including: coordinating care for dual eligible individuals; better management of "super utilizers"; decreasing emergency room over-utilization; strengthening Missouri's MO HealthNet False Claims Act; increasing the asset limit; and adding preventive dental services for adults and the disabled.

INTRODUCTION

At the conclusion of the First Regular Session of the 97th General Assembly, President Pro Tempore Tom Dempsey, pursuant to powers afforded to him under Senate Rule 31, established the Senate Interim Committee on Medicaid Transformation and Reform. The interim committee's webpage states that "The committee was established with the goal of reforming Medicaid by improving system efficiency, financial stability and delivery of care." The committee was charged with issuing a report and making recommendations to the general assembly for legislative action no later than December 15, 2013.

It has now become apparent that the Senate Interim Committee on Medicaid Transformation and Reform has failed to fulfill its stated purpose.

The usual and proper course of action for Senate interim committees is as follows:

1. Senate leadership identifies an often difficult public policy issue and tasks an interim committee with investigating said issue;
2. The committee takes public and expert testimony regarding said issue;
3. The committee considers all of the relevant information gleaned from said testimony; and
4. After careful deliberation, the committee issues a well-reasoned report with recommendations for legislative action based on the testimony and information presented to the committee.

While the Senate Interim Committee on Medicaid Transformation and Reform did undeniably follow those first two steps, the committee has utterly failed to follow the latter two steps. The committee's report is not based on the actual testimony and information presented to the committee. Specifically, the report all but ignores the experts and citizens who testified both for (93.9%) and against (6.1%) the expansion of Medicaid in Missouri. The report not only fails to discuss Medicaid expansion in its "Recommendations" section, it also under-reports the numerous arguments presented to the committee in favor of expansion. Nowhere in the report is there mention of the costs (in terms of dollars, jobs, or lives) of failing to expand Medicaid despite the numerous witnesses who testified regarding such. It should also be noted that the two individuals testifying in opposition to Medicaid expansion have also been disenfranchised by the committee's incomplete and inaccurate report.

Observing this omission in the draft committee report, the minority members of the committee asked for the inclusion of the following statement to the report:

> "The majority of the testimony before this committee stated that in order to save Missouri money and increase access to healthcare, the state should expand Medicaid to 138% of the federal poverty level and accept the federal moneys associated with such."

Note that this suggested addition to the report is not a recommendation by the committee to expand Medicaid, but purely a statement of historical fact. And those facts[1] are clear:

Of the 63 people who appeared before the committee:

- Number of people testifying regarding expansion: **33**
- Percentage of people testifying regarding expansion: **52.4%**
- Percentage of those in favor of expansion: **93.9%**
- Percentage of those against expansion: **6.1%**
- Percentage of those testifying who were told that their Medicaid expansion testimony was beyond the purview or the auspices of the committee: **0%**

In response to the minority members' request to amend the report, the committee chair replied that "Medicaid expansion was not under the purview or the auspices of this committee's responsibility." In other words, despite the fact that 33 individuals (52.4% of the total witnesses) testified regarding Medicaid expansion, their testimony was apparently wholly irrelevant – a fact they were not apprised of before or during their testimony.

Another proposed addition to the report by the minority members (which simply stated that the General Assembly should consider waiver options for expansion) was also rejected by the committee using the same "beyond the purview" argument. This rejection squarely contradicts one of Senator Dempsey's direct charges, which tasked the committee with exploring "how coverage for MO HealthNet participants can

[1] See Appendix A for a complete list of those of testified in favor, against, or expressed no opinion on Medicaid expansion. This tally does not include the 1700+ signatures on the petition favoring Medicaid expansion given to the committee by Jeanette Mott Oxford, Executive Director of the Missouri Association of Social Welfare.

resemble that of commercially available health plans while complying with federal Medicaid requirements." Senator Dempsey's goal can only be achieved via a federal waiver.

To this end, the committee never bothered to discuss the plan being crafted in the Missouri House by State Representative Jay Barnes (Republican – Jefferson City). Rep. Barnes' plan is similar to the Arkansas and Indiana "Premium Assistance" models, as it envisions adding adults with incomes below the poverty level to the traditional Medicaid system while also drawing down federal dollars to assist those earning between 100% and 138% percent of the poverty level in buying private insurance. If Representative Barnes' plan were to become law, the state would be required to apply for a Medicaid 1115 waiver from the federal government. In doing so, Representative Barnes would accomplish Senator Dempsey's request to develop a system for "coverage for Medicaid participants resembling that of commercially available health plans while complying with federal Medicaid requirements."

