The MISSOURI BUDGET PROJECT
Shaping Policy... Protecting Missourians

June 11, 2007

Medicaid Becomes MO HealthNet:
A Tiny Step on the Road to Real Reform

By Signe E. Peterson, Policy Fellow
Ruth R. Ehresman, Director of Health and Budgetary Policy

Health care reform in Missouri is a long and winding road. In 2005, Missouri's leaders decided that transforming Medicaid was the key to balancing the state budget. That year, the legislature enacted the deepest Medicaid cuts in Missouri's history. Two years later—on the last day of the 2007 session, the General Assembly approved the MO HealthNet program to replace Medicaid.

MO HealthNet is not real reform. While some small improvements are included, gaping holes remain. Most important: the vast majority of low-income Missourians who were cut from Medicaid two years ago remain without access to affordable healthcare. **MO HealthNet locks out those who most need the services the new program provides.**

MO HealthNet is a tiny step toward comprehensive health care reform. At this point, it is more promise than substance. Careful monitoring and research will be needed to evaluate which of its components are successful or not, and why.

Following is a summary of MO Health Net's key changes and an analysis of Senate Bill 577 passed by the Missouri Legislature.

Key Changes in MO HealthNet (SB577)

- There were small restorations with approximately 9,000 of the more than 114,000 individuals who lost eligibility for Medicaid in 2005 once again eligible for MO HealthNet
- An additional 1,000 youth aging out of foster care will be eligible for MO HealthNet until they are 21 years old.
- Durable medical equipment and hospice care are covered services under MO HealthNet.
- Dental and vision services are technically restored, but **only if funds are appropriated** for them (they are not in the budget awaiting the Governor's approval).
- Those insured by MO HealthNet get encouragement to live healthy lifestyles, and the promise that their health care will now focus on prevention and will be better coordinated.

Key Changes in MO HealthNet (continued)

- Physicians get the promise of a **plan** to increase their reimbursement rates over four years.
- Physicians will get financial rewards for using best practices in patient care and meeting target health outcomes.
- Providers who defraud taxpayers by overcharging for services or billing for services not rendered receive a slap on the wrist, and are protected from meaningful incentives for whistleblowers to report fraud.
- Insurance companies are likely to benefit from more middle and high-income individuals purchasing long-term care insurance as a result of tax incentives and the Long-Term Care Partnership. (The Long-Term Care Partnership enacted in MO HealthNet has not been shown to provide substantial benefit to individuals or to the states in which pilot programs exist.)

Efforts to Reform Medicaid – *How Did We Reach This Point?*

In the two years since severe cuts were made, Medicaid reform has been a significant topic of discussion. A Medicaid Reform Commission was appointed in 2005, held hearings during the summer across the state, and conducted work sessions throughout the fall. The goal for the Commission was to present a plan for reform by January 2006.

The reform plan was presented, yet the 2006 legislative session brought nothing in terms of health care reform. There was bipartisan agreement to restore Medicaid to a small number of disabled workers who need it to cover services and equipment that are not covered by private insurance. There was also agreement that the affordability test for children to be eligible for State Children's Health Insurance Program (SCHIP) was too restrictive. But the House and Senate were in a stalemate through the last day of the session, and the good ideas died.

Two Interim Committees were assigned to study the merits of two reform components: 1) restoring Medicaid to disabled workers (changing the name from Medical Assistance for Workers with Disabilities to Ticket to Work); and 2) enacting measures to identify and address provider fraud. The committees met throughout the summer of 2006 and again developed recommendations. In 2007, Representative Charles Portwood introduced the recommendations of the Special Committee for Ticket to Work in House Bill 39. Representative Rob Schaaf, Chair of the Special Committee on Healthcare Facilities, introduced the recommendations to address provider fraud in House Bill 353. Both of these bills were eventually amended to SB577.

Senator Charlie Shields (Chair of the Medicaid Reform Commission in 2005) introduced SB577. It passed the Senate fairly quickly, but languished in the House. The Special Committee on Healthcare Facilities was slated to hear the bill. Representative Schaaf, the Committee Chair, held more than 40 hours of hearings over a three-week period to prepare for the Committee's consideration of SB577. By this point, the end of the legislative session was fast approaching, and the time to pass SB577 was diminishing. Representative Schaaf developed a House Committee Substitute for SB577 that was vastly different from the version passed by the Senate.

