

**EXPANDING MEDICAID MANAGED CARE TO PEOPLE WITH
DISABILITIES AND SENIORS WOULD BE RISKY AND UNWISE**

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EXECUTIVE SUMMARY

The issue of expanding risk-based or “capitated” managed care to seniors and people with disabilities in the Missouri Medicaid program gained increasing attention in 2010. First, a working group of the Missouri Senate issued a report identifying \$25 to \$50 million in savings from extending Medicaid managed care to the “Aged, Blind and Disabled.” Then, during the last week of the legislative session, a Senate substitute bill was introduced authorizing a “pilot project” for Medicaid recipients who are elderly or disabled in a single urban area of up to 250,000 people and all contiguous counties. All individuals in the “pilot” would be served by a “single qualified managed care organization.” While the legislature did not act on the abovementioned proposals in 2010, there is likely to be continued interest in expanding managed care to this population – particularly in light of the State’s ongoing budget problems. Any effort to expand Medicaid managed care to seniors and/or people with disabilities would be especially challenging and is unlikely to achieve significant *immediate* savings without compromising the quality of care for individuals with complex health care needs. This concern is borne out by a number of recent Missouri-specific reports, as well as the experience of Missouri’s current Medicaid managed care program for children and families—a much healthier population.

Recent studies highlight problems with Missouri’s existing Medicaid managed care program. A recent report by Alicia Smith & Associates—commissioned by the Missouri Department of Social Services—found no significant difference in access to or quality of care between Medicaid managed care and fee-for-service for the non-disabled population and stated that “in all cases, the differences were very slight with no clear advantage for either of the delivery systems.” The report also found that a higher percentage of children receiving well child exams were referred on for treatment in fee-for-service settings than in managed care. Alicia Smith & Associates could not determine whether this data reflected appropriate medical necessity determinations or under-treatment by managed care plans and denials of appropriate follow-up care. The State should ascertain the extent to which Missouri’s *current* Medicaid managed care enrollees are being denied medically necessary treatment before expanding risk-based managed care to the even more vulnerable elderly and disabled population.

The National Health Law Program found that Missouri Medicaid managed care plans performed poorly on children’s health measures; pregnant women received average or better care; and managed care plans made little progress or showed significant declines in several quality of care indicators. The report concluded that “Missouri’s Medicaid Agency—and its citizens—are not getting their money’s worth from these plans.” The managed care plans’ failure to consistently ensure adequate services for **non-disabled** recipients, including children, does not bode well for an expansion of the managed care system to seniors and people with disabilities who generally need **more** services than children, pregnant women and families. The State also has difficulty ensuring the adequacy of its provider networks in the current Medicaid managed care program. Smith & Associates recommended that the State “consider additional measures to audit provider networks” such as “secret shopper” surveys. Such quality assurance mechanisms should

be tried before extending managed care to special populations with complex and challenging health care needs.

While states across the country have implemented Medicaid managed care for many years, there is insufficient evidence at this point to indicate whether Medicaid managed care for this population can be successful (i.e., ensuring access to health care and improving health outcomes) while still generating the kinds of savings that states would like to achieve. Establishing managed care plans that can serve disabled individuals is exceptionally challenging: the network of physicians, hospitals and caregivers who might provide the best care for cancer might differ from those best suited for HIV and differ even more for those who can best serve patients with severe mental illness or developmental disabilities. In Missouri's current Medicaid managed care program, many specialized services are "carved out" and provided on a fee-for-service basis. Given that so many specialized and more expensive services are "carved out" from the existing managed care program for children, pregnant women, and families—a relatively healthy population—there are legitimate questions as to whether a managed program could effectively deliver *all of these* services to elderly and disabled individuals and still achieve the desired immediate savings for the State.

Managed care for elderly and disabled individuals, *if done correctly*, could cost *more* money than fee-for-service Medicaid. Medicaid managed care savings typically come from replacing expensive emergency room and hospital care with office-based preventive and primary care. However, seniors and people with disabilities have severe and chronic health care needs that require long term care and other specialized services — home health, nursing home care, and specialty physician services—costs that are unlikely to be reduced by managed care cost-cutting techniques. The Lewin Group noted that the State may even need to assume some of the risk of managed care for this population, thus precluding the State from realizing immediate savings. Managed care programs in some states experienced *significantly higher costs than expected* because of "significant unmet need in the fee-for-service program" and that "significant start up costs" would "likely limit the opportunity for short-term savings." In addition, the typical areas of managed care cost-savings – decreases in emergency room utilization and in-patient hospitalization – are especially unlikely to apply in Missouri given that so little general revenue is spent on hospital costs in the Missouri Medicaid (MO HealthNet) program. In fact, the *only* way to ensure significant immediate savings may well be for the State to set capitation rates too low and/or for plans to deny medically necessary care.

In addition to general concerns about risk-based managed care for high-cost populations, there are additional concerns with extending Medicaid managed care to individuals with mental illnesses—an especially vulnerable population. In fact, many of the typical advantages of managed care—providing early intervention and preventive treatments—do not necessarily apply to serving severely disabled individuals, especially those with psychiatric disorders who may not even recognize the need to receive treatment.

Expanding managed care to seniors and people with disabilities would require strong state oversight but Missouri's Medicaid Agency simply does not have the

capacity to oversee managed care plans effectively for this population. The Missouri Medicaid director has noted that the State has not done as well as it could have in holding managed care plans accountable—an assertion supported by the findings of Alicia Smith, the National Health Law Program, and the Lewin Group. This lack of oversight makes a move toward risk-based managed care for these populations particularly problematic.

Missouri ought to explore other options such as primary care case management (PCCM) *before* any further expansion of risk-based managed care—particularly for seniors and individuals with disabilities. As the Alicia Smith Report noted, states such as Oklahoma and Arkansas have abandoned capitated managed care and switched to a PCCM model which they found to be more cost-effective. Lewin recommended pursuing an “enhanced care management program” for the costliest participants in the non-dual eligible ABD population. In fact, “enhanced” primary care case management programs have shown a great deal of promise in a number of states. The State also should explore new opportunities in the recently-passed federal health care reform legislation—the Patient Protection and Affordable Care Act—such as the new state option and enhanced federal funding to provide “health homes” for people with chronic conditions. Finally, the State needs to address long-term care and find ways to alter the existing imbalance between nursing home and home and community based expenditures.

For these reasons, the State should move cautiously, if at all, in extending risk-based managed care to seniors or people with disabilities, and should certainly not do so for the purpose of saving money quickly. The Lewin Group directly cautioned against such an approach and in fact recommended exploring alternatives to risk-based managed care for seniors and people with disabilities. The State should, therefore, explore the alternatives discussed above to coordinate care and improve access for this vulnerable population.

The issue of expanding risk-based or “capitated” managed care to seniors and people with disabilities in the Missouri Medicaid program gained increasing attention in 2010. First, the Missouri Senate’s *Reboot Government* Working Group issued a report identifying hundreds of millions of dollars in budgetary savings in many areas of state government, including \$25 to \$50 million in savings from extending Medicaid managed care to the “Aged, Blind and Disabled” (ABD) population.¹ The report did not address this proposal’s impact on health access or outcomes.²

While initially no legislation was filed to implement this proposal, a Senate Substitute bill introduced near the end of the legislative session would have authorized a “pilot project” for Medicaid recipients who are elderly or disabled in a single urban area of up to 250,000 people and all contiguous counties.³ The managed care pilot provisions, introduced on May 12, 2010, were subsequently removed from the Substitute bill by amendment. Because no separate free-standing legislation had been filed to implement this proposal, there was never an opportunity for a public hearing on the plan, and hence no testimony regarding the many issues involved in mandating managed care for seniors and people with disabilities. These issues, many of which have been identified in reports issued by the State’s own private consultants, should be considered and debated before any future proposal goes forward in this area.

While the legislature did not act on the abovementioned proposals in 2010, there is likely to be continued interest in expanding managed care to this population, particularly in light of the State’s ongoing budget problems. While there is understandable interest in *any* measure that could potentially achieve cost-savings, expanding managed care to seniors and/or people with disabilities would be especially challenging and is unlikely to achieve significant savings without compromising the quality of care for individuals with complex health care needs.⁴ This concern is borne out by a number of recent Missouri-specific reports, as well as the experience of Missouri’s current managed care program for children and families—a much healthier population. As explained below, mandating risk-based managed care for seniors and people with disabilities is not an appropriate way to achieve immediate savings. Moreover, the Missouri Department of Social Services is in no position to provide the kind of strong oversight required to make such a system work for this population.

This paper provides a review of the many challenges that Missouri would face in implementing mandatory managed care for seniors and people with disabilities and explains why this approach is unwise for Missouri.

A. The Experience of Missouri’s Current Managed Care System does not Support an Expansion to Individuals with More Complex Health Care Needs.

• **Recent Reports on Managed Care Performance in Missouri**

Recent studies and experience highlight problems with Missouri’s existing Medicaid managed care program that caution against expanding the program to populations with more complex health care needs.