In fact, any potential market-based Missouri-specific expansion proposal would require the state to obtain a Medicaid 1115 waiver. Yet the committee rejected the Minority's request to append a statement urging the General Assembly to consider waiver options for expansion as "beyond the purview," despite the language of the official committee charge from the President Pro Tempore.

Immediately after the committee voted down the Minority members' "beyond the purview" additions to the report, the committee did approve an addition to the report to include Tort Reform in the committee's recommendation section.

Of the 63 people who appeared before the committee:

- Number of people testifying regarding Tort Reform: **0**
- Percentage of people testifying regarding Tort Reform: **N/A**
- Percentage of those in favor of Tort Reform: **N/A**
- Percentage of those against Tort Reform: **N/A**
- Percentage of those testifying who were told that their Tort Reform testimony was within purview or the auspices of the committee: **N/A**

Unlike Medicaid expansion, the committee never discussed the concept of Tort Reform. However, the committee had no objection to adding Tort Reform to the report's recommendation section.

After the committee publically declared Tort Reform within the purview and Medicaid expansion and waiver requests outside the purview, it became all too clear to the minority members that the Senate Interim Committee on Medicaid Transformation and Reform was created purely to reach a predetermined outcome. Why hold meetings from July to November when the report could have essentially been written in June? Why take hours of testimony on a serious public policy subject just to ignore the overwhelming majority of that testimony? Why waste the time of 33 Missourians, both for and against Medicaid expansion, when their testimony was meaningless?

In retrospect, this turn of events should have been foreseen, as this Senate majority has developed a disturbing pattern with regard to Healthcare interim committees.

In 2011, President Pro Tempore Robert Mayer established The Senate Interim Committee on Health Insurance Exchanges in order to "explore Missouri's options on the establishment of a health insurance exchange." Like the Medicaid Transformation interim committee, the Health Insurance Exchange interim committee also met and took testimony, an overwhelming majority of which supported the establishment of the state-run health insurance exchange in Missouri. To date, the Secretary of the Senate has not yet received that Insurance Exchange interim committee report.

Viewed in the context of the 2011 Health Insurance Exchange committee, perhaps the Medicaid Transformation committee could be viewed as somewhat of an accomplishment. It does appear likely that this committee will actually write and submit a report, not one based on the overwhelming facts presented to it, but a report nonetheless.

Regrettably, healthcare service delivery is far too important in terms of lives, jobs, and the overall economic well-being of the state for the undersigned members of this committee to be complicit in the majority's lack of seriousness in crafting meaningful healthcare policy. We will no longer accept the majority's slouch toward a solution.

It is regrettable that this letter had to be composed. Regardless, the undersigned Senators believe that it is both necessary and prudent to provide information to the public based on the actual testimony presented to the committee. To that end, this letter will now discuss the healthcare policy recommendations presented to the committee that did not fit into the majority's predetermined agenda.

POLICY RECOMMENDATIONS

While there are several other troubling aspects concerning the development of the Majority Report, this letter from the Minority members will now turn to the important task of making policy suggestions based on evidence from the testimony heard by the committee. Therefore, the signers of this letter urge the General Assembly to consider the following recommendations for action:

1. **Expand Medicaid. Medicaid eligibility should be expanded to those Missouri citizens with incomes up to 138% of Federal Poverty Level without delay.**

This recommendation is based on the overwhelming testimony presented to the committee, which robustly articulated the moral, economic, budgetary, and societal benefits of Medicaid expansion.

First and foremost, the undersigned Senators believe that denying any human being healthcare is simply intolerable in a country as wealthy as the United States. While this moral principle is not a quantifiable justification for Medicaid expansion, it should not be ignored as a reason for supporting expansion. Moral beliefs aside, there is quantifiable evidence that Medicaid expansion will, indeed, save lives.