The House passed Representative Schaaf's bill with minor changes. The Senate rejected the House version of SB577, and a Conference Committee was appointed. Negotiations by members of the Conference Committee were tense during the last week of the session as they worked to develop a compromise bill. This version of SB577 was finally passed on May 18, 2007, the last day of the legislative session.

SB577 is waiting for Governor Matt Blunt's signature. When this legislation becomes law, it will change Missouri Medicaid to MO HealthNet. The modified program will bring with it some minimal expansions to Missourians in need and will change the way that some participants receive their health care services. However, MO HealthNet does not take significant steps toward covering all Missourians. A closer look at MO HealthNet reveals some concerns for what this new Medicaid program will mean for Missouri.

SB577 Falls Short of the Governor's and the Department of Social Services' Recommendations in Some Key Areas

While neither the Governor's/Departments' proposal for MO HealthNet nor SB577 contained real Medicaid reform, the final version of MO HealthNet has some less favorable elements than the Governor's/Departments' MO HealthNet proposal.[1] For example, the Department's proposal included more lenient SCHIP affordability provisions. To qualify for SCHIP, children must not have access to affordable insurance premiums offered through their parents' employment.[2] Affordability provisions outline the criteria that health insurance premiums must meet in order to be deemed "affordable" based on a percentage of the Federal Poverty Level (FPL). The Governor's recommendations would have provided coverage to 13,800 more children than the final version of MO HealthNet.

Table 1. Comparison of the Affordability Provisions

Income Category	**"Affordable Premiums"– Department's Proposal**	**"Affordable Premiums" – Final Version (very similar to the Governor's proposal)**
150-185% of FPL	1% of family income	3% of 150% of FPL
185-225% of FPL	3% of family income	4% of 185% of FPL
225-300% of FPL	5% of family income	5% of 225% of FPL
Additional Children to be eligible	13,800	6,000

The final version of MO HealthNet is also more lenient regarding provider fraud and abuse. The Governor recommended a False Claims Act that would establish Medicaid fraud provisions that meet the federal criteria of the Deficit Reduction Act of 2005. The False Claims Act included in the final version of MO HealthNet falls far short of the federal False Claims Act. Under the

[1] See Departments of Social Services, Health and Senior Services, and Mental Health. (December 7, 2006). *TheTransformation of Missouri Medicaid to MO HealthNet.* Available at http//:www.dss.mo.gov/mis/medtransform.pdf.

[2] Prior to the changes enacted in SB539 in 2005, only families with incomes between 225 and 300% of FPL were subject to the affordability test. After 2005, all families with incomes over 150% of FPL had to meet the affordability test.

leadership of Senator Charles Grassley (R-Iowa),[3] the federal government encourages states to enact state false claims acts that are at least as effective as the federal act. If states do so, they may keep an extra 10 percent of the money recovered as a result of fraud investigations. One of the key provisions needed to meet the federal criteria is a whistleblower provision that allows the whistleblower to proceed with a suit even if the Attorney General declines to be involved. The Missouri General Assembly did not include this provision due to concerns about frivolous lawsuits. This concern has not been the experience of the federal government and other states that have enacted a False Claims Act.

In addition, members of the Missouri General Assembly continued to confuse billing errors with fraud. Many provider groups and associations appeared to share in this confusion, and voiced strong opposition to a state False Claims Act.[4]

Missouri's Uninsured Continue to Be Left Out

MO HealthNet will not significantly reach the approximately 700,000 uninsured Missourians. The few populations that will experience small expansions with MO HealthNet include:

- 1,000 youth between the ages of 18 and 21 aging out of foster care;
- Approximately 3,000 workers with disabilities through the Ticket to Work program; and
- 6,000 children through the revision of the SCHIP affordability guidelines. Two other modifications were made to the affordability test in addition to changing the definition of "affordable premiums" described earlier: 1) insurance will not be deemed "affordable" if the child has a medical condition that is not covered by the available employer-sponsored insurance; and 2) employer-sponsored insurance is not "affordable" if the insured child has exhausted the benefits of the insurance package. These will enable children with complicated medical needs to be eligible for SCHIP. The number of children that will be affected by these changes is unknown at this time.

