

**MO HEALTHNET AND SB 577: A PRELIMINARY ANALYSIS OF
REVISIONS TO THE MISSOURI MEDICAID PROGRAM**

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This paper provides an overview of Senate Bill 577, which renames Missouri’s Medicaid program and makes modest changes to it, including some revisions to coverage and services as well as an increased reliance on managed care.

The legislation implements some of the Governor’s recommendations for reforming Medicaid. The Governor proposed to provide a “health care home” for individuals in the new MO HealthNet program. SB 577 revises Missouri law to authorize the Department of Social Services to implement the new “MO HealthNet” program, including the proposed “health care home” concept. However, the “health care home” is not defined in the bill. The final legislation dropped Senate provisions that would have created “health care advocates” to help coordinate participants’ health care. Furthermore, the bill excludes prior proposals to condition the coverage of certain health care services, including “Medicaid-covered services,” on healthy behaviors and responsible lifestyles as determined by the Department of Social Services. The implementation of the “health care home” is left to the Department of Social Services and the private entities with which it contracts.

SB 577 would also require all Medicaid beneficiaries to be enrolled in various types of “health improvement plans” that would be responsible for their care and would be required to provide them a “health care home.” Most of the details of the new “health improvement plans,” including capitated or risk-based managed care plans, are not included in the legislation, but will be developed by the Department of Social Services subject to the approval of a new Oversight Committee. The implementation of “health improvement plans” will likely require extensive advocacy and input from various stakeholders as the rules, policies, and contracts for these plans are developed.

The legislation does not *restore* Medicaid coverage to most of those individuals who lost coverage in 2005, but it does expand coverage for adolescent children who would otherwise lose their Medicaid eligibility because they are no longer eligible for foster care. The legislation also includes a new Ticket to Work Health Insurance Program for disabled workers and modifies the SCHIP “affordability” test to restore SCHIP coverage for about ten thousand children. The legislation also expands access to family planning services for low-income Missouri women.

The legislation adds “hospice” services and “durable medical equipment” as required services under Missouri law – these services were eliminated as statutorily-mandated services by SB 539 for most adults, although hospice services and some types of medical equipment (e.g., wheelchairs, oxygen) were provided through the appropriations process and state regulations. The bill does not restore the other services that were eliminated in 2005. Rather, it provides that dental services and optometric services are “subject to appropriations,” as they are now. The legislation includes a state “False Claims Act,” implements new “Pay-for-Performance” requirements, and includes a number of other provisions that modify the Missouri Medicaid program.

This paper explains the key Medicaid provisions in the version of SB 577 passed by the Missouri General Assembly.¹

I. CHANGING THE NAME OF THE MEDICAID PROGRAM AND REMOVING THE SUNSET (§ 208.201)

SB 577 changes the name of the Missouri Medicaid program to “MO HealthNet” and replaces the word “Medicaid” with “MO HealthNet” throughout state law. The legislation removes sunset dates for the Missouri Medicaid and SCHIP programs. (§§ 208.631 and 208.014 (repealed)).² The name of the Division of Medical Services is changed to the “MO HealthNet Division.” (§ 208.201.1). All existing regulations promulgated by the Division of Medical Services remain intact unless withdrawn or amended by the new MO HealthNet Division (§ 208.201.4). The legislation also deletes the provisions of Missouri law that created the Medicaid Reform Commission. (§ 208.014) (repealed). The continuation of existing regulations and policies indicates that, while the Medicaid program is being modified and renamed, it has not been radically restructured by SB 577.

II. HEALTH CARE HOMES, HEALTH RISK ASSESSMENTS, PLANS OF CARE, AND HEALTHY LIFESTYLES

The legislation requires “health improvement plans” (discussed below) to provide a “health care home” for MO HealthNet recipients.³ However, “health care homes” are never defined in the legislation, nor is the Department of Social Services directed to define a “health care home” through regulations. According to the American Academy of Pediatrics (AAP), the concept of a “*medical home*” involves providing comprehensive, continuous, accessible, coordinated, and family-centered primary care that enables the patient to obtain access to all necessary specialty services and treatment -- certainly a worthy goal for Missouri’s Medicaid program.⁴ However, without a definition of a “health care home,” this provision has little legal significance, and its practical significance is yet to be determined.⁵ Under the final version of SB 577, the “health care home” could be a managed care organization, a nursing home, a hospital, a primary care physician, a physician’s office, a health clinic, or a variety of other entities.

Without further definition, the new health improvement plans -- including private managed care plans, administrative service organizations and the state’s coordinated fee-for-service plan could have a free hand to determine what it means to provide a “health care home.” For example, the plan could provide the patient a list of physicians to contact and a brochure on healthy lifestyles and say it provided a “health care home.” This would not meet the AAP definition of a “medical home” or the legislative intent of SB 577.

The Department could choose to issue regulations that define a “health care home” pursuant to the public comment provisions of the Missouri Administrative Procedures Act, rather than leave it to managed care plans and administrative service organizations. Ultimately, a true “medical home” model would ensure that, at minimum, every Medicaid (MO HealthNet) beneficiary has access to a primary care physician and the case management services needed to help coordinate their care in whatever delivery

system they are enrolled. In addition, the funding and provider reimbursement must be sufficient to ensure that primary care and necessary case management services are in fact provided.

The legislation *does* require health improvement plans to conduct a “health risk assessment” and create a plan of care for each participant. The plan of care must include health status goals “achievable through healthy lifestyles” and must be “appropriate for the individual” based on the individual’s age and the results of his or her health risk assessment. (§ 208.950.7). *The legislation does not address how or whether plans of care would address health status goals that are achievable through means other than “healthy lifestyles,” such as the receipt of medically necessary specialty care (e.g., surgery, mental health treatment, therapies, etc.).*⁶ The legislation does not indicate *who* will create the plan of care. Will it be the patient’s treating physician, a case manager, a social worker, a health coach, a managed care utilization reviewer, or someone else? SB 577 leaves it up to the “health improvement plans” to determine who develops the plan of care. Thus, there is a potential for conflict between the treating physician and the individual who develops the plan of care if that individual is not the treating physician. This conflict could be particularly pronounced if the individuals creating the plans of care work for a risk-based managed care organization.⁷

The final legislation does *not* include the Senate provision that would have required participants to have a “health care advocate” help coordinate their care. These health advocates would have had a wide array of responsibilities ranging from providing health care to developing plans of care to coordinating referrals and providing case management.⁸ The final legislation omitted the House provisions on “wellness coaches,” care coordinators, and individual support team coaches, all of whom would have had certain case management and care coordination responsibilities.

Thus, the actual provision of a “health care home” and needed case management responsibilities are left to the policies and practices of the Department of Social Services, the MO HealthNet Division, and the private entities with which they contract. Advocates and other stakeholders will likely want to provide input to the Department and the Oversight Committee in this area.

- **Health Improvement Agreements And Healthy Practices/Responsible Lifestyle Requirements Not Included.**

Unlike the Senate version, the final legislation does *not* require Medicaid recipients to sign agreements under which their receipt of medically necessary services and other items (such as over-the-counter drugs) would be based upon adopting “healthy practices” or responsible lifestyles. Prior Senate proposals on earning “health improvement” points for healthy practices and responsible lifestyle choices were not included in the House bill and are not included in the final version of the legislation. Physicians will *not* have to report to the State on their patient’s compliance and will not be in the position of having to deny medically necessary services to their own patients. As indicated above, however, health improvement plans must develop plans of care that focus on goals that are

achievable through “healthy lifestyles” – thereby addressing one of the *goals* of the Senate version.

The final legislation also does not include the Senate provisions regarding electronic access cards for tracking health improvement points. The Senate bill had proposed that these cards could be used by participants to satisfy cost-sharing at hospitals, physicians or other health care providers and could be used by participants to earn “enhanced health improvement points” towards additional health care services as discussed above. In addition, the final bill omits the previous Senate provision that would have allowed participants to earn therapy services and comprehensive day rehabilitation services based on a discussion with their health advocate.

III. CHANGES RELATED TO ELIGIBILITY AND SERVICES

A. Disabled Workers Program (§ 208.146.1): The final legislation establishes a new disabled workers or “Ticket to Work Health Assurance” (TTW) program.⁹ The final bill includes, for the most part, the more expansive provisions of HB 39 passed by the House, as opposed to the more restrictive Senate provisions (in the Senate Committee Substitute for HB 39) on income limits and exclusions. The new disabled workers program has a gross income limit of 250% of the federal poverty level, but will disregard *earned* income between 250 and 300 percent of the FPL when determining gross income. The *net* income limit is the same as the net income limit in Missouri’s current Medical Assistance program for disabled individuals. However, the TTW net income determination will disregard: (1) all earned income of the disabled worker; (2) the first \$65 and one-half of the remaining earned income of a non-disabled spouse’s earned income; (3) a twenty-dollar standard deduction; (4) health insurance premiums; (5) a \$75 deduction for optical and dental insurance purchased by the worker (when the total dental and optical insurance premiums are less than \$75); (6) all SSI benefits and the first \$50 of SSDI benefits; and (7) a standard deduction for impairment-related employment expenses equal to one-half of the disabled worker’s earned income. The program will allow disabled workers to save resources up to \$5000 in medical savings or independent living accounts. Individuals with incomes above 100% of the federal poverty level will have to pay premiums to participate in the program. Premiums are graduated, depending on the income of the disabled worker and his or her family.¹⁰

This legislation is estimated to provide coverage to about 3240 disabled workers in the new Ticket to Work program.¹¹ While many of these individuals are currently receiving coverage on a Spenddown basis, it is estimated that 1930 of the individuals covered by the TTW program are not receiving Medicaid coverage now – either because they are not meeting their spenddown amounts or because their incomes exceed the “substantial gainful activity” (SGA) income requirement.¹²

B. Sheltered Workshop Disregard: The bill separately provides for a complete disregard of “any income earned by individuals eligible for certified extended employment at a sheltered workshop” for the purpose of determining eligibility for Medicaid benefits. This provision is estimated to affect 1,604 individuals, many of

whom are now receiving coverage on a Spenddown basis. Almost all of these individuals are covered by Medicaid now but most will have their out-of-pocket health care costs reduced through a reduction in their Spenddowns, while others will benefit from the disregard if they choose to increase their earnings.¹³

C. Changes to SCHIP Affordability test (§ 208.640): The bill would restore SCHIP coverage to some individuals by modifying the SCHIP “affordability” test. Under current rules, Missouri children who are determined to have access to affordable private or employer-sponsored health insurance are denied access to the SCHIP program even if their families are willing to pay the premiums required for SCHIP participation. The amendments would replace current Missouri statutory provisions that define “affordable” health insurance as insurance that costs 133% of the cost of Missouri Consolidated Health Care Plan premiums with new requirements that define “affordable health insurance” based on varying percentages (3%, 4% and 5%) of income in the three SCHIP premium group income tiers (151-185% of poverty, 186-225% of poverty, 226%-300% of poverty).¹⁴ For 2007, the revised “affordability” amounts will be \$64, \$106, and \$161 for these three income tiers. These premium affordability amounts will increase each year as the federal poverty level is adjusted.¹⁵

*The Department of Social Services estimates that 6,349 children will be restored by these modifications of the affordability test.*¹⁶

The final bill also includes *two more positive changes to the affordability test*. First, health insurance coverage that does not cover an eligible child’s pre-existing condition is not considered “affordable health insurance.” The Department of Social Services has estimated that 2353 additional children will receive SCHIP coverage due to the consideration of pre-existing conditions in determining affordability.¹⁷ Second, if a child has exceeded the annual coverage limits for all health care services, the child is not considered “insured” and does not have access to “affordable health insurance” for the purposes of eligibility for SCHIP coverage. Under current Missouri policy, a child can be considered to have access to affordable health insurance unless the child has exceeded the *lifetime* limits for all health care services.¹⁸ The Department of Social Services has estimated that 1,367 children would be restored by this modification.¹⁹

Unfortunately, another beneficial provision from the House bill was not included in the final version of the legislation. That provision would have considered deductibles, co-insurance, co-payments, and other out-of-pocket health care costs in determining whether private or employer-sponsored health insurance was affordable. These other forms of cost-sharing (besides premiums) are very important to a determination whether a private or employer-sponsored coverage is affordable for a low-income family and are required to be considered in determining the cost-sharing that can be allowed in a state’s SCHIP program.²⁰ However, Missouri will not consider these expenses in assessing the “affordability” of private or employer coverage for low-income families under SB 577.

The bill also requires the Department of Social Services to study the expansion of presumptive eligibility for children. Presumptive eligibility for children is an outreach and enrollment strategy for enrolling uninsured eligible children in Medicaid or SCHIP

on a temporary basis while their ongoing eligibility is determined. The House Committee Substitute would have required the Department to expand this outreach and enrollment strategy to federal funded health centers, rural health clinics, mental health providers, and other types of qualified entities, rather than merely study such an expansion.

D. Coverage for Children “aging out” of foster care (§ 208.151.1(26)): The legislation provides coverage to children “aging out” of foster care, an initiative estimated to help 970 such children.²¹ These adolescent children would now be eligible for Medicaid until they are 21 years old without regard to income or assets. The legislation gives the Department of Social Services the option of covering all adolescents leaving foster care meeting federal requirements or choosing the categories of adolescents that it wishes to cover. As indicated below, the bill contains an emergency clause that will implement this provision on the date of enactment.