Professor Sidney Watson, who appeared in front of the committee on September 11, noted in her testimony: "The most significant Medicaid Transformation and Reform Initiative is expansion of coverage for adults with incomes up to 138% of Federal Poverty Level." She further stated: "A large body of research shows that Medicaid coverage lowers financial barriers to access to health services and increases likelihood of having a usual source of care, which translates into increased use of preventive, primary, and other care, and improvement in some measures of health care. Medicaid coverage actually saves lives. A ten year study that compared three states that expanded Medicaid coverage for low income adults with neighboring states that did not concluded that for every 176 additional adults covered by Medicaid it saves one life per year over ten years. In Missouri that means if we expanded Medicaid to cover an additional 260,000 adults we would save 14,770 lives over ten years."[2]

[2] The full text of Sidney Watson's testimony can be found here: http://slu.edu/Documents/law/Centers/Health%20Law/Medicaid/WatsonSenateInterimMedicaidTestimony9-11-2013.pdf

Not only will Medicaid expansion save lives, but health coverage serves an essential purpose other than ensuring health and preserving life: it protects people from financial catastrophe.

More than 62% of all bankruptcies in the United States are attributed to the cost of medical care.[3] The notion that a citizen of the richest country in the world can go bankrupt because they develop cancer is inexcusable. Studies have demonstrated that Medicaid serves a dual purpose, as Medicaid virtually eliminates catastrophic medical costs.[4]

The committee also heard numerous persuasive economic arguments in support of Medicaid expansion.

The Business Health Coalition stated in its testimony that "Medicaid expansion is more than a moral imperative; it will have a substantial impact on Missouri's economy… The cost of care for any one population or program impacts the cost of care for everyone. Ultimately that price is paid by all Missourians, directly and indirectly. Our goal should be to drastically cut the rate of growth for all."

One of the key findings from a report presented to the committee (prepared for the Missouri Hospital Association[5]) states that the decision to expand Medicaid carries the potential to substantially reduce the "hidden health care tax" burden (more colloquially known as the "cost-shift") for privately insured Missourians and their employers. Cost-shifting occurs when some payers underpay health care providers relative to the costs of providing care. These costs are then passed on to private payers in the form of higher premiums. Without Medicaid expansion, the average private insurance premium for a family of four in Missouri is projected to increase significantly. With Medicaid expansion, privately insured individuals and families could potentially save nearly $1 billion[6] due to reductions in premiums.

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[3] American Journal of Medicine: Medical Bankruptcy in the United States, 2007: Results of a National Study. http://download.journals.elsevierhealth.com/pdfs/journals/0002-9343/PIIS0002934309004045.pdf

[4] Oregon Health Study Findings: http://oregonhealthstudy.org/for-participants/findings/

[5] The Economic Impacts of Medicaid Expansion On Missouri. Prepared by the University of Missouri School of Medicine for The Missouri Hospital Association and Missouri Foundation for Health.
http://web.mhanet.com/uploads/media/MU_Medicaid_Expansion_Economic_Report.pdf

[6] Ibid., Page 7.

This "cost-shift" discussion hinges on the fact that not having insurance doesn't actually mean not having any access to healthcare. The current healthcare system provides care for the uninsured population by providing life-saving treatments when a person needs it, notwithstanding their ability to pay. This requirement became law in 1986 when Congress passed the Emergency Medical Treatment & Labor Act. While treatment in the Emergency Room may bankrupt a person, such treatment generally accomplishes enough to keep that person alive. When the uninsured seek hospital care, people who are insured pay for part of this care through health insurance premiums. At a minimum, the committee should have discussed the most logical manner in which to provide the care that is *already being provided* to the uninsured.

According to the Missouri Hospital Association report, expanding Medicaid would result in the creation of over 24,000 new jobs in Missouri. The report calculates the total effects (direct, indirect and induced) of expanding Medicaid in Missouri to be an additional $9.6 billion of value-added output to the state. The severe economic consequences of inaction cannot be over-emphasized.