Additionally, MO HealthNet will extend "well-woman" coverage such as breast and cervical cancer screenings to 90,000 low-income women. However, these women will not receive comprehensive MO HealthNet benefits, including treatment should they be diagnosed with cancer.

Efforts to Expand Access to Employer-Sponsored Insurance Are Not Likely to Have a Significant Impact

A premium offset pilot program in MO HealthNet is the proposed vehicle to reach Missouri's uninsured working adults. This pilot program will be tested in one urban area and one rural area. Through a premium-offset program, an individual may participate in employer-sponsored insurance (ESI) through his/her employer and the state will contribute toward the cost of the

[3] This provision is part of the Federal Deficit Reduction Act passed in February 2006.
[4] Additional information about state false claims acts is available on the Missouri Budget Project website at www.mobudget.org .

premium. To qualify for the Missouri pilot program, an individual must be uninsured for one year and have income at or below 185 percent of the Federal Poverty Level.

At the beginning of the legislative session, proponents of this program claimed that a premium offset program, implemented on a full scale, would provide health care coverage to an additional 100,000 Missourians. However, in general, premium offset programs have low enrollment and do little to provide coverage to low-income uninsured.[5] Other states' experience show that a critical problem with premium-offset programs is that many individuals do not have access to employer-sponsored insurance and therefore cannot take advantage of premium subsidies.[6] Additionally, despite state subsidies, ESI plans still may not be affordable to low-income individuals and/or may not provide comprehensive health benefits. Therefore, it is unlikely that premium offset programs will do little to reach Missouri's most vulnerable uninsured.[7]

MO HealthNet Claims to Provide Preventive Care, But Details Remain Unknown

Proponents of MO HealthNet legislation have consistently stated that the program has an increased focus on prevention and wellness. How this legislation will truly improve prevention and wellness remains unclear. The MO HealthNet legislation will create health care homes for all MO HealthNet participants, which could provide more coordinated care and possibly result in better attention to health care needs. However, at the same time, several services that are essential to prevention are left out. In the final version, dental services and vision services were included for all MO HealthNet participants; however they are *subject to appropriations*. This means that the legislature needs to set aside the money to fund these services each fiscal year. For the Fiscal Year 2008 budget, dental and vision services are <u>not</u> funded for all MO HealthNet recipients.[8]

Additionally, other services essential to prevention are not included as covered services for the whole MO HealthNet population. These essential services and equipment include: physical, occupational, and speech therapies; podiatry; and hearing aids. Finally, an emphasis on prevention and wellness does not help the 114,000 low-income Missourians cut from Medicaid in 2005 and ineligible for coverage under MO HealthNet.

MO HealthNet May Offer Disincentives for Providing Care

Some provisions of MO HealthNet may result in negative unintended consequences by providing a disincentive for providers to care for individuals with significant medical needs. The legislation enacts a "pay-for-performance" incentive program for providers. At this time, it is unclear how

---

[5] See Alker, J. (2005). *Premium assistance programs: How are they financed and do states save money?* Washington, DC: Kaiser Commission for Medicaid and the Uninsured.
[6] See Williams, C. (2003). *A snapshot of state experience implementing premium assistance programs.* Portland, ME: National Academy for State Health Policy.
[7] For more discussion on a premium offset program in Missouri see, Peterson, S.E., & Ehresman, R. (March 21, 2007). *Summary of the premium offset program in MO HealthNet (SCS/SB577) and recommendations to promote participation of low-income workers.* St. Louis: Missouri Budget Project. Available at www.mobudget.org
[8] These services are only funded in the 2008 budget for children, pregnant women and the blind.

this program will be implemented. Furthermore, MO HealthNet will financially penalize managed care plans and administrative services organizations that fail to meet quality targets. The potential danger of these provisions is that they could serve as a disincentive to serve the sickest Missourians who have complicated medical/mental health needs.

