OVERVIEW AND DISCUSSION OF SENATE BILL 577

Joel Ferber, Legal Services of Eastern Missouri, Inc.
Updated March 21, 2007

Senate Bill 577 implements several of the Governor's recommendations for reforming Medicaid. In his State of the State address and supporting budget proposals, Governor Blunt outlined his recommendations to modify the Missouri Medicaid program along the lines suggested in the HealthNet recommendations of the Departments of Social Services, Mental Health, and Health and Senior Services (hereinafter "Departments"). The HealthNet proposal centers around the concept of providing a "Health Care Home" for individuals in the Medicaid program. SB 577 makes some changes in Missouri law to enable the Department of Social Services to implement the new "MO HealthNet" program, including the proposed "Health Care Home" concept.

SB 577 also goes beyond the HealthNet proposal and introduces a new component called "Health Improvement Plans," which includes a capitated managed care alternative for all Missouri Medicaid beneficiaries, including people with disabilities. The legislation does not restore Medicaid coverage or services to those who lost coverage in 2005, but it expands coverage for adolescent children who would otherwise lose their Medicaid eligibility because they are no longer eligible for foster care. Other legislation may address changes in the SCHIP affordability test, and a program for disabled workers was already passed by the House of Representatives (HB 39).

This paper represents a "first take" on some key issues raised by the Senate Committee Substitute for of SB 577. The Committee Substitute adds a promising provision, requiring 24-hour nurse triage lines to be available to all Medicaid recipients under the plan. The bill retains some troubling provisions that would authorize the HealthNet Division to assign seniors and people with disabilities into Medicaid managed care plans. The bill also continues to include confusing provisions regarding the role of the "health care advocate" and "health care home" in the new Medicaid program. The "health care home" is not defined, and the relationship between the "health care advocate" and the treating physician remains unclear. The Substitute bill also retains and expands provisions that would condition the coverage of certain health care services, including "Medicaid-covered services," on healthy behaviors and healthy lifestyles as determined by the Department of Social Services.

I. CHANGING THE NAME OF THE MEDICAID PROGRAM AND REMOVING THE SUNSET (§ 208.001)

SB 577 changes the name of the Missouri Medicaid program to "MO HealthNet" and replaces the "Medicaid" with "MO HealthNet" throughout state law.[1] The legislation removes sunset dates for the Missouri Medicaid and SCHIP programs. (§§ 208.631 and 208.014 (repealed)). 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)

II. HEALTH CARE ADVOCATES AND HEALTH CARE HOMES (§ 208.950.1 (2), 208.10(1) and (2)).

The Governor proposes to provide Medicaid recipients with a "Health Care Home." 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.[2] SB 577 attempts to achieve this goal by creating a new entity called the "health care advocate." There are a number of questions regarding how the health care home and "health care advocate" concepts embodied in SB 577 fit together.

The legislation mandates that Medicaid beneficiaries be offered a "health care advocate" to assist them with the coordination of their health care. The Senate Committee Substitute *defines* the qualifications of the "Health Care Advocate," which were not defined in the original bill. The bill states that a Health Care Advocate must be a health care professional who is either a physician or other health care practitioner licensed, accredited or certified by the State of Missouri to perform specified health services. The bill further states that the "Health Care Advocate" shall be trained and certified by the Department of Social Services to provide the health advocate services listed below. The term, "Health Care Home," is not defined in the legislation. Thus, it is not clear whether the health care advocates and the health care home are one and the same or are different entities. If they are different, there are a number of issues outlined below regarding how their roles may conflict and fail to serve the best interests of the Medicaid beneficiary.

Among the health care advocates' responsibilities are to:

- **Provide comprehensive, coordinated physical and behavioral health** in partnership with the patient,[3] their family, and their caregivers to assure optimal consideration for medical, behavioral or psychosocial needs. (§208.950.1(2));

- **Provide a health care home** for the participant where the primary goal is to assist the patient and their support systems with accessing more choices in obtaining primary care services, coordinating referrals, and obtaining specialty care. (§208.950.1(2));

- **Encourage health-based educational interventions** with related services, both in-home and out-of-home care, and family support assistance from both private and public-sector providers. (§208.950.1(2));

- **Coordinate and facilitate**, either directly or indirectly through care managers, efforts to address an individual's health care needs by making referrals, conducting health risk assessments, providing care management, and helping the participant navigate the health care system (§208.950.10(1);