The expansion of Medicaid coverage for this group of needy children is a significant improvement to the Missouri Medicaid program.

E. Expanding Coverage of Family Planning-related Services (§ 208.659): The final version of the legislation would expand Missouri’s “Uninsured Women’s Health Program” to include uninsured women with net incomes at or below 185 percent of the federal poverty level if their assets do not exceed \$250,000 and if they do not have access to employer-sponsored health insurance. The current Missouri Medicaid program provides one year of “extended women’s health services” to women who lose their eligibility for the Medicaid for Pregnant Women program sixty days after the end of their pregnancy. SB 577 would provide these family planning services (including testing and treatment for sexually transmitted diseases, contraception, etc.) to all women who meet the program’s new financial eligibility requirements rather than limiting these services to women who have already received Medicaid coverage for sixty days after giving birth or limiting the program to one-year of coverage. The Division of Medical Services has clarified that individuals in the expanded Women’s Health Program also will be eligible for Medicaid coverage of breast and cervical cancer screening.²² Some of these women who are diagnosed with breast or cervical cancer will be able to receive full Medicaid coverage through the Breast and Cervical Cancer Treatment (BCCT) Program, including the treatment of their cancer.²³ FSD estimates that 81,788 additional women will receive family planning services as a result of this policy change.²⁴

F. Restoration of Hospice Services and Durable Medical Equipment

1. Hospice Care (§ 208.152.1(20)): The final version of the bill reinstates *hospice care* as a required Medicaid service. Hospice care is a “coordinated program of active professional medical attention within a home, outpatient and inpatient care which treats the terminally ill patient and family as a unit.”²⁵ While SB 539 eliminated this service as a required service under state law, the State has continued to cover hospice care through the budget process and state regulation.

2. Durable Medical Equipment (§ 208.152.1(19)): The legislation adds “Prescribed, medically necessary durable medical equipment [DME]” as a Medicaid service in state law. The bill further states that “[a]n electronic web-based prior authorization system using best medical evidence and care and treatment guidelines, consistent with national standards shall be used to verify medical need.” The details of the new program are left to the regulations and policies of the Department of Social Services, and the effectiveness of the new system will depend upon the details. However, the reinstatement of medically necessary DME would be an expansion of DME coverage from the prior policy which only authorized a narrow list of items of equipment for adults who are not blind or pregnant.²⁶

G. Dental and Optometric Services for Adults Remain Subject to Appropriations (§ 208.152.1(21) and (22)): While earlier drafts of the House Bill would have completely restored Medicaid services that were eliminated in SB 539 (including but not limited to, such services as dental services, vision services, hearing aids, prosthetics, comprehensive day rehabilitation services, wheelchairs and other such services), the final legislation would only restore dental and optometric services *if funds are appropriated by the legislature*.

This provision is not a change from current circumstances because Missouri law *already* allows these services to be provided when money is appropriated for the services. In fact, optometric services (one eye exam every two years) have been provided through the appropriations process and by state regulation during the last two years, even though they were eliminated as *mandatory* services under state law.²⁷ While the reinstatement of these two services for adults would have been a positive change, the legislature did not restore them through the budget process or through SB 577. The final version of the bill also would require prior authorization of dental and optometric services if they are eventually restored through the appropriations process. Perhaps the inclusion of these two services in state law – even though subject to appropriations -- will focus more legislative attention on whether to fund these services in the Fiscal Year 2009 budget.

H. Discrepancies in Medicaid Coverage Remain (§ 208.152.2): The legislation does not eliminate the discrepancies created by the 2005 Missouri Medicaid revisions under which a wide array of medically necessary services such as hearing aids, dental services, therapies, and some vision services are covered for blind elderly and disabled individuals but are not similarly part of the benefits package for non-blind elderly and disabled individuals. Rather, the legislation retains provisions of current law that provide different levels of services for blind and non-blind adults. Dental and optometric services for blind individuals are not “subject to appropriations.” Moreover, hearing aids are still part of the benefits package for blind adults but not for deaf adults, unless they are also blind or pregnant.²⁸ However, as indicated earlier, the legislation reinstates durable medical equipment (e.g., canes, catheters, hospital beds, breathing equipment, feeding tubes, etc.) for non-blind adults.

I. Beneficial Policy Changes for Elderly and Disabled beneficiaries: The bill makes two new beneficial changes affecting Medicaid coverage for seniors and people

with disabilities. The bill would *exclude* the cost of living adjustment (COLA) for Social Security benefits from countable income until the federal poverty level is adjusted, thereby eliminating the disruptions in health coverage and access that result every year when the Social Security COLA goes into effect and causes an increase in Medicaid recipients' Social Security benefits. (§ 208.153.7). In particular, this change would prevent some Missourians from moving into Spenddown status for the first three months of the year when their Social Security increases but the poverty level remains the same.

Second, the bill makes a positive revision for participants who choose to pay their spenddowns on a monthly basis, rather than incur medical bills each month and receive Medicaid coverage only after their incurred expenses meet their spenddown amounts. (§ 208.153.8). The bill would allow individuals who pay their monthly spenddown amount to the State but subsequently incur a valid out-of-pocket medical expense to have that expense counted as a deduction against future spenddown "payments" for up to 3 months. (§ 208.153.8). This revision would reduce out-of-pocket costs for individuals who pay their spenddown on a monthly basis by enabling the Family Support Division to take into account these additional incurred expenses in determining future spenddown payments.

J. Medicaid Extension for Parents Participating in Drug Court: The bill allows parents who are in drug court and have lost custody of their dependent children to have their Medicaid eligibility automatically extended for sixty (60) days from the date the children are removed from the parent's custody. This provision is subject to the approval of the Centers for Medicare and Medicaid Services. (§ 208.151.1(2)).²⁹

IV. COST-SHARING

A. "Additional" Co-Payments (§ 208.152.4)

The legislation amends current Missouri law on Medicaid cost-sharing to provide that co-payments are *in addition* to the payments made to providers. SB 539 (passed in 2005) had cut provider reimbursement by the amount of co-payments charged to recipients.³⁰ However, this bill does not revise the SB 539 provision that allowed providers to *refuse services* to individuals who have accrued debts based on unpaid co-payments under the conditions established in SB 539. Thus, it would appear that providers could still refuse services for *prior* unpaid co-payments even though their payments are no longer reduced by the costs of any unpaid co-payments.

The "additional payment" provision does not go into effect until July 1, 2008. While the legislation continues to authorize Medicaid co-payments, it does not address the *amount* of the co-payment to be paid by Medicaid beneficiaries. However, any proposed increase would be limited by federal Deficit Reduction Act requirements³¹ and could cause a reduction in access to medically necessary services among Missouri Medicaid beneficiaries.³²

There is a wealth of evidence that making poor people pay more for their health care reduces their utilization of *necessary* health care services and reduces access to care.

This impact is particularly problematic for the elderly and people with disabilities who use a large number of medications and other health care services. Studies show that Medicaid beneficiaries' access to health care is diminished when co-payments are imposed.³³ This effect on access is especially true for individuals with chronic health problems who need more health treatment and could be subject to a co-payment for each visit or service needed.

As indicated above, the legislation leaves it to the Department of Social Services to determine the level of co-payments without any direction as to the amounts of the co-pays or protections against excessive co-payment amounts.

B. Co-Payments for Emergency Room Visits Excluded

The final legislation excludes provisions that would have required co-payments for non-emergency use of emergency rooms. Prior versions of the legislation would have imposed co-payments for emergency room visits that did not result in a hospital admission or when the state law definition of an emergency was not met. These provisions would have fallen far short of the federal Deficit Reduction Act (DRA) requirements, which allow co-payments for "non-emergency" use of emergency rooms in limited circumstances, and could have resulted in diminished access to medically necessary emergency care. In particular, the DRA requires that in order for states to impose co-payments on emergency room use, Medicaid *beneficiaries must have access to available alternative non-emergency services*, and hospitals must inform them of available and accessible non-emergency services.³⁴

Instead, *the bill requires managed care companies to monitor the use of emergency rooms for non-emergencies* as one of the quality measures that the State uses to determine payment. The bill also requires all "health improvement plans" to have "*nurse help lines*," which *could* be another effective tool in avoiding inappropriate emergency room use, depending upon the details. (§ 208.950.2). The earlier Senate and House versions of the bill included more detailed requirements for 24-hours nurse triage lines that could be contacted before an emergency room visit and which would advise participants about alternatives to emergency room treatment. The Department could clarify in more detail the role of "nurse help lines" in its rulemaking and require health improvement plans to ensure that the nurse help lines assist participants in finding alternatives to emergency room treatment.

V. "PREMIUM OFFSET" PROGRAM (§ 208.202)

SB 577 authorizes the MO HealthNet Division to establish a "premium offset" program for making "standardized private health insurance coverage available to qualified individuals."³⁵ The new program would be a pilot program that expires in 2011 and is limited to two regions --- one urban and one rural. The pilot appears to be a compromise between the Senate bill, which would have authorized this program on a statewide basis and the House Bill, which excluded the premium offset proposal altogether. The program is "subject to appropriations" and subject to approval by the new Oversight

Committee. The legislature has separately passed appropriations legislation which would authorize \$13.2 million (state and federal) for this program.³⁶

The premium offset provisions of the bill include few details and delegate very broad authority to the new HealthNet Division to design the new program. It is unclear whether the pilot program is intended to be “premium assistance” that provides subsidies for employer coverage, a new health insurance product provided by the State, or a combination of the two. The pilot program would appear to provide premium assistance for purchasing employer-sponsored coverage, under which state and federal Medicaid payments would be used to pay for (or “offset” the cost of) the health premiums with specific employers.

The MO HealthNet Division is given broad authority to apply for waivers and state plan amendments needed to implement the program, and the State could establish a waiting list for the program when funds are depleted. The premium assistance or “offset” would only be required if the employer, the employee, or both pay their share of the required premiums. (§ 208.202.1(3)). Participants who receive the “standardized private health insurance coverage” would not be entitled to any Medicaid “wrap around” services to fill-in the gaps in their private coverage.

“Premium assistance” programs in Medicaid have had very low participation in other states because low-income people have limited income *and* very limited access to employer-sponsored coverage.³⁷ As a recent Kaiser Commission study noted, “enrollment in premium assistance programs has been relatively low, likely reflecting the limited availability of affordable employer-sponsored coverage among low-income workers.”³⁸ The reality is that “many low-income workers do not have coverage available through their employer” and that “the cost of coverage may be prohibitive for low-income workers, even when a state subsidy is provided.”³⁹ In Missouri, individuals in families with incomes that barely exceed 21% of the federal poverty level (\$292 per month for a family of three) are rarely going to have access to employer-based coverage and could not afford to “buy-in” to such coverage even if they could find it.⁴⁰ Some questions for the pilot program include:

(1) **Who are the “qualified individuals?”** The only eligibility requirements described in SB 577 are that the person must *be without insurance for an entire year* before being eligible for the program and must not have gross income exceeding 185 percent of the federal poverty level.⁴¹ The requirement that people without insurance for a year suggests that this will be an “expansion” program rather than one that covers current Medicaid recipients. This requirement is a rather stringent limitation on program participation for people who may have no other access to health insurance, and may well limit the effectiveness of the program. This provision will not allow a person who lost coverage through no fault of their own to participate in the program unless they first were uninsured for an entire year.⁴²

(2) **Will there be *any* standards for the benefits package?** Without such standards, the program could well have a very limited benefits package. For example, the

State could seek waivers that allow them to cover only a very limited number of hospitalizations, physician visits, and/or prescription drugs.⁴³ If program participants have to pay for many of their medically necessary services “out-of-pocket,” the coverage will not be meaningful for many low-income individuals, who cannot afford such expenses.

(3) **Will the program be available to children as well as adults?** If so, the State would be *required* under federal law to provide wrap-around services for children.

(4) **Will there be any *limits on cost-sharing*** (such as co-payments or deductibles) in the proposed premium program? If the program is applied to existing beneficiaries or is an expansion for other very low-income beneficiaries, there are strict limitations on the level of cost-sharing that could be applied without a waiver. In fact, the language of the legislation authorizing *appropriations* for a “premium offset” program (HB 11) authorizes the Department to establish “consumer-driven” plans as part of the benefit design. This terminology typically refers to *high-deductible* plans and/or tax-deductible “health-savings accounts.”⁴⁴ The problem with this approach is that low-income people do not have the income to pay “out-of-pocket” for items or services that are not covered or to meet high deductibles.

(5) **Will there be any minimum employer contribution and any maximum contribution for Medicaid beneficiaries,** some of whom will have such low incomes that they are unable to afford *any* level of premiums?

(6) How will the employee share of the premium be calculated (e.g., based on a percentage of income)?

(7) What will be the State’s share of the premium for these individuals?