- Alicia Smith and Associates Report: A recent report commissioned by the Missouri Department of Social Services found no significant difference in access to or quality of care between Medicaid managed care and fee-for-service for the **non-disabled population** and stated that “in all cases, the differences were very slight with no clear advantage for either of the delivery systems.”⁵ The Alicia Smith Report also found that a higher percentage of children receiving well child exams were referred on for treatment in fee-for-service settings than in managed care.⁶ The Alicia Smith Report **could not determine whether this data reflected appropriate medical necessity determinations or under-treatment by managed care plans** and denials of appropriate follow-up care.⁷ The consultants recommended a follow-up study to assess this finding. The State should ascertain the extent to which Missouri’s *current* Medicaid managed care enrollees are being denied medically necessary treatment before expanding risk-based managed care to even more vulnerable elderly and disabled beneficiaries.
- National Health Law Program Report: The National Health Law Program (NHeLP) recently conducted an analysis of Medicaid managed care plans in five states, including Missouri. After examining quality assurance data obtained from the State, NHeLP found that: (1) Missouri Medicaid managed care plans performed poorly on children’s health measures; (2) pregnant women received average or better care; and (3) managed care plans made little progress or showed significant declines in several quality of care indicators.⁸ In fact, over the period surveyed, Missouri’s managed care plans exceeded the national average on only *one* of the seven selected quality measures and did so just barely.⁹ The NHeLP report concluded: “This data suggest that Missouri’s Medicaid Agency—and its citizens—are not getting their money’s worth from these plans.”¹⁰ The managed care plans’ failure to consistently ensure adequate services for **non-disabled** recipients, including children, does not bode well for an expansion of the managed care system to seniors and people with disabilities who generally need **more** services than children, pregnant women, and families.
- **Provider Network Adequacy in Missouri’s Current Managed Care Program**

The MO HealthNet Division already has difficulty ensuring the adequacy of its provider networks in the current Medicaid managed care program. Missouri’s Medicaid managed care consumer assistance programs (“Advocates for Family Health”) have reported that inadequate provider networks, as well as misleading and inaccurate network lists are a significant problem in the current Medicaid managed care program.¹¹ Members often cannot find a provider in their area—and are asked to travel long distances to receive care. Provider directories and lists from the State’s enrollment broker are outdated and/or inaccurate because the listed providers are not taking new patients (and have not for a long time) and/or have not been taking the participant’s health plan for a long time.¹² Even the managed care plans have recognized problems with the adequacy of their provider networks.¹³ As noted in a recent external review of the Medicaid managed care plans:

Although most MC+ MCOs [managed care organizations] had the number of primary care physicians (PCPs) and specialists required to operate, **they admitted that many of these PCPs had closed panels and would not accept new patients.** Ensuring that there is adequate access for all members, including new members, should be a priority for all MC+ MCOs.¹⁴

If plans' provider panels are closed, then these providers are not available or accessible and the MCO networks are inadequate, in violation of federal regulations and state Medicaid managed care contracts. In fact, the MO HealthNet Division found it necessary to include new requirements and standards in its current managed care contracts to address these very problems with provider network adequacy.¹⁵

One of the State's consultants—Alicia Smith and Associates—correctly notes that “it is not enough that the MCOs can demonstrate a certain supply of providers, but those providers need to demonstrate on a regular basis that they are **available to patients** in the plan.”¹⁶ They noted that financial pressures sometimes cause managed care provider-to-patient ratios to be ignored and that MCO provider panels “can be overstated.”¹⁷ Smith and Associates recommended that the State “consider additional measures in both FFS and managed care to audit provider networks.”¹⁸ One such method discussed by Smith and Associates is to conduct “secret shopper” surveys whereby individuals posing as managed care enrollees request visits with providers on the MCOs' provider lists and test whether these providers are actually available.¹⁹

A “secret shopper” survey conducted by the State of Connecticut found that only about a quarter of the calls requesting an initial visit with a primary care provider resulted in an appointment within the contractual time limits, and that many of the providers contacted were not accepting new patients at all.²⁰ Missouri has never conducted such “secret shopper” surveys to determine the adequacy of its managed care provider networks. Certainly such quality assurance mechanisms should be tried before extending managed care to special populations with complex health care needs. If managed care plans have difficulty developing sufficient networks of providers for a “healthier” population, it is uncertain how they could ensure that there are sufficient networks of specialized, more expensive providers in place to serve individuals with far more complex needs. As discussed more fully below, the adequacy of provider networks is one of the *most* critical issues in extending managed care to people with disabilities.

- **More Expensive and Specialized Health Care Services for the Non-Disabled Population are “Carved out” in Missouri’s Current Medicaid Managed Care Program.**

In Missouri's current Medicaid managed care program, which serves a much *healthier* population than would be covered under an expansion of managed care to the aged, blind and disabled, many specialized services for these types of Medicaid beneficiaries are already “carved out” of the program and provided on a fee-for-service basis. The

aforementioned legislation would have included all services under managed care for seniors and people with disabilities without carve outs.

The State’s managed care capitation rates in its current program cover the acute care services that children and parents use—physician services, diagnostic services, inpatient outpatient hospital services and prescription drugs. In contrast, **almost all of the high cost, specialized care that elderly and disabled beneficiaries use are “carved out”** of the State’s managed care capitation rates and paid on a fee-for-service basis. Among the services carved out are transplant services, protease inhibitors for AIDS, community psychiatric rehabilitation services, comprehensive substance abuse treatment and rehabilitation services (C-STAR), targeted case management for mental health services, home and community-based waiver services for persons in the Mentally Retarded and Developmental Disabilities (MRDD) Waiver, and therapy services (physical, speech or occupational) included in children’s individualized family services plans (IFSPs) or Individual Education Plans (IEPs).²¹

In addition, **the State recently carved out all pharmacy services** in its current managed care contract, after determining that such services could be delivered more efficiently *and less expensively* through the State’s fee-for-service system.²² Consumer advocates argued that MO HealthNet Fee-for-Service (FFS) did a far better job than the managed care plans in providing access to prescription drugs in a consistent manner, and Missouri has touted its fee-for-service system for pharmacy as highly cost-effective and efficient in delivering Medicaid pharmacy services.²³ The system is much easier administratively for providers in that there is only one formulary across the state rather than multiple formularies *for each region* (one for each of the managed care plans). It would seem unwise to unravel this system and hand pharmacy services back to managed care plans for the current enrollees, let alone people with more complex health care needs.²⁴

Given that so many specialized and more expensive services are “carved out” from the existing managed care program for children, pregnant women, and families—a relatively healthy population—there are legitimate questions as to whether a managed care program could effectively deliver *all of these* services to elderly and disabled individuals and still achieve the desired savings for the State. Of course, the more specialized services that are carved out of the capitated amounts paid to managed care plans, the less likely it is that substantial savings can be achieved. The legislation proposed during this past session would have included *all* services with no carve-outs. There was no public hearing to examine how MCOs could effectively provide all of these services that the State has found necessary to carve out for the *healthier* population enrolled in Missouri’s Medicaid managed care program for the last fifteen years.

B. Extending Managed Care to Individuals with Disabilities and Seniors is Especially Challenging and is Unlikely to Save Money Without Compromising Care.

While states across the country have implemented Medicaid managed care for many years, there is still not enough evidence to say conclusively whether Medicaid managed care for those who are elderly or disabled generally hurts, helps or has no substantial effect on their access to health care or on the quality of care that they receive.²⁵ There is also insufficient evidence at this point to indicate whether Medicaid managed care for this population can be successful (i.e., ensuring access to health care and improving health outcomes) while still generating the kinds of savings that states would like to achieve.²⁶ In fact, a recent report commissioned by the Missouri Department of Social Services notes that the “challenge of controlling costs *and* delivering comprehensive services to high-needs populations has deterred some states from mandatory enrollment of these populations in risk-based plans.”²⁷ The challenges of managed care for seniors and people with disabilities are discussed in detail below.

- **Developing Provider Networks and Setting Capitation Rates Would be Especially Challenging.**

Establishing managed care plans that can serve disabled individuals is exceptionally challenging: the network of physicians, hospitals and caregivers who might provide the best care for cancer might differ from those best suited for HIV and differ even more for those who can best serve patients with severe mental illness or developmental disabilities.²⁸ A wide array of specialists in specialized facilities is required, and developing this type of network is not an inexpensive proposition. In its comprehensive review of Missouri’s Medicaid program (MO HealthNet), the Lewin group pointed out that establishing such networks could be challenging, “particularly in more rural areas.”²⁹ Lewin commented that expanding managed care to aged, blind and disabled beneficiaries would require a significant effort by the State to evaluate the adequacy of managed care plans’ networks of providers (including specialists) to “provide access within specified distances and timeframes.”³⁰ At a minimum, the State would encounter substantial challenges constructing adequate provider networks that could appropriately serve seniors or people with disabilities.