- **Create a complete physical and behavioral plan of care** for the participant, based on the participant's unique health care needs and goals (§208.950.10(1)). If "applicable to the participant's health care needs," the plan must be created "in conjunction with a multidisciplinary team of health care professionals (this is a new provision in the substitute bill). The Committee Substitute removes the requirement that the advocate discuss the plan of care with the participant (but does not remove the requirement that participants must discuss their plan of care with the health care advocate in order to access therapy and comprehensive day rehabilitation services);

- **Provide services that are accessible, continuous, comprehensive, coordinated and family-centered.** (§208.950.10(1)). The legislation provides that "vendors" shall take all steps to ensure that health advocates provide services in this manner but does not define who the "vendors" are;

- **Advise the participant regarding the "appropriate health care expenditures"** for each participant consistent with the participant's plan of care (§208.950.10(2)).

This wide range of responsibilities raises the following questions:

(1) Is the "health care advocate" the treating physician? If the "health advocate" is *not* the treating physician, what will be the role of the treating physician in developing the complete physical and behavioral plan of care? Will the health advocate be allowed to develop a plan for the participant's health care without the treating physician's involvement? Will the treating physician have to obtain approval from the health advocate regarding the patient's treatments needs?

(2) If the advocate is *not* required to be a physician, why does the bill state that the "health care advocate … *provides* comprehensive coordinated physical and behavioral health?" Based on prior explanations of the "health care home" proposal by state officials, it seems unlikely that the *provision* of health care services by an advocate was the bill's intent. Rather, the advocates, who are not physicians, would coordinate those services for participants with actual providers of services. As written, the advocate could be any provider licensed under state law.

(3) *Who (or what) is the "health care home?"* A managed care organization? A nursing home? A hospital? The State? Federally qualified health centers? Community mental health centers? If the health care advocate is serving "on behalf of" these or other types of entities, that role is very different from working *on behalf of the patient* and *could well place the advocate in opposition to the patient's treating physician* (particularly if the health care home is the managed care organization)*?*

(4) What is the relationship between the health care advocate and the "health care home?" One provision states that the advocate provides *a health care home* while

another says that advocate *serves on behalf of* the "health care home" (§§ 208.950.1(2); 208.950.10(1)).

(5) What infrastructure and funding will be made available to support all of these responsibilities which go well beyond conducting the health risk assessment that the Governor has proposed to fund?[4]

(6) Will there be any other changes in the reimbursement mechanisms to encourage the establishment of "medical homes" (e.g., such as increases in reimbursement for well-child visits or additional coordination functions)?

(7) Will there be additional support and funding for providers to perform all of the coordination and administrative functions? Who will pay for the training that is required for all health care advocates?

(8) Why would the "health care advocate" advise the participant regarding the "*appropriate health care expenditures* consistent with their plan of care?" This approach would represent a significant departure from current Medicaid requirements under which medical services are provided when they are determined to be "medically necessary" by the treating physician rather than when they are determined to be "an appropriate expenditure" of money by a "health care advocate" who may not be a physician.

(9) How and at what cost will the State monitor whether all of these "advocate" responsibilities are actually performed?

(10) How will it be determined when a "multi-disciplinary team of health care professionals" is needed to help the health care advocate create the patient's plan of care? Who will pay for this multi-disciplinary team and who will make sure that such a team is available? Who will determine the types of health care professionals that will be on the multi-disciplinary team?

The most significant change in this section of the Committee Substitute is the establishment of credentials for the "health care advocate" position. However, *the inclusion of these credentials does not resolve the tension and confusion between the role of the "health care advocate" and the patient's treating physician.* Even if the "health care advocate" is a medical professional, if their role is to serve a managed care organization or some other entity besides the patient, there is a possibility of conflict with the *treating* physician or other treating professional.

If there is to truly be a *health care home*, then the health care advocate ought to be the patient's "primary care provider" or "specialist" in some circumstances (e.g., where the patient is receiving most of their care from that specialist) – the individuals who are truly qualified to develop a plan of care for their patients. And there needs to be sufficient funding for all of the additional "case management" responsibilities that are being imposed on these providers. Under the bill's current provisions, the "health advocates" need not be the patient's primary care provider and need not work for that provider,

thereby creating a potential conflict of interest between the "health advocate" and the treating professional. A better approach would make it clear that the health care advocate works with the treating physician and together they constitute the medical home.