Oversight Committee and Other Administrative Offices to Determine MO HealthNet Details

The MO HealthNet plan lacks most of the detail contained in the original versions of SB577. Significant power now lies with the MO HealthNet Oversight Committee, the Department of Social Services, the MO HealthNet Division, and other administrative offices to develop and implement several aspects of MO HealthNet. Some of the provisions that caused concern, such as providing services based only a plan of care, participants "earning" benefits through healthy living, and independence agreements are not in SB577. However, these were ideas recommended by the Department of Social Services and other Departments[9], and they might try to implement them through Department policy. The plans, guidelines, rules, and regulations that must be developed include (but are not limited to):

- The Department of Health and Senior Services may establish areas of defined need that can receive funds from the Healthcare Access Fund.
- The Department of Social Services may apply to the federal government for 1115 waivers to implement MO HealthNet.
- The Departments of Social Services, Mental Health, and Health and Senior Services shall develop rules for telehealth
- The Department of Insurance, Financial Institutions and Professional Registration shall development requirements and promulgate rules for certifying qualified long-term-care insurance policies for the long-term-care insurance partnership program
- The MO HealthNet Division shall develop a four-year plan to increase provider reimbursement rates to 100% of Medicare rates.
- The MO HealthNet Division may develop and implement additional costsharing requirements.[10]
- The Professional Services Payment Committee, appointed by the Governor, shall develop guidelines for and oversee the pay-for-performance program.
- The Joint Committee on MO HealthNet, composed of representatives and senators, will study a five-year rolling forecast of the MO HealthNet budget needs and make recommendations on ways to satisfy the future needs of the program.
- The MO HealthNet Oversight Committee must approve of the premium offset pilot program in order to be implemented.
- The Department of Social Services, with approval of the MO HealthNet Oversight Committee, shall develop and implement Health Improvement Plans (HIPS) for all MO HealthNet participants.

[9]See Departments of Social Services, Health and Senior Services, and Mental Health. (December 7, 2006). *The transformation of Missouri Medicaid to MO HealthNet*. Available at http//: www.dss.mo.gov/mis/medtransform.pdf.
[10] The adults insured by MO HealthNet are very poor. Working parents (typical a family of three) are eligible only if they have incomes under $300 per month. Individuals with a disability and the elderly are eligible only if they have incomes under 85% of FPL, about $700 per month. Additional costsharing requirements will create an undue hardship and likely result in diminished use of necessary care.

- The MO HealthNet Oversight Committee must review a wide array of data, determine how to best present this data to the Governor and the General Assembly, study whether an office of inspector general should be established, and make recommendations to the MO HealthNet Division regarding rules promulgated to implement MO HealthNet.
- A subcommittee of the MO HealthNet Oversight Committee shall advise the department on the development of a Comprehensive Entry Point for Long-Term Care.

Clearly, there are important aspects of MO HealthNet that are not yet developed. Tracking the development and implementation of these vague provisions in the various committees and administrative offices will be critical to understanding the full effect of this health care reform.

Minimal Cost Containment Provisions

The underlying realities that sparked the idea to "transform" Medicaid largely centered on the increasing cost of Medicaid, and the inadequacy of the state budget to fund it.[11] Proponents of reform reported that Medicaid was becoming one of the largest items in the state's budget, and Medicaid costs were rising faster than any other budget item. Additionally, Governor Blunt reported that Missouri Medicaid was the second costliest program in the country.[12] However, according to an analysis by the Center on Budget and Policy Priorities, Missouri ranked 34th in Medicaid expenditures per enrollee in 2003.[13]

Additionally, simply looking at growing Medicaid costs does not take into account the broader health care system, or the changing demographics of the state. While Missouri Medicaid costs were increasing and becoming a larger part of the state budget, this was not an isolated Missouri experience. Several other states experienced an increase in Medicaid expenditures largely due to changes in demographics such as an increase in the elderly and disabled populations.[14]

Furthermore, Medicaid costs are not rising faster than health care costs in the private market. Actually, health care costs in the private insurance market and in Medicare are growing at a faster rate than Medicaid costs.[15] Thus, in order to address the real problem of health care costs in this state, Missouri must take a look at the broader health care picture. Giving Missouri Medicaid a new name and a modified health care delivery system will not solve the challenges of adequately funding health care in Missouri.