Setting the **capitation rates** for Medicaid managed care for seniors and persons with disabilities also presents special challenges. Rates must be set at a level that will attract and retain the diverse range of specialists needed to care for this population to ensure continuous care and limit the risk of “underservice” to this population.³¹ The Lewin Group noted that “rate setting for a population with diverse and extensive health care needs is more complicated than for the TANF population.”³² In an earlier report written for the health insurance industry, the Lewin Group noted:

[capitation rates] “set unnecessarily high can obviously result in states having **greater expenditures** under their managed care programs than in their FFS [fee-for-service] programs. Rates set too low will make it **difficult to attract or retain health plans** and could violate the federal requirement that rates must be actuarially sound.”³³

These challenges raise significant questions about using risk-based managed care as a way to achieve immediate cost-savings for care for this highly vulnerable population.³⁴

- **Cost-Savings are Unlikely if Managed Care is Properly Implemented.**

Managed care for elderly and disabled individuals, *if done correctly*, could cost *more* money than fee-for-service Medicaid.³⁵ Medicaid managed care savings typically come from replacing expensive emergency room and hospital care with office-based preventive and primary care.³⁶ However, seniors and people with disabilities have severe and chronic health care needs that require long term care and other specialized services—home health, nursing home care, and specialty physician services—costs that are unlikely to be reduced by managed care cost-cutting techniques.

It is not surprising that many policy experts, *including proponents of managed care*, have cautioned against using managed care to achieve *immediate* savings for expenditures on elderly and disabled beneficiaries. For example, a 2003 study of four different states' Medicaid managed care programs for people with disabilities noted “how ill advised it is to pursue managed care to achieve short-term savings for the SSI population,” based on the experiences of state plan officials and managed care plans.³⁷ A former high-ranking federal Medicaid official has similarly noted that providing managed care to this population could cost states *more* money, not less.³⁸

Part of the problem with mandatory managed care for seriously disabled people is that **when done right, it may cost more than traditional FFS care, not less.** The disabled are a severely underserved population; effective assessment, care planning, and case management may greatly increase their use of services. Moreover, as compared with low-income children and their mothers, who have traditionally encountered barriers to access for relatively inexpensive primary care and preventive services while overusing expensive emergency rooms and inpatient hospitalizations, the disabled have traditionally experienced access barriers to specialized therapists, sophisticated equipment, and so forth, which are themselves quite expensive.³⁹

Moreover, the Lewin Group's final comprehensive Missouri report noted that the **State** may even need to **assume some of the risk** (sharing in the unanticipated gains or losses) of managed care for this population and provide the MCOs with “stop-loss” protection (capping their financial losses),⁴⁰ thus precluding the State from realizing immediate savings. Lewin noted that managed care programs in some states experienced *significantly higher costs than expected* because of “*significant unmet need* in the fee-for-service program, particularly related to behavioral health” and that “significant start up costs” would “likely limit the opportunity for short-term savings.”⁴¹

Lewin also noted that implementing managed care for these new populations required careful consideration of a multitude of key issues before implementing mandatory managed care.⁴² The Report found that “significant time and effort would be required to

issue an RFP [request for proposal], oversee rate range determination, and establish contracts with MCOs”—a process that “could easily take 18 months or more.”⁴³ Going forward, it is critical that a thoughtful public process is conducted prior to implementing such a dramatic change in the health care delivery system for seniors and people with disabilities.⁴⁴ In contrast, using managed care solely to achieve immediate cost-savings for these populations is a recipe for disaster.

In addition to all of these costs, the Lewin Group found that “expanding managed care to the ABD population would **require significant resources within MO HealthNet.**”⁴⁵ Lewin noted that “sufficient time and resources will need to be devoted to submitting a waiver modification to CMS and obtaining approval” and noted an impact on several aspects of state operations including but not limited to contracting, financing, systems work, and determination of rates.⁴⁶ Furthermore, “[m]anaged care expansion would require significant staff attention and resources at the same time that national health reform is already stretching limited Medicaid resources nationwide.”⁴⁷ Thus, Lewin recommended that **an “enhanced care management program” for the costliest participants “may be a more viable option” for non-dual eligible ABD participants,** at least in the short-term.⁴⁸

These findings reinforce legitimate concerns with implementing a capitated managed care program for individuals with disabilities that “guarantees” immediate savings of any amount, let alone \$25 to \$30 million in the first year. Moreover, as discussed below, a focus on immediate savings could result in significant risk of underservice, as well as a risk of disruptions in care, for the elderly and disabled Missourians who depend on the MO HealthNet Program.

- **Typical Managed Care Cost-Savings Assumptions are Inapplicable due to Missouri’s Unique Medicaid Financing Structure.**

In addition to all of the points discussed above, the typical areas of managed care cost-savings—decreases in emergency room utilization and in-patient hospitalization—are **especially unlikely to apply in Missouri given that so little general revenue is spent on hospital costs** in the Missouri Medicaid (MO HealthNet) program. The major source of state funding for in-patient and outpatient hospital costs in Missouri is the federal reimbursement allowance (FRA) or provider tax.⁴⁹ For example, the FY 2011 state budget legislation allocates only a little more than \$15 million in general revenue to hospital expenditures (both in-patient hospitalization and outpatient combined) out of more than \$813 million in spending on these services.⁵⁰ In contrast, more than \$482 million in federal funds and nearly \$185 million in FRA funds are spent on “hospital services,” with the remainder coming from other sources of state match.⁵¹ The State’s reliance on this tax for funding Medicaid, as opposed to general revenue, limits its ability to achieve additional savings by expanding Medicaid managed care to low-income elderly and disabled Missourians. Because so little general revenue is spent on hospital costs to begin with, Missouri would be unable to use the traditional source of managed care cost-savings—reducing spending on hospital utilization—to achieve substantial

general revenue savings (the primary goal of any such cost-containment initiative in Missouri).⁵²

Moreover, Missouri's Medicaid program makes special *extra payments* to hospitals to *compensate them for lost revenue* as a result of the utilization decreases that result from managed care. While these payments are being phased out over time, they are not being eliminated.⁵³ It is also unclear whether hospitals would increase the rates charged to managed care plans once these special payments are reduced.

It is not surprising that the Lewin Group noted that Missouri's "existing hospital financing mechanisms tied to fee-for-service patients would be significantly affected by a shift to managed care" for "Non-Dual-Eligible ABD participants."⁵⁴ Moreover, "mitigating these impacts would most likely involve negotiations with CMS [Centers for Medicare and Medicaid Services] which could take a substantial amount of time to complete, further limiting any short-term savings."⁵⁵

- **Cost-Savings Assumptions from Missouri's *Current* Managed Care Program are Not Likely to Be Applicable to Seniors or People with Disabilities.**

As discussed above, there are a multitude of additional costs involved in applying risk-based managed care to seniors or persons with disabilities. In fact, because of their complex health care needs, this population comprises the bulk of the state's Medicaid costs because they are simply more expensive to serve.⁵⁶ Therefore, financial data on the existing managed care program is not necessarily applicable to any effort to shift seniors or people with disabilities to risk-based managed care.

In fact, the Missouri Department of Social Services bases its assumptions about managed care savings on a January 2010 study of Missouri's managed care program costs by Mercer and Associates. That study reports 2.7% annual savings in the current Medicaid managed care system for a relatively healthy population in comparison to what the costs would have been to provide care to the **same population** on a fee-for-service basis in the **same regions**.⁵⁷ However, Mercer readily admits that its results are not indicative of costs or savings for other Medicaid populations such as people with disabilities. Mercer points out that its report is "[n]ot a direct comparison between the existing FFS [fee-for-service] program and MC [managed care] populations and delivery systems, and is "[**n]**ot a depiction of anticipated savings associated with MC expansion opportunities."⁵⁸ Thus, the State should not assume based on Mercer's findings that there will be savings from a managed care expansion for seniors and people with disabilities.

Moreover, the Mercer report does not attempt to explain the *basis* for the alleged savings. For example, the 2.7% savings could well have come from denying medically necessary services rather than delivering appropriate care—a possibility the State should carefully consider before expanding managed care to populations with complex health care needs. The report on health care quality by Alicia Smith and Associates, discussed above, certainly raises questions about possible "under-treatment" by Medicaid managed care plans.⁵⁹

- **There is a Substantial Risk of Underservice if the State Extends Managed Care to Individuals with Disabilities and Seniors.**

Given the difficulty of achieving substantial savings by reducing in-patient hospital utilization and the high cost of meeting the complex needs of seniors and people with disabilities, the *only* way to ensure significant savings may well be for the State to set capitation rates too low and/or for plans to deny medically necessary care. Such underservice has led some states to reevaluate their contracts with Medicaid managed care providers.⁶⁰ Additionally, the Kaiser Commission has noted, “**the inherent financial incentives to provide fewer services under capitated rates may cause people with chronic conditions to be underserved**” under managed care.⁶¹ Missouri policymakers have previously voiced similar concerns. For instance, in 2004, the Missouri Interim Legislative Committee on Medicaid Cost-Containment similarly noted that “in any capitated arrangement, *especially in the elderly and disabled populations*, there is a fear that managed care will result in under-treatment.”⁶² In 2005, the Missouri Medicaid Reform Commission (a Joint Committee of the House and Senate) noted a legitimate fear that managed care for “the disabled and mentally ill” will be “rationed, not managed.”⁶³ In its recent comprehensive Missouri report, the Lewin group found that “continuity of care [for this population] may be jeopardized **without sufficient access to specialists** and the fact that **long-time providers may withdraw** based on managed care.”⁶⁴ This was in fact the experience in Oklahoma. When faced with complaints from MCOs that capitation payments were insufficient especially for the ABD population, the State of Oklahoma gave the MCOs “greater leeway to control their costs” by limiting or eliminating some adult services.⁶⁵ However, only months later, one of Oklahoma’s major providers dropped out of the program altogether when the State did not raise its capitation rate high enough.⁶⁶

For all of the reasons stated above (insufficient provider networks, low capitation rates, etc.), there is a significant risk of underservice, including the possibility of widespread disruptions in care, if the goal of expanding managed care is to *limit cost or achieve immediate savings* rather than provide the highest quality health care to elderly and disabled MO HealthNet beneficiaries. The risk of underservice is magnified if the State does not significantly expand its oversight capacity as discussed below.