Official projections[7] from the office of Budget and Planning estimate that the state would realize significant savings (over half a billion dollars over the subsequent seven fiscal years) to the General Revenue fund if Medicaid is expanded in Missouri, leaving more money for other needed government services such as education, law enforcement, and transportation. This General Revenue savings estimate corresponds to the survey released by the Kaiser Commission, which found that states not expanding Medicaid are expecting a larger increase in their state budget portions dedicated to Medicaid. State spending growth will be lower for the 25 states that are moving forward with Medicaid expansion (4.4 percent) compared to the remaining states (6.1 percent).[8]

2. **If traditional Medicaid expansion is not politically feasible, adopt a hybrid approach based on the "premium assistance" model being proposed by Representative Jay Barnes (R-Jefferson City).**

[7] See Appendix B for the Office of Budget and Planning's full Cost estimates

[8] The Kaiser Commission on Medicaid and the Uninsured: Medicaid in a Historic Time of Transformation: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2013 and 2014. (Page 21.) http://kaiserfamilyfoundation.files.wordpress.com/2013/10/8498-medicaid-in-a-historic-time4.pdf

While the undersigned Senators strongly believe that Medicaid eligibility should be expanded to those Missouri citizens with incomes up to 138% of Federal Poverty Level as envisioned by the Affordable Care Act, they are willing to accept any reasonable compromise in this area including a hybrid expansion approach more in line with the majority's overall governing philosophy. While not preferable to traditional Medicaid expansion, a market-based expansion is better than no expansion at all. Further, a market-based expansion may possess certain benefits, as some Medicaid recipients would be transformed into active health care consumers empowered to choose their own health insurance plans, introducing "cost-consciousness" into their decisions.

The "premium assistance" expansion model is a market-based approach to fund health care for the poor in place of conventional Medicaid expansion. The adoption of such a model would necessitate Missouri obtaining a Medicaid 1115 waiver. Such waivers allow states to use federal Medicaid funding to buy private insurance for low-income people from the health insurance exchanges created under the Affordable Care Act.

State Representative Jay Barnes (Republican – Jefferson City) is proposing a plan that is similar to the Arkansas and Indiana "Premium Assistance" models. Barnes' plan would add approximately 225,106 adults (with incomes below the poverty level) to the traditional Medicaid system while also drawing down federal dollars to assist an additional 82,433 Missourians (making between 100% and 138% percent of the poverty level) in purchasing private insurance.

According to Representative Barnes' self-described "conservative" scoring methodology, his proposal would result in savings to General Revenue of over $779 Million between fiscal years 2014 and 2021.

While the undersigned Senators possess reservations regarding specific elements of Rep. Barnes' proposal (such as the alteration of the term "affordable" in Section 208.640 and the corresponding reduction to the CHIP program) the overall plan is worthy of serious consideration. At a minimum, the General Assembly should use Mr. Barnes' proposal as a blueprint for market-based expansion if traditional Medicaid expansion is not politically feasible.

3. **The General Assembly needs to outgrow partisan politics and recognize that regardless of how one feels about President Obama and his healthcare bill, Medicaid expansion will save the state money.**

While this recommendation is not a true policy proposal (and obviously can't be legislated) it will nevertheless be necessary if the General Assembly is going to adopt any expansion model. To date, there have been four general varieties of arguments against expanding Medicaid:

1) Medicaid needs to be reformed first;
2) The state already spends too much on healthcare for the poor and cannot afford to further expand Medicaid;
3) Medicaid is not a worthwhile program and therefore should not be expanded; and
4) The federal government cannot be trusted to fulfill the enhanced match rates contained in the Affordable Care Act and therefore the state will be left footing the bill.

The Majority Report states the first argument against expansion directly, asserting that before the state can "consider" expanding eligibility and increasing the number of participants, transformation of the entire Medicaid program must occur. To this end, the report contains several recommendations designed to reform the Medicaid program in Missouri. Now that the General Assembly is in possession of the required programmatic reforms, when is it acceptable to consider expansion? If a policymaker truly believed in the "reform then expand" position, that person would include (or at least consider including) expansion in the legislation that houses the reforms in order to accomplish that agenda. Also, the federal government is much more likely to approve a waiver for "reform" when it's paired with something they want – Medicaid expansion. Not including, or even considering, Medicaid expansion along with reform legislation exposes the evasive nature of those asserting this argument.

The second argument against expansion, that the state already spends too much on healthcare for the poor and cannot afford to further expand Medicaid, also lacks merit.

The Majority Report touches on this argument by reporting that the Medicaid appropriations in the FY 2014 budget are close to $9 billion, which is somewhat misleading. The state's General Revenue used to fund Medicaid is approximately $1.8 Billion. (Approximately $4.7 Billion of that $9 Billion is federal "flow-through" money

over which the legislature has no control; the remaining $2.4 Billion comes from other sources, like provider taxes, etc.)