(8) **To what size employers would the program apply** (e.g., small business or employers with 50 employees or less)? Programs focused on small businesses such as Oklahoma’s O-EPIC program have sometimes been cited as models for Missouri, and the final budget legislation specifically references “providing assistance to small employers” as an allowable use of “premium offset funds.”⁴⁵

(9) **What will be the financing arrangements for any Section 1115 Medicaid waivers** that the State seeks to obtain for this program? Some type of capped financing is a typical pre-condition for the receipt of these waivers. Where will the State find the savings from the existing Medicaid program to pay for this program?⁴⁶

All of these questions are left to the discretion of the State agency. The efficacy of such a program will depend on these and other details not included in SB 577. In particular, the “out-of-pocket” costs (including premiums, deductibles, co-payments and uncovered services) under the program will help determine whether the program will provide any meaningful health coverage for the extremely low-income individuals who lost Medicaid coverage in 2005.⁴⁷

- **Possible Individual Option to Participate in Premium Assistance**

The final bill also states that “*absent employer participation*, a qualified employee, or qualified employee and qualified spouse, *may directly enroll* in the MO Health Net premium offset program” (emphasis added). The language and meaning of this provision are not clear. Will there be a new state-administered health insurance product that families can purchase if they have no employer-sponsored coverage at all? This type of program is what some states like Oklahoma are offering as part of their premium assistance programs. If such is the case, the bill certainly does not say so explicitly. What would the new product be? What is the benefits package? Who would qualify to purchase such a product?

If an individual option to purchase a new health insurance product is not intended, then what does this provision envision? Will individuals be able to use Medicaid funds to purchase employer-sponsored coverage without *any* employer *contribution* to the premium? This approach would not seem to be a very cost-effective use of state funds, and it may not be what the bill intends because it would require *some* level of “employer participation” (the statutory provision says “*absent* employer participation”) and would seem to invoke the bill’s other requirements (e.g., the language requiring the “offset” only if the employer, the employee or both, pay their share of the required premiums). (§ 208.202.1(3)). The meaning of this component of the “premium offset” program must be clarified in order to determine its potential impact.

The details of the “premium offset” program will be left to the Department of Social Services to implement through regulations, policies, waivers and state plan amendments. It will be important to ensure public participation in the process for developing and implementing program to ensure that the pilot program has a meaningful and positive impact on Missouri’s uninsured workers.

VI. “HEALTH IMPROVEMENT” PLANS AND MANAGED CARE (§ 208.950)

The final version of SB 577 requires Medicaid recipients to enroll in “health improvement plans.” Health improvement plans include *but are not limited* to a risk-based coordinated care model, administrative services organization (ASO) model, and a “coordinated fee-for-service” model.⁴⁸ The final version of SB 577 eliminates most of the detailed provisions in the House and Senate-passed bills regarding how these health improvement plans will be implemented, *does not define the three delivery system models*, and leaves open the possibility that other models will developed besides those mentioned in the bill.⁴⁹ There are also no statutory requirements regarding *opting in and out* of plans, assignment to plans, good cause for changing plans, selection of providers, grievance procedures, ombudsman services, prohibitions against discrimination, plan provider networks, or an array of other important consumer protection issues. These matters would be left to the health improvement plan contracts and/or any regulations that may be issued by the Department of Social Services and/or the MO HealthNet Division.

The legislation instructs the Department of Social Services to create health improvement plans for all participants in the new Medicaid program, with the advice *and approval* of the MO HealthNet Oversight Committee. The “development of the plans and enrollment [of participants] shall begin July 1, 2008, and shall be completed by July 1, 2011.” (§ 208.950.1). It is not clear how enrollment can begin on the date on which development of the plans begins, so the Department could either have to develop the plans sooner or delay the beginning date for enrollment. Under SB 577’s provisions, the Department could also take the position that it already has health improvement plans in place, in that it has MC+ managed care plans, a Chronic Care Improvement Program (CCIP) for people with certain health conditions,⁵⁰ and a Medicaid fee-for-service system, and that all of these meet the bill’s “health improvement plan” requirements.⁵¹ However, the language of the bill suggests that the MO HealthNet Oversight Committee (see below) would have to approve even these “health improvement plans.”

The development of these plans and enrollment of participants in these plans must take into account “the appropriateness of enrolling particular participants into the specific plans and the time line for enrollment.” (§ 208.950.1). The State must engage in a *public process* for the design, development and implementation of the health improvement plans and “other aspects of MO HealthNet.” The public process must allow for – but not be limited to – input from consumers, health advocates, disability advocates, providers and other stakeholders. (§ 208.950.6). Given the lack of detail in the legislation, the nature of this public process will be very important in determining the parameters of the program.

- **Quality Targets, Financial Penalties, and Plan Requirements**

For risk-bearing *care coordination* plans⁵² and administrative services organization plans, the contracts must require that if the plans do not meet the “quality targets” specified by the state, a reduction in the per diem or some other financial penalty must occur. “Quality targets” are defined to include – but not be limited to – the rates of emergency room usage by plan participants for non-emergency medical conditions. (§ 208.950.1). This provision could be a positive way to address the concern about Medicaid recipients’ use of the emergency room, depending on how the information is used by health plans and the State. While the use of emergency rooms will now be identified in law as a specific “quality target,” the legislation does not provide specificity on other important “quality targets” such as “waiting times,” “geographic accessibility,” and the extent to which plans provide medically necessary services, including EPSDT services, on a timely basis to beneficiaries, including people with disabilities. It is not clear why non-emergency use of the ER is the only quality measurement worthy of inclusion in *state statute* but other quality measurements are not. *It will be important for the rules and contracts to include other quality targets that are at least as important as non-emergency use of emergency rooms.*

All health improvement plans are required to provide every participant a “health care home,” help participants “remain in the least restrictive level of care possible,” use

domestic-based call centers and nurse help lines, and provide reports on participant and provider satisfaction. The plans must use best practices that are evidence-based. The State must evaluate and compare all the health improvement plans based on several criteria (e.g. cost, quality, health outcomes, customer satisfaction, etc) and report these findings to the Oversight Committee. (§ 208.950.2). As discussed earlier, plans must conduct a health risk assessment and develop a plan of care for enrolled participants with “health status goals achievable through healthy lifestyles,” and appropriate for participants’ age and the results of their health risk assessments. (§ 208.950.7).

The bill requires all health improvement plans to conduct the health risk assessments and develop plans of care for “each *enrolled* participant” by July 1, 2008, but as indicated above, other language of the bill states that “[d]evelopment of the plans and enrollment into such plans” shall begin on July 1, 2008. Therefore, it is not clear whether there is any obligation for the State to provide health risk assessments on that date, since the Department may not have created or enrolled people into plans by July 1, 2008.

The Department of Social Services must ensure that any rules or policies regarding the creation of health improvement plans “are promulgated consistent with the principles of transparency, personal responsibility, prevention and wellness, performance-based assessment and achievement of improved health outcomes and cost-effective delivery through the use of technology and coordination of care” (§ 208.950.3). While it may be difficult to ascertain whether rules are promulgated consistently with these principles, the *specific* details that are in rules governing these plans will be very important in determining how the program is implemented.

- **Independent Survey Required (§ 208.950.5)**

By July 1, 2008, the State must commission an independent survey to “assess health and wellness outcomes of MO HealthNet participants by examining key health care delivery system indicators.” (§ 208.950.5). These health care delivery system indicators include: (1) disease-specific outcome measures, (2) provider network demographic statistics, (3) participant program satisfaction surveys, and (4) provider program satisfaction surveys. The State may contract with another organization to do the survey but must give preference to Missouri-based organizations. The survey must be completed within six months and be submitted to the legislature, the governor, and the oversight committee.

As indicated above, the bill does not require the development of health improvement plans until July 1, 2008. Therefore, this study may well be premature in terms of evaluating any new health improvement plans; however it may be useful in evaluating the various measures under the current Medicaid system, including fee-for-service and MC+ managed care.

- **Seniors, People with Disabilities and Capitated Managed Care**

Aged, blind and disabled individuals are prohibited from being required to enroll in a risk-bearing coordination (i.e., managed care) plan. (§ 208.950.4). The legislation

specifically states that “no provision of any state law shall be construed as to require any aged, blind or disabled person to enroll in a risk-bearing coordination plan.” This language should also be read to prohibit the *assignment* of seniors, blind individuals and people with disabilities into risk-based managed care plans altogether, rather than having the State *assign* them to plans and then allow them to “opt out” later. If people with disabilities are assigned to such plans, then they are in fact required to enroll for at least the period of time before which their decision to “opt out” takes effect, a result that would violate the plain language of the bill. More importantly, placing the burden on elderly and disabled beneficiaries to “opt-out,” rather than having them “opt in,” to a plan could limit their choices and disrupt their care if they are not clearly educated as to the choices available or have not retained an advocate to help them navigate the system.

Regardless, the language would not preclude elderly and disabled individuals from enrolling in risk-based managed care on a *voluntary* basis. To the extent that elderly and disabled individuals are allowed to enroll in risk-based plans – even on a voluntary basis, there is an array of questions that must be addressed, including, but not limited to:

(1) **Will the plans have adequate networks of specialists** to serve individuals with chronic and disabling conditions?

(2) **Will the plans have to ensure that network providers’ facilities are accessible to people with disabilities?** Will their offices be wheelchair-accessible, including parking, doorways and restrooms? Will plans have to ensure that their providers have special equipment such as exam tables that can be raised and lowered for people who are in wheelchairs? Will materials and grievance procedures be available in large print, Braille, and other formats?

(4) **What kind of consumer protections will be in place**, such as rights to appeal and grievances systems, prohibitions against discrimination and disenrollment based on disability, choice of plans and providers, waiting times and accessibility standards (e.g., geographic accessibility), access to “Ombudsman” services, exemptions from plan assignment, time periods for choosing a provider, consumer education regarding the selection of a plan and/or primary care provider as well as grievance processes?

(5) **Under what circumstances will individuals be “auto-assigned” to plans?** Auto-assignment poses special risks for people with disabilities, for example, if they are assigned to plans that do not include their primary care provider or specialists.⁵³ As indicated above, compliance with the literal language of SB 577 would preclude auto-assignment of people with disabilities into risk-based or capitated managed care plans.

(6) **Will the State impose mandatory savings targets on managed care plans**, and if so, will managed care plans be able to meet those targets without underserving people with disabilities? People with disabilities may in fact increase their utilization of necessary services if their care is properly managed.

(7) **Which services, if any, will be “carved out” from managed care?** In fact, a wide array of more costly services for people with chronic or disabling conditions is carved out of managed care under the *existing* MC+ managed care system, even though that program serves a healthier population.⁵⁴ Moreover, earlier versions of SB 577 carved out rehabilitative mental health and alcohol and drug abuse services that are provided by mental health or alcohol and drug abuse professionals. It is not clear whether these services and others such as prescription drugs and dental care services would be provided by managed care (risk-based) “health improvement” plans under MO HealthNet.⁵⁵

Even if the State provides a *choice* of delivery systems, these and other issues will still need to be addressed. Adopting managed care for seniors and people with disabilities would not be a simple expansion of the current Medicaid managed care system for parents, children, and pregnant women who are healthier and lower cost populations. Managed care for people with disabilities presents an array of challenges that would need to be addressed by the Department of Social Services, and the Oversight Committee, with the participation of consumers and disability advocates.

Are there Special Concerns with Managed Care for People with Disabilities?

There is still not enough evidence to say conclusively whether Medicaid managed care for people with disabilities hurts, helps, or has no substantial effect on their access to health care or on the quality of care that they receive.⁵⁶ There is also insufficient evidence at this point to indicate whether Medicaid managed care for these populations can be successful while still generating the kinds of savings that states would understandably like to achieve.⁵⁷

Establishing managed care plans that can serve the disabled 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 from those best qualified to serve patients with severe mental illness or developmental disabilities. A wide array of specialists in specialized facilities is required, but such an array is not an inexpensive proposition. In fact, a recent study noted “the very limited extent of state experience with compulsory managed care for persons with disabilities, a fact that we [the researchers] attribute to the complexity of implementing complex systems of care for person who experience extensive medical and health needs and very low income as well as the lack of adequate performance assessment standards.”⁵⁸ The same study noted that managed care for persons with disabilities “involves the development of customized health care systems requiring special knowledge and capabilities on the part of both purchasers and contractors that go well beyond the standardized activities associated with managed care purchasing for a Medicaid population without serious disabilities.” *Id.*

As 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.⁵⁹ The Missouri Medicaid Reform Commission noted the “fear amongst the advocates for the disabled and mentally ill” that “care will be rationed, not managed” and found that “[t]here is some basis for that fear.”⁶⁰ Even in Missouri’s existing MC+ program, problems arise in serving people with chronic conditions or disabling conditions, and many specialized services for this type of Medicaid beneficiaries are already carved out.⁶¹ In addition, disabled children in Missouri’s current MC+ program often have to “opt-out” of their managed care plan due to their special health care needs.⁶²

Given all of these factors, it is not clear that savings can be achieved for elderly and disabled beneficiaries without compromising their care.⁶³ In fact, *managed care for these populations, done correctly, could cost more money than fee-for-service Medicaid.*⁶⁴ Research indicates that immediate savings are very difficult to achieve for this population for a variety of reasons, including an *increase* in utilization if care is properly

coordinated.⁶⁵ Because people with disabilities are a “severely underserved population, effective assessment, care planning, and case management may greatly *increase* their use of services.”⁶⁶

The State will have to come to grips with these issues in evaluating whether to expand managed care delivery systems to seniors and people with disabilities. Therefore, Missouri should proceed cautiously, if at all, in expanding managed care to elderly and disabled beneficiaries – even on a voluntary basis.