In addition to the *general* risk of underservice, the specific legislative proposal that was filed late in the 2010 legislative session would have required all individuals in the “pilot” to be served by a “**single qualified managed care organization** for all covered services.”⁶⁷ This lack of competition increases the risk of underservice in that the single managed organization would not be at risk of losing members dissatisfied with their access to health care services from the single qualified MCO. Such a proposal is far different from Missouri’s current Medicaid managed care program for healthier populations, under which all participants have a choice of at least three plans and thus can “vote with their feet” if they are not properly served by their existing plan. It is doubtful that the Centers for Medicare and Medicaid Services would grant a waiver to allow the State to deny beneficiaries *any* choice of plans, in violation of federal law.⁶⁸

- **Implementing Managed Care for Individuals who are Elderly or Disabled would Require Strong Oversight from the State—Oversight which is now lacking in Missouri’s Medicaid (MO HealthNet) Managed Care Program.**

Expanding managed care to seniors and people with disabilities would require strong oversight by the State. However, Missouri’s Medicaid Agency simply does not have the capacity to oversee managed care plans effectively in any such expansion. As the Lewin Group noted with regard to Missouri’s contracted Medicaid services in general, “MO HealthNet’s current oversight of contracted activities appears limited and may be the result of staffing levels, skill sets, or historical lack of institutional emphasis.”⁶⁹ The Missouri Medicaid director has similarly noted that the State has not done as well as it could have in holding managed care plans accountable—an assertion supported by the abovementioned findings of Alicia Smith and the National Health Law Program as well as the State’s failure to sufficiently monitor the adequacy of managed care provider networks.⁷⁰ Insufficient oversight has also been a problem in other states that rely heavily on Medicaid managed care.⁷¹

The Lewin group specifically advised the MO HealthNet Division that “strong quality oversight is essential” to expanding managed care for elderly and disabled individuals.⁷² However, Missouri’s managed care quality assessment and improvement is currently overseen by a small staff within MO HealthNet Operations which would need to be significantly expanded to adequately oversee Medicaid managed care for elderly and disabled individuals.⁷³ Such an expansion **would “require a far more robust and higher profile oversight unit”** and managed care oversight “should be elevated to a Director-level position within MO HealthNet.”⁷⁴ It is unlikely that any additional funding for oversight is forthcoming in light of the State’s budget problems and the continuing trend of reducing rather than adding state employees. This lack of oversight makes a move toward risk-based managed care for these populations particularly problematic.⁷⁵

- **Risk-Based Managed Care Presents Special Problems for Individuals with Mental Illnesses.**

In addition to general concerns about risk-based managed care for high-cost populations, there are additional concerns with extending managed care to individuals with mental illnesses, an especially vulnerable population.⁷⁶ Because many people with mental disabilities are among Missouri’s disabled Medicaid recipients, they would be included if managed care is expanded to all disabled Medicaid beneficiaries. As noted above, there is insufficient evidence that a risk-based approach would be successful for people with disabilities, let alone psychiatric disorders. In fact, many of the typical advantages of managed care—providing early intervention and preventive treatments—do not necessarily apply to serving severely disabled individuals, **especially those with psychiatric disorders who may not even recognize the need to receive treatment.** Severely mentally ill individuals may go without care altogether until they deteriorate to the point that they become a danger to themselves or others. Thus, some community mental health

centers do aggressive outreach to find their patients – which may well mean finding people who are homeless, living under bridges and very psychotic, or following up repeatedly with people who miss appointments because this is often when they are sickest.⁷⁷ Capitated managed care is not well-suited to serving such individuals, given the financial incentive to underserve rather than *seek out* those people who need services the most.

Moreover, individuals enrolled in Missouri’s existing Medicaid managed care program have experienced significant problems in securing mental health care services through capitated plans and their mental health subcontractors.⁷⁸ In fact, “opting out” of managed care is often the appropriate option for individuals requiring in-patient mental services under the current system.⁷⁹ And as noted earlier, a number of **key mental health services (including all pharmacy services) are already carved out of** Missouri’s current managed care program while children in state custody have their mental health services carved out *entirely*.⁸⁰ Given that the State has already chosen to carve out so many mental health-related services from managed care, it is difficult to see how the State could suddenly shift all of these services back to private managed care plans without severe disruptions in care and rampant underservice. Missouri’s Medicaid managed care program thus does not have a demonstrable track record for providing the full range of mental health services to people with chronic mental health conditions, let alone the seriously mentally ill.⁸¹

Missouri is not the only state whose Medicaid program has difficulty in delivering mental health services through managed care. Connecticut carved out mental health services from its managed care program for parents and children “to address fundamental deficiencies in the current system that limit the provision of timely, appropriate and effective care to children with special behavioral health needs.”⁸² In support of the decision to carve out mental health services, the State’s Social Services Commissioner stated:

The failings of the current system are numerous. There are extraordinarily **long and unnecessary stays in inpatient psychiatric facilities** and excessive reliance on emergency departments with discharge delays resulting in overnight stays for children. There are **long delays in accessing outpatient services and uneven service quality and outcomes**. Under the current system, children fall through the cracks and end up in the child protection or juvenile justice system.⁸³

Such concerns must be seriously considered before embarking on a capitated managed care program for Medicaid beneficiaries with severe psychiatric disorders.

What about individuals eligible for both Medicaid and Medicare?

The State could not easily extend managed care to individuals eligible for both Medicaid and Medicare (“dual eligibles”) which comprise a significant portion of the seniors and

people with disabilities on the Medicaid program. Nor would such a proposal make any sense.

In fact, most elderly beneficiaries who cannot currently be enrolled in mandatory capitated managed care are either “dual eligibles,” or are enrolled in Medicare Savings Programs (e.g., they are Qualified Medicare beneficiaries) under which Medicaid simply pays their Medicare premiums. There are approximately 175,000 such individuals in Missouri.⁸⁴

The aforementioned proposed Missouri legislation excluded “dual eligibles” from the proposed ABD “pilot project” but the *Reboot Government* Recommendations did *not* exclude these individuals from mandatory managed care. The State would need to obtain a federal waiver to put these individuals in mandatory managed care, which could come with significant budgetary risks and the need to demonstrate budget neutrality. However, even if obtaining such a waiver were possible, it would make no sense to include “duals” in any such expansion of Medicaid managed care in that most of their care (e.g., in-patient and outpatient hospital care, physician visits, prescription drugs, etc.) is provided and paid for by the federal *Medicare* program and there would be little, if anything, left for a Medicaid managed care plan to manage and thus little, if any, savings to be achieved by the State.⁸⁵

As Lewin appropriately notes, a more effective way for the **State** to achieve **savings** for duals is to address long-term care services (and the existing imbalance between nursing home and home and community-based care) which are in fact paid for by the State rather than the federal Medicare program which pays for acute care costs.⁸⁶

The new federal health reform law also provides an opportunity for Missouri and other states to better coordinate services for dual eligibles by creating a new federal Coordinated Health Care Office charged with “better integrating Medicaid and Medicare programs” and ensuring that dual eligibles “get full access” to services.⁸⁷

C. The State Should Explore Alternatives to Risk-Based Managed Care.

Missouri ought to explore other options such as primary care case management (PCCM) *before* any further expansion of risk-based managed care—particularly for seniors and individuals with disabilities. As the Alicia Smith Report noted, states such as Oklahoma and Arkansas have abandoned capitated managed care and switched to a PCCM model which they found to be more cost-effective.⁸⁸ Furthermore, Lewin recommended pursuing an “enhanced care management program” for the costliest participants in the non-dual eligible ABD population.⁸⁹ In fact, “enhanced” primary care case management programs have shown a great deal of promise in a number of states.⁹⁰ These programs combine fee-for-service and managed care mechanisms by contracting with a provider (often a physician) who provides basic care and coordinates any further specialty care in exchange for a small case management fee per person per month and some fee-for-service payments.⁹¹ The Lewin Group further suggested that patient-centered medical

homes, which rely on coordinated primary care teams to address a patient's needs, "could meet the State's care management objectives" for this population.⁹²

The State also should explore new opportunities in the recently-passed federal health care reform legislation—the Patient Protection and Affordable Care Act—such as the new state option and enhanced federal funding to provide "health homes" for people with chronic conditions.⁹³ A health home uses a team-based model of care "led by a personal physician who provides continuous and coordinated care throughout a patient's lifetime to maximize health outcomes."⁹⁴ These health homes would employ the kind of "patient-centered" approach that Lewin is recommending. Finally, with regard to achieving "savings"—perhaps the key reason for the recent Missouri managed care proposals for people with disabilities—the State needs to address long-term care and find ways to alter the existing imbalance between nursing home and home and community based expenditures. The new health reform law provides a number of helpful options in this regard as well.⁹⁵

What about Expanding Managed Care *Geographically* Across the State?