Put in proper context, it becomes apparent that the state of Missouri does not spend "too much" on its Medicaid program. [9]

- Missouri spends approximately 21% of its total General Revenue funds on the Medicaid program;
- The national average for all US states is 32.5% of General funds spent on Medicaid;
- Missouri is the ninth lowest state in the nation when comparing the percent of General Revenue funds spent on Medicaid.

The other portion of this budgetary argument, that the state cannot afford to further expand Medicaid, is also a fallacy. There are multiple sources of information (already presented in this letter) that clearly contradict this assertion and demonstrate that the state General Revenue fund will save money under Medicaid expansion.

The Affordable Care Act provides full federal financing for those newly eligible for Medicaid from 2014 to 2016 and then phases down the federal contribution to 90 percent by 2020. Increases in state Medicaid spending will occur in all states, even those not expanding Medicaid, due to significant outreach efforts and what is being referred to as the "woodwork" effect.

There is evidence that this woodwork effect is already happening. Millions currently eligible but not yet enrolled people are expected to sign up as a result of the implementation of the Affordable Care Act. The first enrollment report released on November 13, 2013 demonstrates that this woodwork phenomenon is real, even in the Republican-led states that have fought the healthcare law and refused to expand their Medicaid programs. In the first month of open enrollment, about 91,000 people in the non-expansion states who would have qualified for Medicaid before but had not signed up, came to the federal online marketplace and were deemed eligible for the program.[10]

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[9] The National Association of State Budget Officers. 2012. http://www.nasbo.org/sites/default/files/State%20Expenditure%20Report_1.pdf

[10] http://capsules.kaiserhealthnews.org/index.php/2013/11/about-91000-enroll-in-medicaid-as-result-of-aca-woodwork-effect/

In other words, Medicaid enrollment is going to increase in Missouri whether the state expands its Medicaid eligibility or not. States that do not expand will not receive the enhanced federal match rate for new enrollees and will not be able to transition a portion of their current Medicaid populations to the "newly eligible" group (and thus will not receive the financial benefits of the higher federal match for certain current enrollees.)

Medicaid expansion will generate extensive economic activity in the state by bringing in new revenue, creating new jobs, and expanding income in the healthcare sector due to the "multiplier effect." This multiplier effect will significantly increase economic activity for states that choose to expand Medicaid in relation to states that do not, as medical technology firms and healthcare providers will have economic incentives to invest and create jobs in expansion states over non-expansion states. Unlike the non-expansion states, expansion states will have advantages in improving their overall health care infrastructure, an important economic development aspect of expansion that is difficult to accurately quantify but is significant nonetheless. If the goal is to save state resources on Medicaid then the answer (though perhaps somewhat counterintuitive) is simple and undisputed: expand Medicaid.

The third argument, that Medicaid is not a worthwhile program and therefore should not be expanded, is also factually challenged.

During the July 9, 2013 meeting of the committee, Senator Schaaf (Republican - St. Joseph) referred to a flawed study from Oregon showing Medicaid generated no improvement in physical health outcomes. [11] Other comments from the Senator implied that persons enrolled in the Medicaid program were no better off than persons who lacked insurance entirely.

[11] There are multiple deficiencies in the study's methodology: the study wasn't blinded; the study authors only measured the baseline health status of the uninsured group, not the Medicaid group; the study contains no actual analysis of how a specific Medicaid patient progressed from the beginning of the study to the end; only 60 percent of those eligible to enroll in the Medicaid program did so, again introducing bias into the studied Medicaid population, as the subpopulation that actually signs up for benefits is more likely to need treatment (be sicker) than the subpopulation that does not sign up. Most of these methodological critiques were culled from: http://www.forbes.com/sites/theapothecary/2013/05/02/oregon-study-medicaid-had-no-significant-effect-on-health-outcomes-vs-being-uninsured/"

Contrary to the subtext of the Senator's comments, this lack of statistically significant positive health outcomes for Medicaid enrollees is not limited to the Medicaid program. A review of health care research reveals that the vast majority of studies examining the extent to which *any* health insurance improves health outcomes cannot determine a causal effect.[12] Yet no Senator on the committee suggested that a person with health insurance was no better off than a person who lacked health coverage entirely.