- **Seniors and People with Disabilities Can be Enrolled in ASOs on a Mandatory Basis under SB 577.**

The new legislation contains *no* prohibition against requiring this population to enroll in administrative service organization (ASO) plans. As indicated earlier, SB 577 does not include a definition of an administrative service organization. In an ASO model, states pay contractors an administrative fee and may also make enhanced payments linked to performance. ASOs do not assume risk for the *medical* costs of the populations covered, and the State continues to pay providers on a fee-for-service basis. However, if the administrative fees that the State pays to the ASO are not enough to cover the administrative costs of coordinating services, the ASO may have to pay for any unexpected costs not covered by the administrative fee, sometimes referred to as “administrative risk.”⁶⁷

Under SB 577, payments to ASOs are reduced if quality targets are not met. The only identified “quality target” is the rate of emergency room usage for non-emergencies for plan enrollees. Earlier versions of the bill would also have reduced payments if *savings* targets are not met, and the bill does not necessarily preclude the Department from establishing mandatory savings targets and related financial penalties. The details of the payment arrangements between the State and ASOs are largely left to the Department of Social Services, subject to the approval of the Oversight Committee.

Because the bill does not define ASOs and leaves out other key details (such as the specific “quality targets” that the ASOs will have to meet), there is at least a potential risk to people with disabilities from assignment into these “health improvement plans.” In addition, prior versions of the legislation defined ASOs to include “*utilization management*” as one of their responsibilities. If ASOs have responsibility to manage utilization, and utilization of services (beyond the non-emergency use of emergency rooms) is one of the “quality targets” for ASOs, this model could limit access to medically necessary treatment for people with disabilities. Similarly, if savings targets are imposed (through the administrative or contracting process), there could be similar risks of underservice and a need for strong consumer protections for people with disabilities. Whether these risks become a reality depends upon the details of implementation of the new ASO plans, including how the Department defines “administrative services organizations.” For example, if ASOs are defined to be more like Missouri’s *voluntary* Chronic Care Improvement Program” (CCIP), then their role will more limited and they will be far less likely to limit medically necessary treatment. The CCIP is designed to provide some care coordination services and electronic plan of care for participants, but is not responsible for managing the utilization of providers.⁶⁸

The public process described above will be important in determining how the Department of Social Services, and the Oversight Division structure ASOs for persons with disabilities in the new Medicaid (MO HealthNet) program.

- **Questions Regarding Dual-eligibles and Long-term Care**

Among the *many* unanswered questions in the legislation are how “dual eligible” individuals (those eligible for Medicare and Medicaid) will be served in the new “health improvement plan” system, given that *these individuals receive the majority of their medical care and their prescription drugs through the federal Medicare program*. Dual eligibles tend to have more serious and complex medical, social, and long-term care needs than other Medicare and Medicaid beneficiaries and to generate higher health care costs.⁶⁹ The Medicaid program has very little ability to manage their care in *any* of the three “health improvement” models identified in the legislation. In addition, some individuals are only eligible for Medicare-savings programs such as the Qualified Medicare Beneficiary program under which Medicaid only pays Medicare premiums and other cost-sharing (e.g. co-payments, deductibles, etc.) and does not pay for any additional medical care. It is not clear what kind of Medicaid-funded health improvement plan would apply to these individuals.

The bill also does not address how the “health improvement plan” model will apply to long-term care other than the broad requirement that the plans are required to “help participants remain in the least restrictive level of care possible.” (§ 208.950.2). As indicated below, a Subcommittee of the new Oversight Committee is charged with developing a plan for individuals’ entry into the State’s long-term care system. The role of Medicaid-financed “health improvement plans” in providing and managing health care for long-term care beneficiaries is simply unclear.

- **Protection for Managed Care Plans to Continue as the Delivery System for MC+ eligibility groups (§ 473.398 (Section 3)).**

The bill protects capitated managed care plans by ensuring that counties presently covered by capitated managed care plans will continue to have such plans for the eligibility groups that they currently serve. The bill specifically states that “[c]ounties with a risk bearing care coordination plan as of July 1, 2007, shall continue as risk bearing care coordination plans for the categories of aid in such program as of July 1, 2007.” While this language is somewhat imprecise (e.g., it states that “counties” will continue as “risk-bearing care coordination plans”), it means that counties that have risk-based managed care for children, parents, and pregnant women in the MC+ program would continue to have those types of plans rather than the new ASO or coordinated fee-for-service options.

Therefore, this provision would likely prevent individuals who fall within *these* groups from choosing a fee-for-service option (whether a state-administered approach or an ASO model) if they are in counties that are currently served by capitated managed care plans. One potential issue is that this provision appears to prohibit the State from returning to a

fee-for-service delivery system in these areas if: (1) managed care plans were to leave the state or a particular geographic area; (2) managed care plans go out of business; or (3) managed care networks become inadequate. In Missouri's MC+ program, one geographic area (Northwest Missouri) already returned to a fee-for-service model after employing managed care for a period of time. It is at least possible that other managed care regions might have a need to switch back to fee-for-service health care at some point in time, but the final version of SB 577 would appear to preclude this flexibility. This provision would also appear to limit the state's ability to test alternative models of delivering care in areas that have capitated managed care now.

This section of the bill also provides that there must "be a request for proposal for at least six regions of the state, however in no case shall there be a single state-wide contract." It further provides that nothing in the bill's health improvement provisions "shall be construed to void a chronic care improvement plan contract existing on August 28, 2007." § 473.398, Section 3. Thus, the current CCIP vendor also receives protection from any new health improvement plans that the Department may seek to develop.

VII. HEALTH TECHNOLOGY FUND (§ 208.975)

SB 577 will create a "Healthcare Technology Fund" administered by the Department of Social Services. Subject to appropriation by the General Assembly and the recommendations of the MO HealthNet Oversight Committee, the fund will be used to promote technological advances to improve patient care, decrease administrative burdens and increase patient and provider satisfaction. This bill sets out a variety of technological improvements for which the fund may be used (including but not limited to: electronic medical records, community health records, personal health records, e-prescribing, telemedicine, telemonitoring and electronic access for participants and providers to obtain MO HealthNet service authorizations).

VIII. LONG-TERM CARE PARTNERSHIP PROGRAM (§ 208.690)

This provision modifies Missouri law so that the State of Missouri can participate in the long-term care partnership program as modified by the Deficit Reduction Act of 2006 (DRA). Prior to the DRA, only 4 states were allowed to operate such programs. Under this program, Missourians who purchase qualifying long-term care insurance would be able to retain more of their assets and qualify for Medicaid. The State will disregard the assets in an amount equal to the insurance benefit payments made by individuals toward their long-term care insurance.⁷⁰ States' limited experience so far with this program suggests that the promise of Medicaid "asset protection" has helped to encourage the purchase of long-term care insurance and that there may be state Medicaid savings from participation in the program.⁷¹

IX. NEW ASSET REQUIREMENT FOR NURSING HOME CARE (§ 208.152.1(4))

The legislation implements a new provision in the federal Deficit Reduction Act (DRA) by limiting the availability of nursing home coverage to participants with \$500,000 or less equity in their home. The legislation does not take up the DRA's option to raise this threshold to \$750,000.⁷²

X. "PAY-FOR-PERFORMANCE" (§§ 208.153.2, 208.197)

The legislation authorizes the Department of Social Services to establish a "pay-for-performance" program "subject to appropriations by the General Assembly." The Governor proposed to pay providers based on results rather than the provision of certain tests and treatments.⁷³ SB 577 would require all three types of health improvement plans mentioned in the legislation (risk-bearing managed care organizations, administrative services organizations and state-administered point-of-service plans) to participate in a "pay for-performance" system. If funds are not appropriated, these health improvement plans would not be required to participate under the legislation's current wording.

"Pay-for-performance" is somewhat controversial with providers and raises a valid concern about whether providers would be discouraged from treating individuals with the greatest needs because the health "outcomes" of those patients could have a detrimental impact on the ratings of the providers who serve them.⁷⁴ The benefits of this proposal will depend upon the details about what types of quality measures would be used to determine performance, how performance is measured, the specific financial incentives that are provided, and the funding for such incentives. The final bill provides that the program must operate in a manner that "does *not discourage providers from caring for patients* with complex or high risk conditions." (§ 208.197).

The final bill also requires a new "Professional Services Payment Committee" (appointed by the Governor) that would oversee and develop the Pay-for-Performance system. (§ 208.197). Nine of the eighteen members must be physicians licensed to practice in Missouri, along with two patient advocates and the attorney general or his designee. The remaining members must be persons who are "actively engaged" in hospital or nursing home administration, dentistry, or pharmaceuticals. The bill provides some general guidance regarding the pay-for-performance system (e.g., ensures quality of care, fosters the relationship between patient and provider, uses accurate data and "evidence based measures," provides "fair and equitable program incentives, etc.")(§ 208.197.2).

The final bill does *not* include House provisions that would have delayed implementation of the Pay-for-Performance program until physician reimbursement rates are brought up to up to Medicare reimbursement levels and after pay-for performance is implemented in the federal Medicare program. These provisions would have made it very likely that "Pay-for-Performance" would not be implemented at any time in the near future in the revamped Missouri Medicaid program. The final bill requires that any employer of a

provider who receives a “Pay-for-Performance” payment to pass on those payments to the provider without a decrease in that provider’s compensation. (§ 208.153.2).

XI. PROVIDING EMPLOYER INFORMATION ON MEDICAID BENEFICIARIES (§ 208.230)

The legislation requires the Department of Social Services to issue quarterly reports that include specific information about Missouri employers and the prevalence of Medicaid-funded health coverage among employees.⁷⁵ These reports will be based on information collected from MO HealthNet recipients during the application and “reverification” processes, information collected by a vendor contracting with the State, and information that is voluntarily submitted by employers.

This initiative is not new, as the Governor has already issued an executive order requiring that this information be collected,⁷⁶ but the legislation codifies this requirement in state statute.

XII. FALSE CLAIMS ACT (§§ 191.900 to 191.914)

The legislation includes a state false claims act to address provider fraud in the Missouri Medicaid program. The Federal False Claims Act has been highly successful in prosecuting fraud in the federal Medicare program.⁷⁷ Generally speaking, the proposed provision would authorize certain individuals who provide the original information that the Attorney General uses to sue a Medicaid provider for fraud to receive ten percent of any recovery in such cases.⁷⁸ The Attorney General is the only person who can initiate a lawsuit under this provision of SB 577.⁷⁹

The Attorney General’s fraud unit and the Department of Social Services is each required to submit reports that include various types of information, including the number of provider investigations due to allegations of fraud, the number of referrals made to the Attorney General’s fraud unit and the Department of Social Services, the amount of recovery and fines, and the total number of arrests, indictments and convictions.

The legislation is less stringent in addressing provider fraud than the Federal False Claims Act and other proposed Missouri legislation on provider fraud in that it does not allow “whistleblower” lawsuits to be filed by individuals (referred to as *qui tam* actions) or provide the same financial incentives that the federal law provides to whistleblowers who bring these causes of action.⁸⁰ The ability of an individual whistleblower to file a cause of action and the additional financial incentives for doing so makes it more likely that individuals will risk the loss of employment and related consequences of reporting provider fraud to state officials. The exclusion of these provisions makes it difficult to assess the potential impact of this anti-fraud measure. Moreover, because the Attorney General is the only person who can initiate a lawsuit under this provision, Missouri would not be eligible for federal financial incentives that are now available to states that adopt the Federal False Claims Act in their Medicaid programs.⁸¹

XIII. PROVISIONS REGARDING MEDICAID WAIVERS

- **Protection Against Waivers For FQHCs And RHCs (§ 208.151.5)**

The final legislation modifies Missouri law to prohibit the *Department of Social Services* from requesting waivers of the services provided by federally funded health centers (FQHCs) or Rural Health Clinics (RHCs) or the payment methods (i.e., cost-based reimbursement) for such centers and clinics. However, the Department is still free to request waivers of all other Medicaid services (e.g., hospital services, physician services, prescription drugs) under the legislation, and some waivers are given more latitude under new provisions described below. In fact, as indicated earlier, the Department is given broad authority to request waivers to implement the proposed premium offset program and to *limit services* in that program.

- **Reduced Legislative Oversight For Medicaid Waivers (§ 208.151.5)**

The final version of SB 577 would reduce legislative oversight of waiver applications made by the State regarding the Medicaid program. Current state law only authorizes the Department of Social Services to request waivers that do not exceed \$1 million in additional costs to the State and requires that waiver applications must be submitted to the General Assembly. The final version of SB 577 will allow waivers exceeding \$1 million in additional cost to the State if the waiver is “subject to appropriation” or if it is “directed by statute.”