Apart from the recommendation for Aged, Blind, and Disabled, the *Reboot Government* Report also includes a separate recommendation to "bring all Medicaid eligibles under Managed Care statewide" to achieve a savings of \$23 million – expanding from a "pilot program to a full program."⁹⁶ State agency officials have similarly reported their plans for a geographic expansion of managed care to areas of the state that do not currently have managed care. The State has expressed interest in implementing managed care statewide beginning July 1, 2011 and has already held a public forum on a potential statewide expansion of managed care for the current population of children, pregnant women, and low income parents on July 30, 2010.

Expanding risk-based managed care on a geographic basis does not present the same challenges as expanding managed care to new populations. However, given the findings of Alicia Smith and Associates and the National Health Law Program study of Missouri Quality Assurance data, it would seem wise to move cautiously with regard to any geographic expansion as well. Moreover, there has been very strong resistance to expanding managed care among providers in regions that are still "fee-for-service."⁹⁷ In Southwest Missouri, MO HealthNet Division Director McCaslin reported providers' "[u]niform opposition to managed care."⁹⁸

Such provider resistance at least calls into question the State's ability to develop sufficient provider networks in these regions. Director McCaslin also acknowledged that one of the reasons for resistance to expanding managed care was that **the State had not done as well as it could have "in holding [managed care] health plans fully accountable to provide services for people."**⁹⁹ It's also noteworthy that the state's most recent geographic expansion in 2008 had to be reduced from 21 to 17 counties because of the plan's inability to establish sufficient provider networks in some of the more rural counties—a problem that is likely to be repeated in any attempt to expand managed care

to all geographic areas of the state.¹⁰⁰

Given these findings, the state may well want to test different approaches such as primary care case management (PCCM) models in some of the areas of the state that do not currently have risk-based managed care.¹⁰¹

Conclusion

The foregoing discussion demonstrates that there are *significant questions* regarding the ability of Medicaid managed care to achieve cost savings while delivering quality health care for a population that suffers from chronic, long-term health conditions. Missouri would have to address several challenges such as assuring that managed care plans have adequate provider networks and properly setting capitation rates to ensure that Medicaid managed care plans can effectively deliver services to seniors and people with disabilities without denying medically necessary services. The experience of Missouri's existing managed care system raises additional questions about whether it is appropriate to expand risk-based managed care *at all* in this state. For the reasons stated above, the State should move cautiously, if at all, in extending risk-based managed care to seniors or people with disabilities, and should certainly not do so for the purpose of saving money quickly. The Lewin Group directly cautioned against such an approach and in fact recommended exploring alternatives to risk-based managed care for seniors and people with disabilities. Thus, as discussed above, the State should explore alternatives such as primary care case management and additional options available in the Patient Protection and Affordable Care Act to coordinate care and improve access for this vulnerable population.

Endnotes

* The authors wish to thank Mary Beekman for her assistance in the preparation of this paper.

¹ Missouri Senate, *Reboot Government Working Group Recommendations*, undated (available at: http://www.senate.mo.gov/RebootMO/RebootMO_Recommendations.pdf) (“Reboot Government Recommendations”). On March 23, 2010, a working group of the Missouri Senate considered various proposals to achieve savings in the state budget. Shortly thereafter, the Senate’s *Reboot Government Working Group* issued a report with multiple recommendations for achieving savings ranging from \$689.3 to \$789.4 million, including the \$25 million to \$50 million in savings from extending managed care to these additional populations. *Id.*

² *Id.* at 12.

³ The Medicaid managed care pilot provisions were included in a Senate Substitute for House Bill 2205, a bill originally intended to address disclosure of health information. The managed care pilot in the substitute bill was very similar to a proposed amendment circulated earlier in the General Assembly but which had not been formally introduced. The substitute bill would have authorized a Medicaid managed care pilot project, “Missouri ABD Care Management Pilot Project,” for aged, blind and disabled individuals. The proposed pilot program would have provided full risk care by a “**single qualified managed care organization**,” subject to the approval of the Centers for Medicare and Medicaid Services. § 208.183 (emphasis added). Enrollment in the pilot program would have been mandatory for “all Medicaid recipients who are identified in the aged, blind and disabled program categories who are over the age of twenty-one, who are not enrolled in a Medicaid waiver program, who do not have eligibility for Medicare and who do not reside in a nursing facility.” *Id.* at § 208.183.1(2). Enrollment would be required no later than July 1, 2011. *Id.* at § 208.183.1(10).

The benefits provided by the pilot program would have included hospital, physician, ancillary, pharmacy and behavioral health benefits and the program would have been required to contract with community mental health centers to provide services. *Id.* at § 208.183.1(3). The pilot program would have been required to include any and all providers willing to accept current Medicaid fee for service reimbursement rates. *Id.* at § 208.183.1(9). The MO HealthNet Division Director would have been required to provide an annual report to the Legislature that included information on cost-savings, consumer satisfaction, provider reimbursement timeliness, and other quality measures. *Id.* at § 208.183.1(8). The pilot program would have sunset in three years. *Id.* at § 208.183.1(10). The Senate, however, adopted an amendment proposed by Senator Mayer stripping the bill of all of these provisions.

⁴ This paper does not dispute that some states have achieved savings through managed care for Medicaid beneficiaries, including people with disabilities in a few instances. A Lewin Group report commissioned by America’s Health Insurance Plans detailed savings in several states. The Lewin Group, *Medicaid Managed Care Cost Savings – A Synthesis of 24 Studies*, America’s Health Insurance Plans (updated March 2009) at 1-2 (hereinafter “Lewin AHIP Report”). However, as will be discussed, the barriers to savings here—not to mention quality health care—are Missouri-specific financing mechanisms, data, and structural issues. In addition, the Lewin Group’s recent Missouri report found that

several challenges must be overcome in order for Managed Care to even be a “viable option” in Missouri. The Lewin Group, *Mo HealthNet Comprehensive Final Report* (April 30, 2010) at 65 (hereinafter “Lewin Comprehensive Report”) (available at: <http://www.dss.mo.gov/mhd/oversight/pdf/final-report2010apr30.pdf>).

⁵ Alicia Smith & Associates, Inc., *Comparative Analysis of Quality of Care and Access to Services in MO HealthNet Managed Care and MO HealthNet Fee-for-Service*, Missouri Department of Social Services (December 2009) at 3 (hereinafter “Alicia Smith Report”) (available at: <http://www.dss.mo.gov/mhd/oversight/pdf/ffs-mgdcare10feb18.pdf>). The Missouri Hospital Association asserted that federal payments to Medicare Advantage plans “are being reduced after repeated findings that they are *more costly per enrollee* than unmanaged fee-for-service care and *do not produce significantly better outcomes.*” MO HealthNet Division, Missouri Department of Social Services, *Summary of Missouri Hospital Association Comments Regarding a Proposed Expansion of Medicaid Managed Care*, July 30, 2010 (available at: <http://www.dss.mo.gov/mhd/mc/pdf/mo-hospital-assoc.pdf>)(emphasis added)(hereinafter “MHA Comments”).

⁶ Id. at 47.

⁷ Id. at 47.

⁸ Memorandum from the National Health Law Project (NHeLP) to Missouri Sunshine Partners, dated February 11, 2010. NHeLP found that the percentage of children receiving six well child visits in the first 15 months of life, children receiving well child visits for the third, fourth and sixth year of life, adolescent well care visits, and childhood immunizations either remained stagnant or declined over a three year period. Id. at 7-8.

⁹ Id. at 9-10.

¹⁰ Id. at 11.

¹¹ Letter from Joel Ferber, Jo Anne Morrow and Katie Lamb to Ian McCaslin, Director, MO HealthNet Division, dated Aug. 22, 2008, regarding new RFPs for MO HealthNet Managed Care (“RFP Comments”) at 1-2; Jennifer Wiemann, *Medicaid Expansion Presentation*, Advocates for Family Health (Legal Services of Western Missouri), July 30, 2010 (available at: <http://www.dss.mo.gov/mhd/mc/pdf/medicaid-expansion.pdf>).

¹² Id.

¹³ See endnote 69, infra.

¹⁴ Amy McCurry Schwartz, Esq., MHSA, EQRO Project Director, Behavioral Health Concepts, Inc., *2006 MC+ Managed Care Program, External Quality Review, Report of Findings*, PowerPoint Presentation, dated Jan. 23, 2008, at slide 43.

¹⁵ The MO HealthNet Division included new protections and standards in its current contract to address these very problems with provider network adequacy. See Missouri RFP, Sections 2.4.1 and 2.4.12 (modifying requirements for plans provider networks).

¹⁶ Alicia Smith Report, supra, at 31.