Further, Senator Schaaf's assertion fails to contemplate that health insurance coverage protects people from financial ruin and that enrollment in Medicaid virtually eliminates catastrophic medical costs, protecting our citizens from existing in a world where a single tragic health event automatically results in bankruptcy.

The fourth argument against Medicaid expansion is that the federal government will fail to fulfill its promise of enhanced federal match rates at some point in the future, leaving the state to foot the bill for expansion. This concern could easily be addressed by including a "severability clause" in the expansion legislation, allowing the state to reduce eligibility if the enhanced Federal match rates are reduced or eliminated.

In fact, 21 states have legislation (whether pending or not) that allows the state to discontinue expansion if the federal matching rate is reduced or if it falls below a certain threshold.[13]

4. **Enact the following Recommendations from the Majority Report along with Medicaid expansion:**

Despite the minority members' profound disappointment with the deficiencies of the Majority Report as a whole there are recommendations contained therein that were actually based on the information presented to the committee and to which the undersigned members would generally approve if coupled with some form of expansion. It is regrettable that these areas of agreement could not have served as a basis to construct a truly bipartisan report.

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[12] Said review was conducted for The Economic Research Initiative on the Uninsured (ERIU) at the University of Michigan by University of Chicago health economists Helen Levy, Ph.D., and David Meltzer, M.D., Ph.D. See: http://www.rwjf-eriu.org/pdf/research-highlight-mar.pdf

[13] https://www.statereforum.org/tracking-medicaid-expansion-decisions

Nevertheless, the minority members of the committee would largely support the following recommendations contained in the majority report if accompanied with some form of Medicaid expansion in order to create a more efficient and effective Medicaid system in Missouri:

- The Majority Report recommends that the current MO HealthNet Managed Care program should be extended statewide for certain or all populations currently in managed care, which would primarily include low-income custodial parents, pregnant women, and children. The minority members of the committee would support an extension of the Managed Care program to those populations (or perhaps to all populations) if such a policy alteration would advance the Medicaid expansion agenda.
- Transition populations (currently in the fee-for-service programs) to regionally-based Accountable Care Organizations. Based on the preponderance of the committee testimony, such a transition could lead to increased efficiency and delivery of care within the system.
- Hospital payment reforms should be explored, as MO HealthNet currently pays hospitals based on a complicated and outdated reimbursement methodology. A new payment structure should be developed in order to promote consistency among payers, quality, and value in hospital inpatient and outpatient settings. However, it should also be noted that Medicaid expansion is vital to continued hospital health, as the Affordable Care Act was crafted under the assumption that all states would expand Medicaid. Because of this assumption, the law contains cuts to other federal healthcare spending (such as Disproportionate Share Hospital funding) that were designed to be offset by increases in Medicaid coverage. While hospital payment reform is vital, Medicaid expansion is even more essential for hospital health in Missouri.

5. Enact the following Recommendations from the Majority Report regardless of whether Medicaid is Expanded:

The Minority Members of the committee would generally support the following recommendations contained in the majority report even if not accompanied with Medicaid expansion as these recommendations are based on the preponderance of the information presented to the committee and would enhance the state's healthcare service delivery:

- The DSS should develop options for coordinating care for dual eligible individuals (persons who meet eligibility requirements for both Medicare and

Medicaid) in order to integrate Medicaid and Medicare services and provide a more effective and efficient method of healthcare service delivery.

- Technology should be utilized in order to further enhance both telehealth and transparency. While amorphous in nature, this recommendation is reasonable and congruent with committee testimony.
- Reforms should be implemented to better manage "super utilizers" and decrease emergency room over utilization. This goal could be partially achieved by extending the Managed Care program and transitioning populations to regionally-based Accountable Care Organizations as discussed above.
- Strengthen Missouri's MO HealthNet False Claims Act.
- Adopt Incentives for Participants to seek preventive services, encourage healthy behavior and to participate in his or her health care.
- Encourage health savings accounts that can be used for deductibles and copays.
- Increase the asset limit to allow for health care items or services.
- Add preventive dental services for adults and disabled to reduce ER visits.
- Reinvest future transformation savings into technology and provider payments.