XIV. INCREASING PROVIDER REIMBURSEMENT RATES AND PROVIDER ACCESS (§ 208.152(23)).

The final bill contains provisions designed to increase the provider reimbursement rates to 100 percent of the provider reimbursement rate in the federal Medicare program. Beginning January 1, 2008, and annually thereafter, the MO HealthNet Division is required to report the status of provider reimbursement rates in comparison with Medicare reimbursement rates and average dental reimbursement rates in Missouri (§ 208.152.1(23)) The MO HealthNet Division must provide *a four-year plan to achieve parity with Medicare reimbursement rates* and “third-party payer average dental reimbursement rates” to the General Assembly by July 1, 2008. The Division also must include these amounts in its budget requests to the Governor. Implementation of the four-year plan is subject to appropriations. Increasing provider reimbursement is an important step toward improving access to the program for existing Medicaid beneficiaries. While any increases would be subject to appropriation, it is useful to identify the amounts needed to bring payments up to Medicare rates and identify the funds needed in the Department’s budget requests.

In addition, the bill requires that any money left over in the “MO HealthNet fraud reimbursement fund” after the required disbursement of funds are to be used to help increase provider reimbursement rates to the Medicare level. (§ 191.905.11).

As noted earlier, the independent study on health and wellness outcomes for MO HealthNet recipients includes an assessment of provider network and provider availability that will be submitted to the General Assembly, the Governor and the Oversight Committee. (§ 208.950.5).

XV. MO HEALTHNET OVERSIGHT COMMITTEE (§ 208.955)

The legislation would establish an “MO HealthNet Oversight Committee.” The Committee consists of two members of the Missouri Senate; two members of the Missouri House of Representatives, a consumer representative, four physicians (two of whom are primary care physicians), one dentist, one “nonphysician health care professional who cares for participants,” a representative of the state hospital association, two “patient advocates”, a “public member,” and the Directors of the Departments of Social Services, Mental Health and Health and Senior Services, or their designees (who serve as ex-officio members of the Committee) (§ 208.955.1 (1) through (11)). With the exception of the legislators and the ex-officio members, the Governor will appoint the members of the Committee. The bill sets out requirements for the Committee to meet, review data, and report findings on the Program. (§ 208.955.2(1) through (12)). By July 1, 2011, the Committee must issue findings to the General Assembly on the “success and failure of health improvement plans” and recommend whether to discontinue any of the programs. (§ 208.955.3)

As indicated earlier, the Oversight Committee must approve the “health improvement plans” including managed care plans that are established by the Department of Social Services.

The legislation establishes a new *Subcommittee* to the Oversight Committee that would advise the Department on the development of a “*comprehensive entry point*” system.⁸² This system would provide a way for individuals to access the state’s long-term care system under which people would be advised of their options regarding home and community-based care and institutionalized care. The bill would *not* set up or require a comprehensive point-of-entry system for long-term care. It simply requires that there be a subcommittee to develop recommendations for consideration by the Governor and the General Assembly. With the exception of the above-mentioned durable medical equipment provision, the revised bill does not change the incentives in the current system, which is skewed heavily in favor of institutionalized care. For example, the legislation fails to reverse the more restrictive “level of care” criteria for long-term care that Missouri adopted in 2005 and continues to provide a number of Medicaid services to people in nursing homes that are not available to those who try to remain in the community. Therefore, even if the Subcommittee develops a new system to advise people of their long-term care choices, that system will not necessarily increase the likelihood people will remain in the community as opposed to nursing homes.

XVI. JOINT COMMITTEE ON MO HEALTHNET (§ 208.952)

The legislation would create a Joint Committee on MO HealthNet. The purpose of the committee would be to study the resources needed to “continue and improve the MO HealthNet program over time.” The committee will have ten members as follows:

- (1) The chair and ranking minority member of the House Committee on the Budget;
- (2) The chair and ranking minority member of the Senate Committee on Appropriations;
- (3) The chair and ranking minority member of the House Committee on Appropriations for Health, Mental Health and Social Services;
- (4) The chair and ranking minority member of the Senate Committee on Health and Mental Health;
- (5) A representative chosen by the Speaker of the House of Representatives; and
- (6) A senator chosen by the President Pro Tem of the Senate.

No more than three members from each house could be from the same political party. The Committee is to “meet as necessary.” The Committee is to receive and study the annual five-year rolling MO HealthNet budget forecast from the legislative budget office. (See § 473.398.6, Section One). The Committee is to make annual recommendations to the legislature on “anticipated growth in the MO HealthNet program, needed improvements, anticipated needed appropriations, and suggested strategies on ways to structure the state budget in order to satisfy the future needs of the program.”

XVII. PERSONAL CARE CONTRACTS AND TRANSFERS OF ASSETS (§ 208.213)

The legislation modifies the transfer of assets provisions of Missouri Medicaid law to provide that “personal services” contracts must meet specified conditions in order that they not be considered an impermissible transfer of assets. Individuals who transfer assets for less than the fair market value of the assets can be disqualified from receiving long-term care under Medicaid for up to sixty months, subject to some exceptions. The new SB 577 provision responds to a court decision in a case called *Reed v. Department of Social Services*.⁸³ In that case, the court had found that an institutionalized resident’s transfer of money in exchange for “personal services” (e.g., personal shopping, monitoring the applicant’s physical and mental condition and nutritional needs, arranging or transportation to health care providers, assistance in carrying out directives of health care providers, arranging for social services, etc.) was “fair and valuable consideration” and, therefore, was not an impermissible transfer of assets that would disqualify the claimant from Medicaid eligibility because the personal services were not provided or duplicated by the residential facility.⁸⁴ In *Reed*, the Court also noted the lack of any legally valid rules governing such transfers. SB 577 creates specific rules governing whether “personal services” contracts are permissible transfers of assets in determining Medicaid eligibility.

Under the SB 577 provisions, the personal services contract is “fair and valuable consideration” only if the following provisions are met:

(1) There is a written agreement between the individual or individuals providing the personal services and the individual receiving care which specifies the type, frequency, and duration of the personal services to be provided;

(2) The contract/agreement must be signed and dated on or before the date the personal services began;

(3) The services do not duplicate those which another party is being paid to provide;

(4) The individual receiving the services has a documented need for the personal care services provided;

(5) The services are essential to avoid institutionalization of the individual receiving benefit of the services;

(6) Compensation for the services shall be made at the time services are performed or within two months of the provision of the services; and

(7) The fair market value of the services provided prior to the month of institutionalization is equal to the fair market value of the assets exchanged for the services. The fair market value for services provided must be based on the current rate paid to providers of such services in the county of residence.

Thus, these provisions tighten up the criteria for transfers of assets that create personal services contracts, and may affect estate planning by elderly individuals who need to enter nursing homes.

XVIII. PERSONAL CARE SERVICES MODIFIED (§ 208.152.1(14)).

The bill creates “tiers” of services for the provision of personal care services to individuals in residential care (RCFs) or assisted living facilities. These tiers must be based on the service(s) the resident requires and the frequency of the service(s). This arrangement would replace the current system for these residents, under which units of services are reimbursed based on 15-minute increments, a process that can be burdensome for providers to document. The details of how this process will work (including the way the tiers are defined) are left for implementation, rather than described in the bill.

If a physician prescribes personal care services to an institutionalized individual who qualifies for supplemental payment assistance pursuant to Mo. Rev Stat § 208.030, that individual must, at minimum, qualify for the tier level with the *fewest* services. The

payment rate for each tier will be subject to appropriations. The legislation further provides, subject to appropriations, that individuals who meet level of care criteria shall be authorized, at minimum, for up to one unit of personal care services per day if these services are prescribed by a physician. The authorized units of personal care services cannot be reduced or the tier level lowered for any individual receiving personal care services unless approved by a primary care physician. Authorized units of personal care services or tier levels shall be transferred with the resident if he or she transfers to another facility.⁸⁵

XIX. CHANGES RELATING TO THIRD-PARTY LIABILITY (§§ 208.215, 208.217)

The bill makes a number of technical changes to third-party liability provisions of Missouri law, including changes designed to comply with the federal Deficit Reduction Act and Health Insurance Portability and Accountability Act (HIPAA):

- Recipients who have notice or actual knowledge of the State’s rights to third-party benefits and receive these benefits is required to either (1) pay the State within sixty (60) days after receiving the benefits or (2) put the benefits in a trust account for the benefit of the State pending judicial or administrative determination of the state’s right to third-party benefits. (§ 208.215.4).
- Judgments, awards, or settlements in “an action by a recipient to recover damages for injuries or other third-party benefits in which the [State] has an interest” may not be satisfied without first giving the State notice and a reasonable opportunity to file and satisfy the claim. (§ 208.215.6).
- All “third-party payers” must provide the MO HealthNet Division with information regarding health care benefits pursuant to HIPAA, excluding accident-only, specified disease, disability income, hospital indemnity or other fixed indemnity insurance policies. (§ 208.215.7).⁸⁶
- The State is permitted to forgo reimbursement from a liable third party in cases where the amount that the State expects to recover is less than the cost of recovery or where recovery efforts will not be cost-effective. (§ 208.215.18).
- To comply with Section 6035 of the Deficit Reduction Act, the final bill adds to the list of entities required to provide information to the State about the health insurance status of an individual to include third-party administrators, administrative services organizations and pharmacy benefit managers who are either (1) transacting or doing business in Missouri or (2) administering or processing claims and/or benefits for residents of Missouri. (§ 208.217.1(3)(d)).
- The State is allowed to make requests regarding health insurance status of any individual at least twice a year. (§ 208.217.4). Any responses to the state’s

requests must be HIPAA-compliant and the requirement that the responses be in writing is eliminated. (§ 208.217.6).

- Health insurance carriers are required to accept and respond to HIPAA ANSI standard transactions for the purpose of validating eligibility (§ 208.217.6).⁸⁷

Again, these provisions merely clarify Missouri’s rules regarding third-party liability while bringing the State into compliance with certain federal requirements.

XX. REVISION TO STATE LAW ON TREATMENT OF ANNUITIES IN DETERMINING MEDICAID ELIGIBILITY (§ 208.212)

SB 577 clarifies some provisions related to the treatment of annuities that had been addressed previously in SB 539. Under the final bill’s provisions, the stream of income from annuities is *excluded as an available resource* if the annuity: (1) is actuarially sound as measured against the Social Security Administration Life Expectancy Tables, as amended, (2) provides equal or nearly equal payments for the duration of the device and excludes balloon-style final payments, (3) provides the State of Missouri secondary or contingent beneficiary status if the individual predeceases the duration of the annuity in an amount equal to the State’s expenditures on the individual’s behalf, and (4) *names and pays the Medicaid (MO Health Net) claimant as the primary beneficiary*. (§ 208.212.1). *This subsection* modifies current Missouri law regarding how annuities are treated in determining Medicaid eligibility. The practical effect of the revised language may be to prevent individuals from qualifying for Medicaid by establishing annuities that designate the Medicaid claimant’s *community spouse* as the beneficiary and enable the community spouse to retain additional assets while the claimant qualifies for Medicaid (i.e. because the income from the annuity is excluded as a resource).⁸⁸

XXI. ACCESS TO PSYCHOTROPIC MEDICATIONS (§ 473.398, Section 2).

The final legislation prohibits limits on “initial access requirements” for psychotropic medication prescribed to fee-for-service beneficiaries, except for “dose optimization” or new drug combinations.⁸⁹ The medication must be prescribed to people diagnosed with mental illness or another illness for which treatment with psychotropic medication is indicated. The medication must be approved by the federal Food and Drug Administration and must be a recognized treatment. In addition, the State cannot impose restrictions that “preclude availability” of any individual “atypical antipsychotic monotherapy” for the treatment of schizophrenia, bipolar disorder, or “psychosis associated with severe depression.” (§ 473.398, Section 2) The primary impact of this provision will be to prevent the State from imposing prior authorization on these important medications for people with mental illness.⁹⁰

XXII. ROLLING FIVE-YEAR BUDGET FORECAST (§ 473.398, Section 1)

The bill requires the legislative budget office to conduct a “rolling” five-year MO HealthNet forecast every year. The forecast must be submitted to the legislature, the

Governor, the Joint Committee on MO HealthNet and the Oversight committee. The forecast must include the projected budget of the entire MO HealthNet program, the projected budgets of selected programs within the MO HealthNet program, the projected MO HealthNet enrollment growth (categorized by population and geographical area), the projected required reimbursement rates for MO HealthNet providers, and the projected financial need “going forward.”

XXIII. TELEHEALTH SERVICES (§ 208.670)

The bill authorizes the new MO HealthNet program to make payments to providers who utilize “telehealth” services for beneficiaries. It would require the Department of Social Services, in consultation with the Department of Mental Health and Department of Health and Senior Services, to promulgate rules regarding the practice of telehealth in the MO HealthNet program. Telehealth is defined as the “use of medical information exchanged from one site to another via electronic communications to improve the health status of a patient.”