¹⁷ Alicia Smith Report, supra, at 39.

¹⁸ Alicia Smith & Associates, *Comparative Analysis of Quality of Care and Access to Services in MO HealthNet*, PowerPoint Presentation, dated Oct. 27 2009, at slide 40 (available at: <http://dss.mo.gov/mhd/oversight/pdf/managedcare091218.pdf>).

¹⁹ Alicia Smith Report, supra, at 39.

²⁰ Alicia Smith Report, supra, at 39 (and citation therein). See also State of Connecticut, Department of Social Services, *Mystery Shopper Project* (Oct. 2006).

²¹ See Missouri Medicaid Managed Care Request for Proposal (RFP), Central, Eastern and Western regions (“RFP”), §§ 2.10.1 through 2.10.12. The managed care plans also do not cover the long term care services--nursing home care, intermediate care facilities for the mentally retarded and home and community-based waiver services--that account for a significant share of state spending for elderly and disabled beneficiaries. See Center on Budget and Policy Priorities, *Analysis of Medicaid Statistical Information System data for Missouri for FY 2004* (March 28, 2006). These long term care costs are still paid by the state on a fee-for-service basis.

²² See RFP, § 2.10.6. The State estimates that it saves **more than \$5.3 million in a single month** by providing pharmacy service on a fee-for-service basis for managed care enrollees. MO HealthNet Division Data, April 2010, attached to E-mail from Rhonda Driver to Joel Ferber, dated June 24, 2010. In addition, State data indicate that effective management of this benefit by the State agency results in expenditures that are lower than appropriations for this benefit. See also MO HealthNet Power Point Presentation, dated June 24, 2010, Slide 6. There is certainly no guarantee that Missouri would achieve the same result if it allowed managed care organizations to administer the benefit.

²³ RFP Comments, supra, at 9.

²⁴ The Centers for Medicare and Medicaid Services recently issued guidance to States to implement a provision of the Patient Protection and Affordable Care Act (PPACA) that increases the Medicaid drug rebates that Manufacturers must give to the States, but also increases the amount of money from these rebates that States must remit to the Federal government. Cindy Mann, Letter to State Medicaid Directors, Centers for Medicare and Medicaid Services, dated April 22, 2010 at 1-2. This provision also requires drug manufacturers to extend rebates to Medicaid MCOs which previously were not able to receive them. Id. at 2. This change thus eliminates one disincentive for states to provide pharmacy benefits through managed care plans. Thus far, however, Missouri has found it cost-effective and efficient to provide these services on a fee-for-service basis, taking

advantage of the pharmacy tax as well as its state administered systems of “clinical edits” and “smart prior authorization,” irrespective of the rebates MCOs obtain from drug manufactures. The state-administered pharmacy provider tax is the primary reason for the cost-effectiveness of Missouri’s carve out of the pharmacy benefit. Like the hospital provider tax (the FRA), this financing mechanism makes it extremely unlikely that savings would be achieved by providing this benefit to people with disabilities through risk-based managed care.

²⁵ See Kaiser Commission on Medicaid and the Uninsured, *Medicaid and Managed Care: Key Data, Trends and Issues* (February 2010) at 5-6 (hereinafter “Kaiser Commission Paper”); Sara Rosenbaum, et al., *Achieving “Readiness” in Medi-Cal’s Managed Care Expansion for Persons with Disabilities: Issues and Process*, (George Washington University, School of Public Health and Health Services, Department of Health Policy, August 2005) at 17 (hereinafter “*Medi-Cal Report*”); California Health Care Foundation, *Medi-Cal Beneficiaries with Disabilities: Comparing Managed Care with Fee-for-Service Systems* (August 2005); Marsha Regenstein, Christy Schroer, et al., *Medicaid Managed Care for Persons With Disabilities: A Closer Look*, Kaiser Commission on Medicaid and the Uninsured (April 2000) at iv and 5-6 (hereinafter “Kaiser Report”); *Medi-Cal Lessons Report* at 6.

²⁶ See endnote 4, *supra*.

²⁷ Alicia Smith Report, *supra*, at 7 (emphasis added).

²⁸ *Medi-Cal Report*, *supra*, at 6-7. The *Medi-Cal Report* also highlighted several issues relating to expanding the pool of specialized providers: whether these specialized providers will be easily accessible (e.g. whether they are too far from the service area), whether existing providers can be retained in the networks after expanding managed care to people with disabilities, and whether these networks will cover out of network providers. *Id.*

²⁹ Lewin Comprehensive Report, *supra*, at 61.

³⁰ *Id.*

³¹ John Holohan and Shinobu Suzuki, *Medicaid Managed Care Payment Methods and Capitation Rates in 2001: Results of a New National Survey*, Urban Institute (March 2003) at 1.

³² Lewin Comprehensive Report, *supra*, at 60. The “TANF population” is intended to refer to the current Missouri managed care population, which includes children, families and pregnant women, and is not limited to individuals receiving TANF benefits.

³³ Lewin AHIP Report, *supra*, at 7 (emphasis added). Of course, it is difficult to ensure that capitation rates are actuarially sound *and still save money over the FFS system* when one considers that many of the specialized services needed by individuals with disabilities and seniors are quite expensive.

³⁴ Indeed, the “higher than expected” costs of serving the ABD population and insufficient capitation rates were “one of the underlying factors” that resulted in the end of Oklahoma’s SoonerCare Plus managed care program in late 2003. James Verdier, et al., *SoonerCare 1115 Waiver Evaluation: Final Report*, Mathematica Policy Research Institute (January 2009) at 14. See further discussion at page 9, infra, regarding Oklahoma’s abandonment of risk-based managed care for a primary care case management model.

³⁵ See Tobias, et al., *Reinventing the HMO: The Next Generation of Medicaid Managed Care* (Center for Health Care Strategies, Inc., Aug. 2005) at 25. In Massachusetts, the State’s attempt to implement a managed care program for its Medicaid enrollees with disabilities and chronic illnesses resulted in increased expenditures, but for the “right reasons.” Id. Enrollees who received little to no care in the fee-for-service program received more care during the demonstration period. Id. Similarly, New Mexico implemented a capitated plan for its behavioral health system after finding that its previous system was under-utilized. Lewin AHIP Report, supra, at 26. This “intentional effort” to improve the behavioral health services delivery system resulted in an estimated increase in costs of 26% in the first year. Id. at 26.

³⁶ Cost savings could be expected if the groups of patients in question were using emergency rooms for care that can be provided more appropriately in routine visits to a primary care physician. Studies on cost-savings in Medicaid managed care – *including studies commissioned by managed care plans* --- point to “decreases in in-patient hospitalization” as the primary basis for cost-savings in the program. Lewin AHIP Report, supra, at 2.

³⁷ Medi-Cal Policy Institute, *Adults with Disabilities in Medi-Cal Managed Care: Lessons from Other States*, Center for Health Care Strategies (September 2003) at 20-21. The report also briefly summarized why such immediate savings are difficult to obtain and, therefore, an ill-advised goal for states: (1) increased utilization of services due to better access; (2) increased utilization of services due to improved care coordination; and (3) increased up-front administrative costs for both the state and health plans. Id. at 21.

³⁸ Bruce C. Vladeck, *Where the Action Really Is: Medicaid and the Disabled*, Health Affairs (Jan.-Feb. 2003) at 97 (emphasis added).

³⁹ Id.

⁴⁰ Lewin Comprehensive Report, supra, at 60. See also Kaiser Commission Paper, supra at 6-7 (noting that Medicaid rates are important to Medicaid-focused managed care organizations because they “cannot cross subsidize their Medicaid enrollment with premiums from commercial enrollees” and that states have resorted to a variety of risk reduction strategies, including risk corridors).

⁴¹ Lewin Comprehensive Report, supra, at 60 (emphasis added). See endnotes 34 and 35, supra and the studies cited therein; MHA Comments, supra, at 1.

⁴²Lewin identified eleven key issues that would need to be carefully addressed by the State before implementing managed care for seniors and people with disabilities:

- (1) How to engage beneficiary stakeholders and obtain their support;
- (2) How other stakeholders (e.g. providers, contractors, etc.) would be impacted;
- (3) Whether to enroll the SSI population on a voluntary or mandatory basis;
- (4) What regions of the State to include in any future managed care expansion;
- (5) Whether to include dual eligible and non-Medicare eligible participants in a managed care expansion;
- (6) What services should be provided by the managed care plans in a managed care expansion;
- (7) What financial arrangements are appropriate for the managed care plans in a managed care expansion;
- (8) Whether the current provider networks are adequate for the new populations to be serviced in a managed care expansion;
- (9) What resources are needed within the MO HealthNet Division to ensure a successful expansion of Medicaid managed care;
- (10) How to ensure that the State will have sufficient resources to exercise adequate oversight of the managed care plans in a managed care expansion; and
- (11) How the managed care expansion will impact the financing mechanisms for the MO HealthNet Program.