While the Missouri Budget Project strongly supports preventive care and efforts to encourage MO HealthNet participants to live a healthy lifestyle, it is improbable that this will net significant savings. The bulk of Medicaid resources are spent on individuals with a disability and on elderly

---

[11] See Departments of Social Services, Health and Senior Services, and Mental Health. (December 7, 2006). *The transformation of Missouri Medicaid to MO HealthNet*. Available at http//:www.dss.mo.gov/mis/medtransform.pdf.
[12] See Blunt, M. (January 26, 2005). *2005 State of the State Address.* Available at http://gov.missouri.gov/State_of_the_State_2005.htm
[13] See Ku, L. & Solomon, J. (April 5, 2005). *Is Missouri's Medicaid program out-of-step and inefficient?* Washington, DC: Center on Budget and Policy Priorities.
[14] See Ku, L. & Broaddus, M. (January 13, 2003). *Why are states' Medicaid expenditures rising?* Washington, DC: Center on Budget and Policy Priorities.
[15] See Ku, L. (November 13, 2006). *Medicaid costs are growing more slowly than costs for Medicare or private insurance*. Washington, DC: Center on Budget and Policy Priorities.

in long-term care. The last weeks of life are the most expensive. These populations will have limited capacity to greatly improve their health. Children are the largest group insured through MO HealthNet (which now includes Medicaid and SCHIP), numbering 447,000 in April 2007. Children, along with the 81,000 parents/caretakers who are eligible for MO HealthNet, are already the least expensive to insure.

Some argue that placing all MO HealthNet participants into a health improvement plan will lower costs because care will be more coordinated, and fewer MO HealthNet participants will need to access health care through the emergency room. The Missouri Budget Project agrees that this should net some savings.

However, this assessment that lack of coordinated care drives rising health care costs is too narrow. It does not take into account the growing costs of pharmaceuticals, expensive end-of life care for growing numbers of elderly, or the costs generated by providing care to the uninsured.

After MO HealthNet is implemented there will still be nearly 700,000 Missourians who are uninsured, many of these created by cutting Medicaid eligibility in 2005. These uninsured individuals often have nowhere to go to access care except for emergency rooms and free clinics. Care provided under these circumstances often could have been provided at less expense in a doctor's office, or could have been avoided if preventive care were available.

The costs of providing health care to the uninsured – whether it is in emergency rooms or clinics—increase the cost of health care for everyone.[16] There is no such thing as "uncompensated" care. It is eventually paid by someone, with most of the costs absorbed into the premiums of those who are insured. Thus, by ignoring the uninsured and the other factors that contribute to rising health care costs, it is unrealistic to expect decreasing costs for the government or for individuals with private insurance

Furthermore, it does not appear that a thorough, realistic assessment of the costs of implementing the large administrative burdens of SB577 such as monitoring performance of both providers and participants, and staffing the numerous committees created by it, has been completed.

Missouri Must Address Uninsured & Provide Adequate Health Care Revenues

As the implementation and evaluation of MO HealthNet move forward, it is important to remain committed to securing adequate affordable health care for the tens of thousands of low-income uninsured Missourians. Other states that have made significant efforts to cover all of their uninsured citizens provide public health insurance to these poorest individuals with incomes below 100% of the Federal Poverty Level. Missouri is currently unwilling to face that reality, and continues to look at private insurance strategies to insure these very poor Missourians.

Perhaps the greatest challenge facing the Governor and General Assembly is assuring adequate revenue for MO HealthNet in the future. Tax credits and tax deductions enacted this year are

[16] See Davis, K. (2003). *The costs and consequences of being uninsured.* New York: The Commonwealth Fund.

estimated to result in a deficit of $500 million by 2010.[17] The decreased revenue means a large budget deficit. Since Missouri's general revenue is overwhelmingly used to support education and health care, the future leaders of our state will face tough choices.

The Missouri Budget Project is a statewide, nonprofit, nonpartisan organization that informs the public about the state's budgetary and tax policy options and their impact on low-income Missourians.

[17] See Missouri Budget Project, *$500 Million Reasons to be Concerned About a Tax Cut in Missouri*, March 2007, available at www.mobudget.org