XXIV. EMERGENCY CLAUSE (Section B.)

SB 577 includes an emergency clause providing that the amended version of Mo. Rev. Stat § 208.151 take effect immediately after the Governor signs the legislation. This requirement means that the provisions regarding eligibility for children aging out of the foster care system will take effect immediately upon enactment. The legislation states that “immediate action is necessary to ensure that the youth aging out of foster care are able to obtain services” but provides that “the repeal and reenactment” of the entire Section 208.151 “shall be in full force and effect upon its passage and approval.” However, the 60-day extension of eligibility for participants in drug court is subject to CMS approval and will likely require a waiver, which would almost certainly preclude its implementation on an emergency basis, even though it is in the section covered by the emergency clause.⁹¹

The other eligibility and service changes in SB 577 are not subject to the emergency clause.

CONCLUSION

SB 577 removes the sunset date for the Missouri Medicaid program and changes its name to “MO HealthNet.” The legislation implements the “health care home” concept, but leaves most details of providing a health care home to “health improvement plans” that will be developed over the next few years. The key details will be addressed by the Department of Social Services subject to the approval of a new Oversight Committee. There will be many areas where input from key stakeholders will be needed to determine how well health care is provided in the new system. The legislation does not restore coverage to most groups that lost Medicaid coverage in 2005, but expands coverage to a small group of adolescent children who would otherwise lose coverage when they become too old to remain in foster care. The legislation includes a small program for

disabled workers, restores SCHIP coverage for some children, restores coverage of durable medical equipment, and expands access to family planning services. While SB 577's modest changes in eligibility and services will have a clear positive effect, the bill's overall impact will depend largely on the implementation decisions of the Department and the Oversight Committee as well as the advocacy efforts of key stakeholders.

Endnotes

¹ The legislation includes several provisions that do not directly relate to Medicaid or Medicaid reform. The bill: (1) creates a Chronic Kidney Disease Task Force to “develop a plan to educate the public and health care professionals about the advantages and methods of early screening, diagnosis, and treatment of chronic kidney disease,” make recommendations for cost-effective screening, diagnosis and treatment of chronic kidney disease, identify barriers to adopting best practices in screening, diagnosing and treating chronic kidney disease and submit a report to the Legislature by August 30, 2008. (§ 192.632); (2) makes it a class D felony for individuals to assume responsibility for managing the affairs of an institutionalized disabled person (the current law limits it to elderly people in nursing homes) and fails to make payment to the institution. (§ 198.097); (3) creates tax deductions for the purchase of long-term care insurance (§ 135.096.1); (4) creates a “Missouri Health Access fund” (§ 191.1056); (5) allows tax credits for contributions to the Missouri Health Access fund (§ 135.575); (6) expands access to the State’s “Legal Expense Fund” (§ 105.711); (7) prohibits long-term care companies from working together to establish rates and rating systems (§ 135.096.3); (8) requires that when any person who is released from a residential care facility (e.g. hospital or skilled nursing facility) and returns to an assisted living facility, the assisted living facility must immediately implement physician orders and, within the first 24 hours of the return, review the orders and modify the individual service plan accordingly; and (9) extends the sunset for the consumer-directed personal care program to 2019 (§ 208.930.12).

² The sunset date for the Missouri SCHIP program is replaced with a provision that would make the program void if Congress stops providing the funding for the program. (§ 208.631).

³The term “medical home” is more commonly used in the medical literature. As indicated above, the “health care home” of SB 577 is not defined in the bill.

⁴ See American Academy of Pediatrics, National Center on Medical Home Initiatives for Children with Special Needs (available at <http://www.medicalhomeinfo.org/>). While the concept of a medical home began with pediatricians, “many experts argue that *medical homes are important for all patients, not just children and adolescents.*” Stephen C. Schoenbaum and Melinda Abrams, *No Place Like Home*, The Commonwealth Fund, December 19, 2006 (emphasis added). Medical homes “could ensure the provision of appropriate preventive services, help patients manage their chronic conditions, and reduce spending on emergency or other acute care.” Moreover, nurses “would play central roles, working with primary care physicians to develop disease management programs for patients with chronic illness and provide support for all patients in their efforts to live healthy, productive lives.” *Id.*

⁵ Various versions of the *House bill* included definitions of the “health care home.” For example, the House Committee Substitute provided as follows:

"Health care home" is defined as the personalized, collaborative, multi-disciplinary team of health care professionals who work in partnership with the patient, his or her family,

and his or her caregivers to create an individually-tailored physical and behavioral health plan of care for the participant. The home is led by a clinically appropriate provider, who directs a team of individuals who collectively take responsibility for the ongoing care of patients. The health care home is responsible for providing all the participant's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. A health care home includes, but is not limited to a PCP or PCP extender. It targets a participant's predominant needs and diagnoses, and is tailored to the individual participant's needs based on the individual's health status or combination of risk factors. The health care home assists with coordinating and integrating care across all elements of the health care system and the participant's community.

§ 208.950(12) of the House Committee Substitute.

⁶ The legislation does not define the “healthy lifestyles” that will qualify to achieve health status goals in the plans of care. In many instances, however, it will take more than “healthy lifestyles” to improve or maintain an individual’s health.

⁷ In Missouri’s new Chronic Care Improvement Program (CCIP), the primary care physician (PCP) must sign off on the plan of care that is developed by the health coach or case manager. If the PCP does not approve the plan of care, then there can be no plan of care for the CCIP participant.

⁸ See Joel Ferber, Overview and Discussion of Senate Bill 577, Updated April 13, 2007, at 3, and citations therein; §§ 208.950.1 and 208.950.12 of the Senate-passed bill.

⁹ Sometimes, this program is referred to as a “buy-in” program.

¹⁰ The premium amounts would be as follows: 4 percent of income at 100 percent of the federal poverty level (FPL) for people whose gross incomes are between 100 percent and 150 percent of FPL; 4 percent of income at 150 percent of FPL for people whose gross incomes are between 150 percent and 200 percent of FPL; 5 percent of income at 200 percent of FPL for people whose gross incomes are between 200 percent and 250 percent of FPL; and 6 percent of income at 250 percent of FPL for people whose gross incomes are between 250 percent and 300 percent of FPL.

¹¹ Missouri General Assembly, Oversight Division, Committee on Legislative Research, Fiscal Note for the House Committee Substitute for Senate Bill 577, June 4, 2007 (“SB 577 Fiscal Note”), at 11 (available at <http://www.moga.mo.gov/oversight/OVER07/fispdf/2227-16T.ORG.PDF>).

¹² SB 577 Fiscal Note at 11-12. Of the 1930 individuals who will have Medicaid coverage restored, approximately 795 individuals are not eligible for Medicaid because their income exceeds the Social Security Administration’s “substantial gainful activity” requirements that are also used in determining Medicaid eligibility. The remainder of this group includes 1,135 persons currently eligible for spenddown who do *not* meet their spenddowns and will qualify for TTW by paying a premium. The Department projects that 1,310 of the 3240 persons affected who are *already* meeting their spenddowns will qualify for TTW by paying a premium. See SB 577 Fiscal Note at 11-12.

It is important to note that the numbers of individuals *meeting* spenddown and those *not* meeting spenddown are average numbers, e.g., it is not the same 1310 people who meet their spenddown each month. Everyone in the Medicaid Spenddown group is affected similarly by this provision in that their out-of-pocket costs are likely to be reduced if they become eligible for the new TTW program.

¹³ SB 577 Fiscal Note at 14. Only 41 individuals who are *not* meeting their spenddown are projected to have a reduced spenddown which they will *now meet* as a result of the new disregard. Of the remaining individuals, the Department projects that 464 persons will move from spenddown to non-spenddown, 178 non-spenddown persons earning less than \$65 will remain non-spenddown, 722 persons currently meeting spenddown will have a *reduced* spenddown. Moreover, 199 persons currently not meeting spenddown will

have a *reduced* spenddown, but will *not* meet it. See SB 577 Fiscal Note at 14. Again, these are average numbers – individuals meeting their spenddown in a given month may not meet their spenddown in a subsequent month.

¹⁴ The Missouri Consolidated Plan is the plan that provides coverage to state employees. In addition to revising the SCHIP affordability requirements, the legislation removes the Missouri Consolidated Plan as the basis for determining *premium* amounts in the SCHIP program and, instead, leaves the premium determination to the appropriation processes. (§ 208.640.1).

¹⁵ The bill also includes a provision which states that “Children in households with incomes up to one hundred fifty percent of the federal poverty level may meet all Title XIX program guidelines as required by the Centers for Medicare and Medicaid services.” (§ 208.631). Children in households with incomes from 151% to 300% of the federal poverty level would continue to be eligible under current Missouri SCHIP requirements and receive the same services they do now, unless the General Assembly makes subsequent changes to Missouri law.

This provision is intended to allow the Department of Social Services the flexibility to provide SCHIP children in families with incomes up to (i.e., not exceeding) 150% of the federal poverty level with full Medicaid coverage *or* to cover them in a separate SCHIP program. The State currently provides SCHIP coverage under a waiver that allows the State to disregard certain federal Medicaid requirements such as “prior quarter coverage” and non-emergency medical transportation. As Missouri’s current § 1115 waiver is scheduled to expire on August 31, 2007, the State will have to choose (per instructions from CMS) whether to provide SCHIP coverage under a “separate SCHIP program” or through a “Medicaid expansion” program. This new statutory provision is intended to provide Missouri with the flexibility to make *either* choice for children in families with incomes not exceeding 150% of the federal poverty level. If the State chooses to provide full Medicaid coverage to this population (without a waiver), rather than cover them through a separate SCHIP program, then more children would be eligible for the program because certain SCHIP restrictions would no longer apply, such as the requirement that children be without insurance for six months before receiving coverage through the State. However, nothing in SB 577 requires the State to cover these lower-income SCHIP children in this manner. It appears that Missouri will cover the higher-income children (with family incomes above 150% of FPL) through a separate SCHIP program.

¹⁶ SB 577 Fiscal Note at 19-20; Department of Social Services, Division of Medical Services, *Fiscal Year 2008 Budget Request: Printed With Governor’s Recommendations*, February 2007, at 483.

¹⁷ SB 577 Fiscal Note at 20.

¹⁸ Missouri Income Maintenance Manual, § 0920.020.05.10 (Health Insurance Definition (MC+)).

¹⁹ SB 577 Fiscal Note at 20.

²⁰ 42 U.S.C. § 1396cc(e)(3) and 42 C.F.R. § 457.560. A new study reveals that the “financial burden of full year private insurance is more than most families below 300 percent of poverty are able or willing to bear. *This evidence suggests that typical spending levels among this income group are unlikely to be considered affordable by most of that population.*” Linda J. Blumberg, John Holahan, et al., *Setting a Standard of Affordability for Health Insurance Coverage*, Health Affairs, vol. 23, Number 3, at 471, June 4, 2007 (emphasis added). The study indicates that policymakers should consider all types of health care spending (premiums, cost-sharing, deductibles, et al.) in determining what level of spending is considered affordable in the context of private health insurance and should set the affordability standard as a share of income devoted to health care spending. *Id.* at 471-472. Thus, Missouri’s failure to include deductibles, co-insurance, co-payments, or other out-of-pocket health care spending in the new SCHIP affordability standards means that many Missouri children will continue to be uninsured.

²¹ Department of Social Services, Division of Medical Services, *Fiscal Year 2008 Budget Request: Printed With Governor's Recommendations*, February 2007, at 53.

²² See SB 577 Fiscal Note at 22. Missouri's current policy does not specifically describe these screenings as part of the benefits package for this program. Missouri Income Maintenance Manual, § 0925.050.05 (Covered Women's Health Services (EWHS)).

²³ See Missouri Income Maintenance Manual, § 1300.000.00. This program provides Medicaid coverage for uninsured women under the age of 65 who have been screened through Missouri's Breast and Cervical Cancer Control Project (BCCCP) and are in need of treatment for breast or cervical cancer. The Department of Social Services has indicated that it will broaden the program by changing the definition of screening for BCCCP to include screenings by any Medicaid provider. Fiscal Note for House Committee Substitute for SB 577 at 22.

²⁴ SB 577 Fiscal Note at 22. A prior version of this legislative proposal would have provided family planning services to over 90,000 additional women. See General Assembly, Committee on Legislative Research, Oversight Division, Fiscal Note for SB 653, March 21, 2007. The number of women added by SB 577 will be somewhat lower because of the asset limitation and the requirement that eligible women do not have access to employer-sponsored health insurance.

²⁵ The program "provides relief of severe pain or other physical symptoms and supportive care to meet the special needs arising out of physical, psychological, spiritual, social and economic stresses which are experienced during the final stages of illness and during dying and bereavement and meets the Medicare requirements for participation as a hospice" (§ 208.152.1(20)). The final bill also mandates that the reimbursement rate paid to a hospice provider for room and board furnished by a nursing home to an eligible hospice patient must be at least 95 percent of the rate of reimbursement that would have been paid for facility services in the nursing home for that patient. *Id.*

²⁶ The *Lankford* court decision found that the State's previous limitations on DME coverage violated the federal Medicaid statute. *Lankford v. Sherman*, 451 F.3d 496 (8th Cir. 2006).

²⁷ 13 C.S.R. 70-40.010 (2) (children, pregnant women and blind individuals can receive one eye examination *per year*). Other services such as prosthetics, wheelchairs and hospice services also have been provided through appropriations and state regulations even though these services are not required in state statute.

²⁸ Mo. Rev. Stat. § 208.151.2(4).