Lewin Comprehensive Report, supra, at 53. It is important to note, as indicated above, that mandatory managed care is not the only option for people with disabilities as some states have opted to provide such care on a voluntary basis. In the voluntary model, consumers have a choice as to whether they participate in managed care or FFS. John Barth, *Enrollment Options for Medicaid Managed Care for People with Disabilities*, Center for Health Care Strategies (July 2007) at 1 (hereinafter “CHCS Summary”). Some states have used this model as a transition to an eventual mandatory model. *Id.* As Lewin suggested, “voluntary enrollment allows for a gradual phase-in of the program while learning about the population and its unique needs.” Lewin Comprehensive Report, supra, at 56.

⁴³ Lewin Comprehensive Report, supra, at 62.

⁴⁴ The Senate Substitute for House Bill 2205 would have created an “advisory council” comprised of the managed care organization awarded the contract, state officials, and stakeholder groups. However, the bill would not have required that the issues identified by Lewin be addressed nor would it have ensured the necessary stakeholder involvement *prior* to setting up the pilot program. The bill also would have required that the program begin *no later* than twelve months from passage of the law. As Washington’s chronic care management program (not a risk-based program) demonstrates, successful implementation of programs that coordinate care for people with disabilities may depend

upon gradual phase-in of various components. Center for Health Care Strategies, *Case Study Washington State Medicaid: An Evolution in Care Delivery* (Dec. 2008) at 3.

⁴⁵ Lewin Comprehensive Report, supra, at 62 (emphasis added).

⁴⁶ Id. at 62-67.

⁴⁷ Id. at 66.

⁴⁸ Id. Lewin appropriately noted that Missouri's existing Chronic Care Improvement Program (CCIP) (which was just recently cut back significantly) would have to be substantially revised to provide the kind of care management that is needed for this population. Id. at 71. Missouri would do better to explore new options in the health reform law and other states' primary care case management programs rather than resurrect CCIP.

⁴⁹ Through the FRA program, hospitals pay a provider tax which serves as a "substitute" for general revenue. See Missouri Hospital Association, *Missouri's Federal Reimbursement Allowance Program* (Feb. 2009), available at: <http://web.mhanet.com/UserDocs/articles/FRA.pdf>. The State then uses the majority of those funds to reimburse hospitals for MO HealthNet Services (for which the State earns federal matching funds). Id.

⁵⁰ H.B. 2011, 95th General Assembly, 2nd Reg. Sess., § 11.500 (Mo. 2010).

⁵¹ Id.

⁵² The other major area of potential savings for managed care is pharmacy; however, Missouri has found it more cost-effective to provide pharmacy care on a fee-for-service basis in its existing managed care program. Pharmacy services are also supported by a large provider tax which far exceeds the general revenue portion of the state match for these services. Letter from Ian McCaslin to Joel Ferber, dated April 22, 2010, and attached state data for fiscal year 2010. Thus, it is unlikely that substantial *general revenue* savings would be achieved by paying managed care plans to provide these services.

⁵³ See 13 C.S.R. § 70-15.010(15). Effective July 1, 2011, the utilization adjustment will no longer apply to any hospital other than safety net hospitals, children's hospitals and special pediatric hospitals as defined in the regulations. 13 C.S.R. § 70-15.010(15)(B)4.C.

⁵⁴ Lewin Comprehensive Report, supra, at 66. Lewin noted a potentially significant impact on the FRA if MCOs reimburse hospitals at rates substantially lower than total Medicaid payments. Id. at 64.

⁵⁵ Id. at 60.

⁵⁶ In state fiscal year 2007, seniors and persons with disabilities comprise about 26% of enrollees but accounted for 65% of Missouri Medicaid expenditures. Department of Social Services, Medicaid/MC+ Enrollees and Expenditures, SFY 2007 (available at <http://www.dss.mo.gov/mhd/general/pdf/mhdollars.pdf>).

⁵⁷ Angela WasDyke and Michael Cook, *MO HealthNet Managed Care Cost Avoidance*, PowerPoint Presentation, Mercer (Feb. 2010) at slide 2 (hereinafter “Mercer PowerPoint”); Mercer, *Managed Care Cost Avoidance Model* (Jan. 2010) at 9 (available at: <http://www.dss.mo.gov/mhd/oversight/pdf/cost-avoidance10jan29.pdf>) (hereinafter “Mercer Report”).

⁵⁸ Mercer PowerPoint, *supra*, at slide 5; Mercer Report, *supra*, at 10. Mercer stated that the Fee-for-Service “benchmark” against which managed care savings were measured is reflective of those populations that would be in managed care if it were offered in that geographic region. It does **not** include categories of assistance (i.e., aged, blind and disabled) that are not currently eligible for managed care. MO HealthNet Oversight Committee Meeting Minutes, February 2, 2010, available at <http://www.dss.mo.gov/mhd/oversight/pdf/minutes2010feb02.pdf>.

Mercer also makes a number of assumptions which *may* be perfectly appropriate but are not explained in its report. For example, Mercer indicates that it has made a number of “adjustments” (“Mass adjustments” and “Geographic Adjustments”) without indicating how those adjustments were determined. *Id.* at 5-6. The report also does not take into account the direct payments made to hospitals in its cost comparison, including the specific “add on” payments that are made to hospitals to compensate them for lost revenue that results from reduction in in-patient hospital utilization – which defeat the purpose of using capitated managed care in the first place. *Id.* at 12. It is unclear how these payments would affect the cost-savings analysis. The report also does not appear to account for the interest on money held by the plans for a prior year’s “unpaid claims” that would otherwise accrue to the State in the absence of managed care. Missouri Department of Insurance, Financial Institutions & Professional Registration, Sep. 2009 at 69.

⁵⁹ See discussion at page 9, *infra*.

⁶⁰ Wisconsin is reconfiguring its Medicaid contracts, dropping some Managed Care Organizations entirely, claiming that one insurer “was creating profits at the expense of patient care.” Alec MacGillis, *Some States Say They’re Not Receiving the Medicaid Services They’re Paying For*, *The Washington Post* (July 8, 2010) at A10. Wisconsin’s Medicaid Director commented that the State was “unsatisfied” with the level of care provided to its beneficiaries “given the amount of money [it] was paying.” *Id.* Furthermore, Florida received in \$40 million in restitution after one of its insurers admitted to shortchanging children on Medicaid. *Id.*

⁶¹ Kaiser Commission on Medicaid and the Uninsured, *Medicaid’s Disabled Population and Managed Care* (March 2001) at 2.

⁶² Missouri House of Representatives, *Report of the Interim Committee on Medicaid Cost and Containment* (Jan. 2004) at 26 (emphasis added).

⁶³ Missouri General Assembly, Medicaid Reform Commission, *Final Report of the Medicaid Reform Commission* (Dec. 2005) at 28.

⁶⁴ Lewin Comprehensive Report, *supra*, at 56 (emphasis added). These consultants further noted that implementing managed care on a voluntary enrollment basis would be more complicated but “allows for a gradual phase-in of the program *while learning about the population and its needs.*” *Id.*

⁶⁵ James Verdier, *supra*, at 21-22.

⁶⁶ *Id.* at 23.

⁶⁷ See endnote 3, *supra* (emphasis added).

⁶⁸ 42 U.S.C. § 1396u-2(a)(3) (2006).

⁶⁹ Lewin Comprehensive Report, *supra* at 12.

⁷⁰ Ian McCaslin, *How Are Our Patients Best Served*, Power Point Presentation to the MO HealthNet Oversight Commission, Nov. 18, 2008 (available at: <http://www.dss.mo.gov/mhd/oversight/pdf/handout2008nov18.pdf>) (hereinafter “McCaslin Presentation”); Ian McCaslin, *How are Our Patients Best Served*, Power Point Presentation to the July 30, 2010 Managed Care Forum, July 30, 2010 (available at: <http://www.dss.mo.gov/mhd/mc/pdf/mhdpresentation.pdf>). In addition, the State’s current Quality Assurance (QA) methods are wholly inadequate. The current QA reviews generally find the plans to be compliant based on the providers that MCOs *claim* to have in their network, rather than the providers that are *actually* available to see MO HealthNet patients. Plans readily acknowledge that many of their panels are closed, yet they are still found to be in compliance with their contracts. Amy McCurry Schwartz, Esq., MHSA, EQRO Project Director, Behavioral Health Concepts, Inc., *supra*, at 43. This result indicates a lack oversight in one of the most important areas of quality assurance for people with disabilities—the adequacy of provider networks.

⁷¹ See note 75, *infra*. A five-state study of Medicaid managed care programs noted the importance of a “stable source of reliable, comparable data on all participating plans” to a state’s ability to hold plans accountable. James Fossett, et al., *Managing Medicaid Managed Care: Are States Becoming Prudent Purchasers?*, 19 *Health Affairs* 36, 43 (August 2000). The report went on to say that because several states “have yet to establish stable reporting relationships with all the plans and **lack any institutional means of ensuring the quality of the data they receive**, prudent purchasing may be beyond the reach of many states.” *Id.* (emphasis added). See also Robert E. Hurley and Susan Wallin, *Adopting and Adapting Managed Care for Medicaid Beneficiaries: An Imperfect Translation* (Urban Institute, June 1998) at 23, available at

<http://www.urban.org/UploadedPDF/Occa7.pdf> (“States freely admit to lagging in the development of quality oversight and other monitoring functions...”); GAO, *Medicaid Managed Care: Challenge of Holding Plans Accountable Requires Greater State Effort* (May 1997) at 8, available at <http://www.gao.gov/archive/1997/he97086.pdf> (“many states are struggling to maintain the staff needed to establish and oversee their programs, since frequent turnover of staff with managed care expertise is common. It is not surprising, then, that states are at various stages in their program development and monitoring efforts.”); Manjusha M. Kulkarni, *Managed Care’s Impact on Lead Testing of Medi-Cal Beneficiaries in Los Angeles County*, National Health Law Program (December 2002) at 2 and 26 (noting that the lack of oversight over Medicaid managed care plans by states render federal and state mandates meaningless).