Appendix

For	Against	No Mention
Barbara Davis- League of Women Voters		Mary Schantz-MO Alliance for Home Care
Joel Ferber, Legal Services of Eastern Missouri		Lauren Tanner-Ranken Jordan Pediatric Specialty Hospital
Anita Parran- AARP		Sergeant Mike Krohn-Boone County Sheriff
Todd Richardson- Missouri Association for Community Action		Richard MCCullough- Missouri State Chiropractors Association
Missouri Developmental Disabilities council		Wayne Lee-Advocate for disabled
John Orear-NAMI and parent	Charles Willey, MD	Dr. Lee Parks- Crider Center
Erin Brower-Partnership for Children		Shelly Keller- self
Dr. Chuck Hollister -Missouri Psychological Assn	Jeanie Gault (Argued that before Med Exp, look at exp.	Mike Keller- Mo council for the Blind
Andrea Routh-MO Health Advocacy Alliance	for the aged, blind and disabled first- a social justice	Dr. Jeffery Kerr
Sara Guardilo-Student	question)	Missouri Dental Association
Dawn Martin-Participant		Steve Halper- Healthcare Fraud Control Unit
Joe Hardy-Missouri Rural Crisis Center		Joan Gummels AG
Wendy Chambers-Foster and Adoptive Parent		John Knopp AG
April Neiswinder-self		Pam Victor Aetna
Debbie Minton-Self		Bob Adkins Aetna
Jackie Lukitish- NAMI St Louis		AHIP Howard Weiss
Michelle Scott-Huffman- Missouri Faith Voices		Bob Reed PagemInder
Alaina Macia- MedIcal Transport Management		Well Point/Blue Cross Blue Shield- Christian Jensrud
Mo Coalition Community Mental Health Centers		Home State Health Plan
Mo Academy of Family Physicians		dennis g smith-Mckenna, Long and Aldridge LLP
Sidney Watson-Professor- St. Louis University School of Law		christie herrera-Foundation for Government Accountability
margarida jorge-Healthcare for America Now		
		Ed Weisbart-Vice President- Missouri Consumer Council
Business Health Coalition		Brent Gilstrap- MO Mental Health Counselors Assn
Timothy McBride		Sara Gentry-MS Society
Craig Henning-Executive Director- Disability Resource Assn		BJC
Jeaneter Mott Oxford -Mo Assn Social Welfare **+ 1700 signatures**		MHA
Dr. Mark Bradford		Dr. Larry Lewis
James King-Adapt Missouri		Dr. John Marshall
Mercy Health		Jason White
Dr. Heidi Miller		Cerner
Steve Goldberg- Wellcare Health Plans		