²⁹ Because these parents will no longer meet the family composition requirements of Section 1931 of the federal Medicaid law, the state will likely need to request a waiver to implement this provision. The Department estimates that 86 individuals will be eligible for the extended eligibility period for persons participating in a drug court. SB 577 Fiscal Note at 14.

³⁰ The legislation provides that "[a]ny payments made by participants . . . shall be in addition to and not in lieu of payments made by the state for good or services. § 208.152.4. Prior law (SB 539) provided that payments by the State to providers would be reduced by amount of the co-payments paid by Medicaid beneficiaries.

³¹ There are also clear federal limitations on the State's ability to increase co-payments on Medicaid beneficiaries under the Deficit Reduction Act of 2005 ("DRA") and other recent federal legislation, particularly for people with very low-incomes. The Tax Relief and Health Care Act of 2006 (TRHCA), which was signed into law on December 20, 2006, clarified the cost-sharing provisions of the Deficit Reduction Act. For a discussion of these changes, see Judy Solomon, *Cost-Sharing and Premiums in Medicaid: What Rules Apply?*, Center on Budget and Policy Priorities, February 28, 2007.

³² The State already imposes co-payments for a wide variety of both mandatory and optional services consistent with federal Medicaid requirements. If the State intends to *increase* the amount of those co-payments, it would raise serious questions about the impact that such additional cost-sharing would have on low-income Missourians' access to health care. The legislation does not indicate whether there is any intent to increase co-payments or what the increase would be.

³³ Joseph Newhouse, "Free for All: Lessons from the Rand Health Insurance Experiment," Cambridge: Harvard University Press, 1996 (hereinafter, "Lessons"), discussed in Leighton Ku, "Charging the Poor More for Health Care: Cost-Sharing in Medicaid," Center on Budget and Policy Priorities, May 7, 2003 (hereinafter "Cost-Sharing"); Joel Ferber, *Economic and Health Benefits of Missouri Medicaid*, Missouri Foundation for Health, April 2004; Robyn Tamblyn, et al. "Adverse Events Associated with Prescription Drug Cost-Sharing Among Poor and Elderly Persons," *Journal of the American Medical Association*: 285(4): 421-429, January 2001. Other studies demonstrate similar negative consequences from the imposition of cost-sharing on low-income people. See Ku, Cost-Sharing, *supra*, for an excellent overview of the research in this area.

³⁴ The DRA requires hospitals to inform individuals: (1) of their determination that the individual does not have an emergency medical condition; (2) that they may require payment before providing services; (3) of the name and location of an alternative non-emergency services provider that is actually available and accessible; (4) that such alternative providers can provide the service without the imposition of cost-sharing. § 6043 of the DRA. None of these DRA-mandated provisions were in the prior versions of SB 577.

³⁵ The term "premium offset" is not typically used in other states that have premium assistance programs nor is this term defined in the proposed Missouri legislation. Under the proposed Missouri program, state and federal Medicaid funds would "offset" the cost of the premium to the employer and the employee. For additional discussion of the "premium offset" model, see Joel Ferber, *Broad Waiver Authority to Pursue Premium Assistance (offset) Program raises Concerns*, April 27, 2007 ("Premium Assistance").

³⁶ House Bill 11, § 11.525.

³⁷ See Joan Alker, *Premium Assistance Programs: How are they Financed and Do States Save Money?* Kaiser Commission on Medicaid and the Uninsured, October 2005, at 2, 8, and 14; Cynthia Shirk and Jennifer Ryan, *Premium Assistance in Medicaid and SCHIP: Ace in the Hole or House of Cards?* National Health Policy Forum, July 17, 2006. Overall, premium assistance enrollees constitute less than one percent of total population in Medicaid and SCHIP, and an even smaller percentage of program spending. Shirk and Ryan, at 3.

³⁸ See Joan Alker, *supra*, at 2, 8, and 14; See also Shirk and Ryan, *supra*.

³⁹ Shirk and Ryan, *supra*, at 13.

⁴⁰ Testimony of Linda J. Blumberg, Ph.D, before the Subcommittee on Health, Employment, Labor and Pensions, United States House of Representatives, *Expanding Health Insurance Coverage to the Uninsured: Rationale, Recent Proposals, and Key Considerations*, March 15, 2007, at 9 (Blumberg Testimony).

⁴¹ The final budget legislation provides that initially the Department may pursue coverage for adults with incomes at or below 100% of the federal poverty level, and that the eligibility standards may be adjusted annually by appropriation. House Bill 11, § 11.525.

⁴² A preferable approach to discourage people from dropping employer coverage would not have been so restrictive. For example, Missouri's SCHIP program requires that children be without insurance for *six months* to be eligible for the program and includes some "good cause" exceptions from this limitation on

coverage (e.g., termination of the parent's employment or the parent changes jobs but the new job does not provide health insurance). Missouri Department of Social Services, Family Support Division, Income Maintenance Manual, § 0920.020.05.15.

⁴³ An example of this approach is Arkansas's new "Safety Net" benefit program for businesses with 2-500 employees who have not offered insurance in more than 12 months. The program provides a very limited benefits package with stringent limits on all services such as prescription drugs (2 prescriptions per month), hospital visits (7 in-patient days and 2 major outpatient services per year), physician visits (6 visits per year) and mental health (2 outpatient visits per year). Arkansas Department of Health and Human Services, ArHealthNet Benefits (undated) (available at: <http://www.arhealthnet.com/benefits>).

⁴⁴ A recent GAO study confirmed that health savings accounts, which were purportedly designed to help low-income people, primarily help high-income individuals. Edwin Park and Robert Greenstein, *GAO Study Confirms Health Savings Accounts Primarily Benefit High-Income Individuals*, September 20, 2006. The average adjusted gross income of individuals making contributions to health savings accounts was \$133,000. *Id.* Clearly, even with the addition of health savings accounts, low income individuals still find the cost of health care coverage prohibitive. Additionally, recent testimony before Congress revealed that it "is widely accepted that those with incomes below 100 percent of FPL have virtually no ability to finance their own health care needs, and that those of modest incomes require significant assistance as well." Blumberg Testimony, *supra*, at 9 (emphasis added).

⁴⁵ House Bill 11, § 11.525. It is noteworthy that states that have implemented such programs have not had the large impact that was perhaps anticipated. One program that is sometimes cited as a model for a Missouri premium assistance program is O-EPIC, the Oklahoma program for small businesses with less than 50 employees, which subsidizes the premiums for individuals at or below 185% of poverty at varying levels and provides a relatively comprehensive benefits package to those who are enrolled. When the program was established, the Oklahoma Governor announced that the program for small businesses would enroll 50,000-70,000 people. However, as of April 2007, there were *only 903 businesses and 1,699 employees* enrolled in the program. O-EPIC Premium Assistance, *Fast Facts: April 2007*, April 6, 2007 (available at: http://www.okhca.org/reports/pdflib/O_EPIC_PA_FF_4_2007.pdf). The next phase of O-EPIC allows *individuals without access to employer-based coverage* to enroll and should thereby increase enrollment, but it is not clear that either SB 577 or HB 11 would establish this type of program.

⁴⁶ This means that the state could essentially be gambling that health care costs will be predictable and controlled under the new system. If the state loses that gamble, then the State could have to limit the program or make additional Medicaid cuts. It does not make fiscal sense to implement a new system of delivering Medicaid-covered services that would shift costs from the federal government to the State and its citizens. Therefore, the flexibility that the State would need in order to implement the new program may not be worth the risk. In addition, the Section 1115 waiver financing arrangements can be quite complicated. For example, even though the policy changes in Florida's Section 1115 Medicaid waiver program are initially limited to just two counties, the program's per capita caps apply to the State's entire Medicaid program. Joan Alker, *What Will Florida's "Medicaid Choice" Waiver Mean for Children?*, Georgetown University Health Policy Institute, Center for Children and Families, updated January 4, 2006 (available at: <http://ccf.georgetown.edu/pdfs/florida1105.pdf>).

⁴⁷ The Bush Administration is now promoting that states expand though "private coverage," which for some people means coverage in the individual market that simply may not work for them. The Bush Administration's "Affordable Choices" initiative encourages states to divert federal funds presently supporting hospitals and other health care providers and use them to pay for "basic, private health insurance" for uninsured state residents. See The White House, *Affordable, Accessible, And Flexible Health Care Coverage*, undated (available at: <http://www.whitehouse.gov/stateoftheunion/2007/initiatives/healthcare.html>); Leighton Ku, Andy Schneider, and Judy Solomon, *The Administration Again Proposes to Shift Federal Medicaid Costs to States*, Center on Budget and Policy Priorities, February 14, 2007. This direction may well be how such a proposal will proceed in Missouri if broad authority is granted to pursue waivers and state plan

amendments under the DRA. The State would likely divert some state general revenue, provider taxes, “disproportionate share” hospital (DSH) payments and/or other funds to support the development of its “premium offset” program. The Administration is promoting models that employ high deductibles, high cost-sharing and very limited benefits. Judith Solomon, *President's “Affordable Choices” Initiative Provides Little Support For State Efforts To Expand Health Coverage*, April 3, 2007, at 7. However this approach would be both inadequate and unaffordable for many low-income people, particularly the highly destitute parents who lost Medicaid coverage in 2005. For additional discussion of these issues, see Ferber, *Premium Assistance*, *supra*.

⁴⁸ These plans are not defined in the final version of the legislation. However, the Senate-passed and House-passed versions had defined the parameters of the various plans. See § 208.950.1(1), (5) and (6) of the Senate version and § 208.950.1(4), (26), and (37) of the House Committee Substitute version. The failure to define these plans in the final version means that the Oversight Committee, advocates and providers will need to pay close attention to the development of these plans.

⁴⁹ Under the Senate bill, the “risk bearing” plans would coordinate care, ensure that services are covered, and conduct utilization management, claims adjudication, participant education, primary care case management and pharmacy management. However, these plans could choose to subcontract pharmacy management to the state. § 208.950.10(1). In the “Administrative Services Organization” (ASO) model, health care would be provided on a fee-for-service basis, but the ASO would be “at risk” in that its fees would be reduced if savings and quality targets set by the State were not met. (§ 208.950.11). The ASO would provide care coordination, utilization management, participant education, and primary care case management. The State would retain provider reimbursement, pharmacy management, eligibility determination, provider network management, and ensure that Medicaid services are covered. § 208.950.11. For further discussion of the ASO model of managed care, See National Health Law Program, *Administrative Services Organizations (ASOs): An Alternative to Mandatory Enrollment for individuals with Disabilities into Managed Care?*, March 2006. The third plan, the “state care management point of service program,” was defined as a “system of health care delivery administered by the department of social services.” As indicated above, none of these terms are defined by the final version of SB 577.

⁵⁰ Missouri’s Chronic Care Improvement Program (CCIP) is an enhanced primary care case management program that seeks to improve the health status for patients with chronic illnesses, including asthma, Chronic Obstructive Pulmonary Disease (COPD), diabetes, cardiovascular disease and Gastroesophageal Reflux Diseases (GERD). Division of Medical Services, Provider Bulletin, Vol. 29, No. 22, January 16, 2007 (available at http://www.dss.mo.gov/dms/providers/pdf/bulletin29-22_2007jan16.pdf). Patients are invited to participate based on a “risk assessment” tool, and participation is voluntary. *Id.* The contractor (APS health care) that administers the program is supposed to attempt to coordinate care on a fee-for-service basis for patients with their current primary care providers. *Id.* Providers will receive incentive payments for actively participating in CCIP. *Id.* These “pay-for-performance” measures have not yet been established. *Id.*

⁵¹ Like the other plans, the “coordinated fee-for-service” system has no definition and could well be interpreted to include Missouri’s existing Medicaid fee-for-service system.

⁵² The terms “risk-bearing care coordination plans” and “risk-bearing coordination plans” are used interchangeably in the legislation.

⁵³ Among the issues that arise for persons with disabilities are whether individuals would be assigned to plans whose network includes the individual’s primary care provider; the qualifications of plans that are allowed to accept auto-enrolled persons; the level of information on health status and special needs that must accompany auto-enrollment; the time frames given to plans to assign patients to physicians, and make initial contact, and the opportunity for switching plans after auto-enrollment has occurred. Joel Ferber and James Frost, *Expanding Medicaid Managed Care to Elderly and Disabled Beneficiaries: Preliminary Observations about Senate Bill 1123*, March 30, 2006; National Health Law Program, *Administrative*

Services Organizations (ASOs): An Alternative to Mandatory Enrollment of Individuals with Disabilities into Managed Care?, March 2006 at 2-3.

⁵⁴ Missouri's current MC+ capitation rates cover the acute care services that children and parents use -- physician services, diagnostic services, inpatient 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 MC+ 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). In addition, MC+ managed care contracts also "carve out" pharmacy services from managed care capitation rates for those plans that choose not to provide this service. In that instance, prescription drugs are provided by the state agency on a fee-for-service basis. MC+ 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. These long-term care costs are still paid by the state on a fee-for-service basis.

⁵⁵ Earlier versions of the bill took varying approaches to "carve outs" of dental care and pharmacy. Currently, plans have the option of bidding on pharmacy services or having the state provide those services on a fee-for-service basis. These are all issues that will have to be sorted out as the bill is implemented by the Department and the Oversight Committee.