⁷² Lewin Comprehensive Report, *supra*, at 63.

⁷³ *Id.*

⁷⁴ *Id.* at 63 (emphasis added). The aforementioned legislation did not include any provisions for strengthening oversight of managed care plans or provide funding for new staff to hold health plans accountable for the substantial new funds they would receive to serve these additional populations.

⁷⁵ The State of Florida’s experience with WellCare, a national Medicaid HMO illustrates the significant concerns associated with states’ contracting out their Medicaid programs to private HMOs, especially with insufficient oversight. Carol Gentry and Mike Wells, *Unsealed Complaint Slams WellCare*, HealthNews Florida, June 28, 2010. The unsealed complaint against WellCare documents a number of abuses, including efforts to achieve profits by dumping sick newborns and terminally ill patients from its membership rolls back into the State’s fee-for-service system. *Id.* In light of the WellCare debacle, Florida Legal Services (FLS) expressed its concern that Florida’s Agency for Health Care Administration (AHCA) “was not collecting the data necessary to ensure that medically necessary services are actually provided.” Letter from Anne Swerlick and Miriam Harmatz to Tom Arnold, Secretary, AHCA, July 26, 2010 at 1. FLS also noted that the allegations in the WellCare complaint “seriously call into question the Agency’s ability to ensure HMO’s compliance with legal and contractual requirements.” *Id.*

⁷⁶ People with serious mental illness die, on average, 25 years earlier than the general population. Barbra Mauer, *Morbidity and Mortality with People with Serious mental Illness*, National Association of State Mental Health Program Directors (NASMHPD) Medial Directors’ Council (Joe Parks et. al., Editors) (October 2006) at 5.

⁷⁷ Written Testimony of Francie Broderick (before the Missouri Medicaid Reform Commission), Executive Director, Places for People, Oct. 13, 2005 (emphasis added), citing Cynthia Claassen et al., *Psychiatric Emergency Service Use After Implementation of Managed Care in a Public Mental Health System*, 56 *Psychiatric Services* 691 (June 2005).

⁷⁸ RFP Comments, *supra*, at 10-11. Testimony of Cathy Goldstein, Project Director, MC+ Consumer Advocacy Project, before the Missouri Medicaid Reform Commission, September 13, 2005. *See* Citizens for Missouri’s Children, *Missouri’s Fragmented Children’s Mental Health System Demands Reform* (2002) at 2, 9-13 (hereinafter “CMC Mental Health Report”), (discussing mental health services “carve-outs” and problems with providing mental health under Medicaid Managed Care).

⁷⁹ Legal Services’ Advocates for Family Health Programs report the following difficulties in obtaining mental health services:

One of the most significant issues is the inability to obtain in-patient mental health services at psychiatric hospitals. The difficulty in obtaining this service is another reason why needy children sometimes have to opt out of managed care. They opt out because the plans simply refuse to provide the specialized care that children with severe mental health needs require. Some children with very serious problems and very destructive behaviors are discharged in three days because they are not considered suicidal or homicidal—even though they have not been stabilized and their medications have not been properly regulated. Child psychiatrists are often overruled when they suggest that a child needs to remain hospitalized. This practice can infuriate the psychiatrist while the parent can be afraid to have the child come home. Children **should not have to opt out** to receive necessary mental health treatment when remaining in managed care may well be beneficial for some of their other health care needs. And of course, the State is paying plans to provide these services as part of their capitation rates.

RFP Comments, *supra*, at 10 (emphasis in original).

⁸⁰ Endnotes 21 and 22, *supra*.

⁸¹ Indeed, one study of mental services in the state’s managed care system suggested that mental health services should be carved out *altogether* from capitated managed care programs given the difficulties that such programs have in providing high-cost services. *See* CMC Mental Health Report, *supra*, at 10-11, (citing Department of Health and Human Services Office of Inspector General Report regarding the potential benefits of carving out high-cost or specialty services).

⁸² Memorandum from Patricia A. Wilson-Coker, Commissioner, to the Honorable Toni Nathaniel Harp, Senate Chair, et al., dated May 5, 2005.

⁸³ *Id.* at 1-2 (emphasis added).

⁸⁴ E-mail from George Oestreich, PharmD, MPA, Deputy Divisions Director-Clinical Services, Mo HealthNet Division to Joel Ferber, dated June 2, 2010.

⁸⁵ As the Lewin group notes, “dual eligibles present a unique challenge since most of their acute care costs are covered by Medicare, and any potential managed care savings “are most likely to accrue to Medicare,” rather than Medicaid. Lewin Comprehensive Report, supra at 58. The Senate Reboot Government report does not appear to recommend capitating long-term care, which is a major component of the Missouri Medicaid budget for elderly and disabled beneficiaries. As the Lewin Group and others have recommended, rebalancing nursing home and home and community based services is the way to achieve significant cost-savings in long-term care. Managing medical care through risk-based managed care for seniors and people with disabilities will not address the cost of long-term care for this population.

⁸⁶ The Lewin Group, *Missouri Medicaid Report on High-Cost Beneficiaries* (March 2000) at 15. Lewin also suggested that Missouri could save \$10,000 per person by rebalancing, or “right-sizing” its nursing home population by moving those individuals back into the community who would be better served there. The Lewin Group, *MO HealthNet Long-Term Care Review* (Nov. 2009) at 19, 24. The federal health reform law creates a number of new options to help facilitate such rebalancing of long term care services which are beyond the scope of this paper. See National Senior Citizens Law Center, *The Medicaid Long-Term Services and Supports Provisions in the Health Reform Law* (April 2010).

⁸⁷ NHeLP, *An Analysis of the Health Care Reform Law: PPACA and the Reconciliation Act, Part II* (June 2010) at 34 (hereinafter “NHeLP Health Care Reform Analysis”).

⁸⁸ Alicia Smith Report, supra, at 22-25.

⁸⁹ Lewin Comprehensive Report, supra, at 66.

⁹⁰ The Kaiser Commission found a five-state evaluation indicates that PCCMs “may perform as well as or better than capitated MCOs on measures of access, cost, and quality if sufficient resources are devoted to their design, implementation, management, and funding. Kaiser Commission Paper, supra, at 4.

⁹¹ Kaiser Commission Paper, supra, at 3.

⁹² Lewin Comprehensive Report, supra, at 68.

⁹³ Patient Protection and Affordable Care Act (PPACA) § 2703. Beginning January 1, 2011, the PPACA creates a new state option to provide coordinated care through a “health home” for eligible individuals with chronic conditions. NHeLP Health Care Reform Analysis, supra, at 37-39. The health home can consist of a designated provider, a team of health professionals or a health team selected by the eligible individual with chronic conditions to provide “health home” services. Id. at 38. For the first two years that the state plan amendment is in effect, the state will receive a 90 percent FMAP rate to pay the designated provider, a team of health care professionals, or a health team for health home services. Id. at 39.

⁹⁴American College of Physicians, *Understanding the Patient-Centered Medical Home* (undated)(available at: http://www.acponline.org/running_practice/pcmh/understanding/index.html). The Missouri Hospital Association similarly endorsed using the various options from the PPACA, noting that the “focus is on *provider-centered* adoption of better care management processes.” MHA Comments, *supra*, at 1 (emphasis added).

⁹⁵ *See*, National Senior Citizens Law Center, endnote 57, *supra*.

⁹⁶ Reboot Government Recommendations, *supra*, at 12.

⁹⁷ McCaslin Presentation, *supra*, at 19.

⁹⁸ McCaslin Presentation, *supra*, at 18 (emphasis added).

⁹⁹ McCaslin Presentation, *supra*, at 17. (emphasis added).

¹⁰⁰ *See, e.g.*, Family Support Division, Income Maintenance Memoranda on the Expansion of Managed care, September 21, 2007 and January 7, 2008.

¹⁰¹ The Lewin Group suggested that patient-centered medical homes, which rely on primary care teams to address a patient’s needs, “could meet the State’s care management objectives.” Lewin Comprehensive Report, *supra* at 68. States using enhanced PCCM, including Oklahoma, North Carolina, Pennsylvania, Indiana, and Arkansas all have some “medical home elements” in their programs. Verdier, et al., *Enhanced Primary Care Case Management Programs in Medicaid: Issues and Options for States*, Center for Health Care Strategies (Sept. 2009) at 9; Doug Trapp, “Medical Homes for Medicaid: The North Carolina Model,” *American Medical News* (August 2, 2010).