Medicaid Expansion-Draft
Impact on New Eligibles

		FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	
A.	**Number of Newly Eligible Medicaid Participants**									
1.	Parents	115,685	115,685	115,685	122,626	129,567	129,567	129,567	129,567	Take up: 70% 2014-16, 75%-2017, 80%-2018-21
2.	Childless Adults	124,032	132,572	141,112	149,653	158,193	158,193	158,193	158,193	60%-2014, 65%-2015, 70%-2016, 75%-2017, 80%
3.	Medically Frail	19,782	19,782	19,782	19,782	19,782	19,782	19,782	19,782	95% each year
4.	Total	259,499	268,039	276,579	292,061	307,542	307,542	307,542	**307,542**	
B.	**Cost-For Newly Eligible Participants**									
1.	Parents	($295,228,120)	($593,276,466)	($602,786,700)	($635,562,228)	($694,049,896)	($740,241,898)	($768,460,180)	($799,328,353)	PMPM: $435.50 / $371.97 crowd out trended
2.	Childless Adults	($421,124,008)	($876,409,389)	($951,682,642)	($1,035,653,215)	($1,131,694,800)	($1,207,414,140)	($1,253,533,345)	($1,303,932,763)	PMPM: $582.55 / $486.61 crowd out trended
3.	Medically Frail	($191,135,894)	($388,100,804)	($400,843,961)	($414,939,280)	($430,616,399)	($447,971,948)	($466,074,646)	($485,298,482)	PMPM: $1,635 / $1,540 crowd out trended
4.	Total	($907,488,022)	($1,857,786,660)	($1,955,313,303)	($2,086,154,723)	($2,256,361,094)	($2,395,627,986)	($2,488,068,171)	($2,588,559,598)	
5.	State Share-GR	$0	$0	$0	($30,112,261)	($69,303,438)	($86,590,613)	($117,617,393)	($143,257,483)	
6.	State Share-Other	$0	$0	$0	($23,944,742)	($55,266,828)	($69,351,136)	($94,577,215)	($115,598,477)	
7.	Federal Share	($907,488,022)	($1,857,786,660)	($1,955,313,303)	($2,032,097,720)	($2,131,790,829)	($2,239,686,237)	($2,275,873,562)	($2,329,703,638)	
C.	**Savings-State Share Change in Existing Programs**									
1.	Pregnant Women	$14,031,232	$42,262,986	$57,649,242	$56,051,495	$53,549,081	$54,087,840	$52,758,603	$52,246,279	Coverage for 20,892 will be at enhanced rate
2.	Ticket to Work	$521,989	$1,357,171	$1,705,442	$1,653,183	$1,572,910	$1,586,251	$1,541,873	$1,522,533	Coverage for 225 will be at the enhanced rate
3.	Breast/Cervical Cancer	$1,363,670	$4,915,851	$8,223,776	$8,741,350	$8,310,441	$8,515,064	$8,276,841	$8,173,027	Coverage for 1,093 will be at enhanced rate
4.	Spenddown	$16,230,288	$33,142,247	$34,534,221	$33,577,107	$32,078,060	$32,400,799	$31,604,532	$31,297,628	Coverage for 3,118 will be at enhanced rate
5.	Women's Health Services	$522,249	$1,066,431	$1,111,222	$1,157,893	$1,206,524	$1,257,198	$1,310,001	$1,365,021	Coverage for 63,107 will be at enhanced rate
6.	Blind Pension	$627,067	$1,280,470	$1,334,250	$1,354,816	$1,368,854	$1,411,250	$1,438,741	$1,475,088	121 will get Medicaid coverage
7.	Corrections	$1,559,556	$3,119,112	$3,119,112	$3,119,112	$3,119,112	$3,119,112	$3,119,112	$3,119,112	150 inpatient hospital days per month
8.	DMH	$11,299,836	$22,599,671	$22,599,671	$22,599,671	$22,599,671	$22,599,671	$22,599,671	$22,599,671	33,829 will get Medicaid coverage
9.	Total	$46,155,884	$109,743,939	$130,276,936	$128,254,627	$123,804,653	$124,977,185	$122,649,373	$121,798,360	
10.	GR Share	$31,046,711	$71,355,159	$82,283,976	$81,243,754	$78,914,722	$79,579,907	$78,383,904	$77,975,810	
D.	**Revenue Increases -- GR**									
1.	Increased Ind Income Tax	$9,872,846	$30,537,382	$32,412,653	$33,523,622	$33,222,612	$33,523,852	$34,217,870	$34,810,951	Salary portion only at 4.5%. No multiplier.
2.	Increased Sales Tax	$1,914,734	$4,069,823	$4,309,206	$4,254,108	$4,249,218	$4,375,990	$4,387,800	$4,593,866	19.2% of income spent on GR taxable goods.
3.	Misc Other Sales Tax	$912,160	$1,938,822	$2,052,862	$2,026,614	$2,024,285	$2,084,677	$2,090,303	$2,188,471	6.9% of non salary on GR taxable goods.
4.	Avoided Tax Credits	$2,900,000	$17,013,832	$18,513,832	$21,971,082	$23,471,082	$24,971,082	$26,471,082	$27,971,082	Credits on insurance taxes for MHIP.
5.	Total	$15,599,740	$53,559,860	$57,288,553	$61,775,426	$62,967,197	$64,955,602	$67,167,055	$69,564,371	
E.	**GR Summary**									
1.	GR Cost New Eligibles	$0	$0	$0	($30,112,261)	($69,303,438)	($86,590,613)	($117,617,393)	($143,257,483)	
2.	GR Savings	$31,046,711	$71,355,159	$82,283,976	$81,243,754	$78,914,722	$79,579,907	$78,383,904	$77,975,810	
3.	New Revenues	$15,599,740	$53,559,860	$57,288,553	$61,775,426	$62,967,197	$64,955,602	$67,167,055	$69,564,371	
4.	Total	$46,646,450	$124,915,020	$139,572,528	$112,906,918	$72,578,481	$57,944,896	$27,933,566	$4,282,698	