⁵⁶ See 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 Policy Institute, *Adults with Disabilities in Medi-Cal Managed Care: Lessons from Other States*, Prepared by Center for Health Care Strategies, September 2003 ("*Medi-Cal Lessons Report*"), at 6.

⁵⁷ The typical basis for cost-reductions in Medicaid managed care for healthier populations -- reductions in in-patient hospital care -- may not work for this population. 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. America's Health Insurance Plans, *Medicaid Managed Care Cost Savings -- A Synthesis of Fourteen Studies*, July 2004. It is very unclear that such savings are achievable in Missouri through this same route for this population. *In Missouri, very little general revenue is spent on in-patient hospitalization.* The major source of state funding for in-patient hospital costs in Missouri is the federal reimbursement allowance (FRA) or provider tax. For example, the proposed FY 2008 House Budget legislation would allocate only a little more than \$46 million in general revenue to hospital expenditures (both in-patient hospitalization and outpatient combined) out of more than \$692 million in spending on these services. H.B. 11, 94rd General Assembly, 1st Reg. Sess., § 11.495 (Mo. 2007).

⁵⁸ Sara Rosenbaum et al., *Managed Care and Medi-Cal Beneficiaries with Disabilities: Assessing Current State Practice in a Changing Federal policy Environment*, June 2006, at 3 (emphasis added).

⁵⁹ Kaiser Commission on Medicaid and the Uninsured, *Medicaid's Disabled Population and Managed Care*, March 2001.

⁶⁰ Missouri General Assembly, Medicaid Reform Commission, *Final Report of the Medicaid Reform Commission*, December 22, 2005, at 28 (emphasis added).

⁶¹ See note 54, *supra*.

⁶² According to State data, 388 SSI recipients (children and adults) have opted out of MC+ managed care plans since January 2005. This figure does not include children in the “Medical Assistance for Disabled Children” (MADC) Program, and of course the great majority of SSI adults are in the Medical Assistance program, not MC+. In the Medical Assistance program (as opposed to MC+), care is provided on a fee-for-service basis.

⁶³ There are still unanswered questions regarding the extent of managed care savings and whether managed care improves quality of care for these populations. For example, in Missouri, very little general revenue expenditures go towards in-patient hospitalization. Since the decrease in in-patient utilization is usually considered the major component of managed care savings, one must seriously examine the degree of savings that can be achieved through further expansion of Medicaid managed care. The major source of funding for in-patient hospital costs in Missouri is the federal reimbursement allowance (FRA) or provider tax. Moreover, the State of Missouri makes direct payments to hospitals to make up for decreased utilization under the Medicaid Managed care program. 13 C.S.R. 70-15.010(15). These payments would at least offset some, if not all, of the savings that would be achieved from switching to Medicaid managed care.

⁶⁴ Bruce C. Vladeck, *Where the Action Really Is: Medicaid and the Disabled*, Health Affairs, January-February 2003, at 97. 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. *Id.*

⁶⁵ A 2003 study of four different states’ Medicaid managed care programs for people with disabilities questioned the pursuit of managed care to achieve short-term savings for the SSI population. Medi-Cal Lessons Report at 20-21. The report also briefly summarized why such immediate savings are difficult to obtain, including: (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. In this study, even the proponents of Medicaid managed care cautioned against using managed care to achieve *immediate* savings for expenditures on elderly and disabled beneficiaries.

⁶⁶ *Id.* (emphasis added). As the Medicaid director of the Arizona Medicaid program recently noted, “it is a very short-sighted strategy to establish [capitation] rates based on a predetermined budget figure. It may work for a year or so but will eventually create deterioration of managed care plan effectiveness and participation.” Senator Smith’s Medicaid Roundtable, Testimony of Anthony Rodgers, Director, Arizona Health Care Cost-Containment System, September 13, 2006.

⁶⁷ SB 1123 Paper, at 2-3.

⁶⁸ For more information about the CCIP, see note 50 (and the citations therein).

⁶⁹ Ann Tumlinson, et al., *Limitations in Medicare Managed Care Options for Integration with Medicaid*, Center for Health Care Strategies Inc., March 2003, p. 2.

⁷⁰ The legislation also requires the Department of Insurance to develop requirements regarding long-term care partnership policies and to develop rules and regulations to carry out the new long term-care partnership provisions of Missouri law.

⁷¹ See Julie Stone Axelrad, *CRS Report for Congress, Medicaid's Long-Term Care partnership program*, January 21, 2005.

⁷² See Kaiser Commission on Medicaid and the Uninsured, *Deficit Reduction Act of 2005: Implications for Medicaid*, February 2005.

⁷³ Governor Matt Blunt, State of the State Address, January 24, 2007 (available at: http://www.gov.mo.gov/State_of_the_State_2007.htm).

⁷⁴ A recent study of the new Medicare “pay-for-performance” pilot program found that “pay-for-performance” generated little, if any, improvement in care compared to voluntary quality care improvement guidelines. Seth W. Glickman, et al, *Pay for Performance, Quality of Care, and Outcomes in Acute Myocardial Infarction*, *Journal of the American Medical Association*, Vol. 297, No. 21, at 2373 (June 6, 2007).

⁷⁵ More specifically, the legislation would require the Department of Social Services to issue an annual report that includes the following information about any employer with more than 50 employees who are receiving health care benefits through a MO HealthNet program: (1) the name and address of the employer; (2) the number of employees who are receiving health care benefits through a MO HealthNet program; (3) the number of employee spouses or dependents who are receiving health care benefits through a MO HealthNet program; (4) whether the employer offers health insurance to employees and their dependents; (5) whether “the employer receives health insurance company through the company” (this is most likely a typographical error and likely means whether the *employee* receives health insurance *coverage* through the company); (6) the level of premium subsidies for the insurance; and (7) the cost to the State of providing public health care benefits for the employees and dependents.

⁷⁶ Missouri Department of Social Services, Family Support Division, Income Maintenance Memorandum #8, January 29, 2007 (available at: http://www.dss.mo.gov/fsd/iman/memos/memos_07/im8_07.html).

⁷⁷ The Federal False Claims Act has brought in \$15 for every \$1 that the federal government invests in health care fraud prosecutions or investigations. Vicki Wachino and Jim Moorman, *The New Fiscal Incentive to Establish False Claims Acts: How Can It Benefit State Medicaid Programs and State Budgets?*, Center on Budget and Policy Priorities Conference Call Presentation, December 14, 2006, at 6. Sixteen states and the District of Columbia have enacted a state False Claims Act that would cover their Medicaid programs.

Some providers are concerned that a strong False Claims Act would penalize them for simple clerical errors. However, the Federal False Claims Act only targets cases in which there is *intentional* fraud. In order to be liable to the federal government for Medicare fraud, a person must knowingly present, or cause to be presented, a fraudulent claim, conspire to defraud the government by getting a fraudulent claim paid, or knowingly make, use or cause to make or use, a false record or statement to conceal, avoid or decrease an obligation to pay or transmit money or property to the government. 31 U.S.C. § 3729 (2007). The terms “knowing” and “knowingly” are defined by federal law. *Id.* Moreover, statistics on the federal False Claims Act demonstrate that out of more than 800 federal FCA cases reviewed, doctors were defendants in only 49 cases, and that 15 percent of federal FCA cases are brought by *doctors* themselves. Wachino and Moorman, *supra*.

⁷⁸ Such recovery is precluded if the court finds that this person planned, initiated or participated in the fraudulent conduct.

⁷⁹ This is in contrast to the Federal False Claims Act and Senate Bill 465 (sponsored by Senator Callahan) which would have allowed private parties to sue on behalf of the state and receive a certain percentage of the award or settlement.

⁸⁰ Section 6031 of the DRA provides States the ability to keep up to 10 percent more of Medicaid monies that were fraudulently obtained if states enact a Medicaid false claims act that is at least as stringent as the

Federal False Claims Act. The Federal False Claims Act contains several components: (1) provisions making providers liable to the government for fraud, (2) *Qui tam* provisions that allow whistleblowers to bring lawsuits on behalf of the State, (3) provisions that require the complaint/lawsuit to be held under seal for at least 60 days, (4) whistleblower protections from the provider/employer, and (5) civil penalty provisions that allow double or treble damages and civil penalties that are at least \$5,000 for each false claim. These provisions are contained in 31 U.S.C. § 3730. SB 577 contains provisions that would make the providers liable to the State for fraud, whistleblower protections, and civil penalties of at least \$5,000 for each false claim. However, the failure to include *qui tam* provisions in the Senate-passed bill means that the State will not be able to keep additional federal Medicaid funds recovered as a result of fraud prosecutions and/or investigations.

⁸¹ The bill does not appear to articulate the standard of proof is for civil cases in which Medicaid fraud is alleged – the Federal False Claims act uses a “preponderance of the evidence” standard.

⁸² This is a variation on the “single point-of-entry” idea that has been proposed previously. *See e.g., The Transformation of Missouri Medicaid to MO HealthNet, Recommendations of the Departments of Social Services, Health and Senior Services and Mental Health*, December 7, 2006, at 19 (“HealthNet Report”). The HealthNet Report recommended a “single point of entry” as one of the policy choices that could help to reduce or delay institutionalization. The report noted that a “single point of entry system would provide a user-friendly access for current, comprehensive information and assistance” regarding long-term care options. That system should be guided by an overarching goal to support consumer choice and decision making through enhanced information, education and assistance in navigating the social and medical health care system. *Id.* Presumably there would be *multiple* points of entry into the State’s long-term care system, rather than *one* entry point through the Department of Health and Senior Services or private agencies such as the Area Agencies on Aging. The bill does not set out what these entry points would be.

⁸³ *Reed v. Missouri Department of Social Services*, 193 S.W.3d 839 (Mo. Ct. App. 2006).

⁸⁴ *Id.*

⁸⁵ The legislation states that “such provision shall terminate upon *receipt* of relevant waivers from the federal Department of Health and Human Services” (emphasis added).” Thus, if the State received a waiver that addressed the reimbursement of personal care for these residents, the provision would no longer be valid. The bill goes on to state that if CMS determines that the provision does not comply with the state Medicaid plan, the provision shall be null and void. § 208.152.1(14). For example, there is a potential question as to whether Missouri can provide personal care services differently for Medicaid recipients who reside in the facilities affected by this provision and those who do not. The legislation is not clear as to whether the entire section is contingent on these determinations by the federal government or whether the waiver and “state plan” requirements only apply to one or more provisions, such as the ability to transfer units of personal care services from one facility to another.

⁸⁶ Upon request by the MO HealthNet Division, all third-party payers shall provide the MO HealthNet Division with information contained in the 270/271 Health Care Eligibility Benefits Inquiry and Response standard transaction mandated under the federal health insurance Portability and Accountability Act, with the exceptions noted above. (§ 208.215.7). See also 45 C.F.R. § 162.1202. Transactions are activities involving the transfer of health care information for specific purposes. For more information about the requirements for transactions under HIPAA, see Centers for Medicare and Medicaid Services, Transaction and Code Sets Standards (available at :<http://www.cms.hhs.gov/TransactionCodesetsStands/>).

⁸⁷ The “eligibility for a health plan” transaction is the transmission of either of the following: (a) an inquiry from a health care provider to a health plan, or from one health plan to another health plan, to obtain any of the following information about a benefit plan for an enrollee; (1) eligibility or receive health care under the health plan, (2) coverage of health care under the plan, (3) benefits associated with the benefit plan, (b) a response from a health plan to a health care provider’s (or another health plan’s) inquiry described in paragraph (a) of this section. 45 C.F.R. §162.1201. Health insurance carriers required to accept and

respond to HIPAA transactions under the bill include carriers that are administrators of ASO accounts and third-party administrators for fully insured or self funded employers. § 208.217.6.

⁸⁸ The bill also clarifies current Missouri law to more clearly delineate that the annuities provision addresses when such annuities can be *excluded as a resource*. The prior provision stated that for Medicaid eligibility purposes, annuities “shall be limited” to those which meet the statutory definition. The issue, however, is not whether annuities are permitted but the extent to which they are treated as a resource for Medicaid eligibility -- a point that the new legislation addresses.

⁸⁹ Thus, the Department could require prior authorization if the dosage requested for a particular drug exceeds the optimal dosage for the drug as developed through research.

⁹⁰ For a discussion of some of the arguments against prior authorization of psychotropic medications, see *Mental Health Association Psychotropic Medication Brief: The Case Against Prior Authorization*, Mental Health Association of Greater St. Louis, February 2004. For a discussion of the potential success of atypical antipsychotic monotherapy, see Alan F. Schatzberg, *New Approaches to Managing Psychotic Depression*, *Journal of Clinical Psychiatry*, vol. 64, Supplement 1 (2003)(available at: <http://www.psychiatrist.com/pcc/pccpdf/v05s01/v64s0104.pdf>).

⁹¹ The provisions modifying the requirements for seeking Medicaid waivers under state law (discussed above) are also covered by the emergency clause, however these provisions do not require any immediate action by the State, so the emergency clause is likely to have little if any practical effect on these provisions of SB 577.