III. HEALTH IMPROVEMENT AGREEMENTS, HEALTHY PRACTICES AND RESPONSIBLE LIFESTYLE CHOICES (§ 208.950.10(2)).

- **Earning Health Care Services based on Responsible Lifestyles and Healthy Practices.**

The Governor proposes to provide Medicaid recipients with incentives to engage in healthy behaviors by adopting the "HealthNet Plus" proposal that the Departments had recommended. Under HealthNet Plus, people who comply with certain behavioral requirements (such as losing weight, quitting smoking, or making their medical appointments) could earn credit for other Medicaid services (such as dental care, vision services, and smoking cessation services).[5]

While the legislation does not use the term "HealthNet Plus," it includes similar provisions to establish this program. The bill provides that individuals who sign a "*health improvement participant agreement*" with the State agency, participate in "healthy practices," and make "responsible lifestyle choices" can earn credits to pay for "approved health care expenditures." *The legislation authorizes the MO HealthNet Division to promulgate a regulation that includes a "range of approved activities or behaviors that can earn credit amounts."* None of these approved lifestyles and behaviors is described in the legislation, except for "following the plan of care." However, the "healthy practices" and "responsible lifestyle choices" must be "consistent with the participant's unique health care needs and goals" (a new provision in the Substitute).

The Senate Committee Substitute describes *some* of the health care services that would be available to individuals who meet these requirements. The legislation directs the MO HealthNet Division to "promulgate a list of approved health care expenditures" that can be earned, including but not limited to:

(1) Medicaid-eligible services;

(2) co-pays (presumably the participant would earn the right to have the State pay the co-pays),

(3) spenddown (presumably meaning that the State would pay the individual's spenddown),

(4) over-the counter drugs, and

(5) vitamins.

This list of health services is a new feature of the Committee Substitute. *The legislation does not specify which "Medicaid-eligible services" would have to be earned* or whether *such services include both mandatory services (e.g., in-patient hospital services, physician services) as well as optional services (e.g., prescription drugs, vision services, dental care).* The inclusion of "Medicaid-eligible" services in this section at least suggests that *mandatory* services could be purchased with earned credits, though this approach would require additional waivers and/or state plan amendments, depending on the groups involved. Making Medicaid services dependent on state-determined healthy practices and responsible lifestyle choices would be a serious departure from the current Medicaid system, under which services are provided when the individual's treating physician deems them to be medically necessary rather than whether an individual makes the lifestyle choices that the government deems appropriate. In fact, even "optional" services like vision, dental, and smoking cessation are important services that ought to be provided when they are medically necessary, rather than conditioned upon proper behavior and lifestyle choices.

As indicated above, the legislation does not set out which healthy practices and responsible lifestyle choices (besides compliance with the plan of care) will be required, what will be included in the health improvement agreements, or how doctors, other providers and the State will monitor compliance with these requirements.

- **Additional Services Can be Earned by Having a Discussion with a Health Care Advocate.**

In addition to the ability to earn points for engaging in proper behavior and lifestyle choices, *participants who "engage in a discussion with their health care advocate" regarding their plan of care will also be able to receive therapy services* (physical, occupational and speech) and *comprehensive day rehabilitation services*, but only if: (1) the General Assembly appropriates the money for these services; (2) the Governor signs the appropriations; and (3) the therapy is part of the participant's plan of care "that includes evidence-based performance measures." The bill does not define these evidence-based performance measures or whether they only apply to therapy services. This proposal is also very different from the traditional Medicaid program, under which services are provided if they are determined to be medically necessary by the patient's treating physician rather than based on whether the beneficiary has a discussion with a "health care advocate." It is also unclear *why these particular services* are identified as worthy of coverage based on a dialogue between the participant and the health advocate, as opposed to other services that may be medically required.

The Senate Committee Substitute added "comprehensive day rehabilitation services" as another service that could be obtained, along with therapies, if all three of the above conditions are met.

IV. ELECTRONIC CARDS (§ 208.950.10(2))

For "all programs" in MO HealthNet (i.e., the three health care delivery systems discussed below), vendors will be required to issue electronic access cards to participants. The legislation indicates that these cards *may be used by participants to satisfy cost-sharing* at hospitals, physicians or other health care providers and can be used by participants to earn "enhanced health improvement points" towards additional health care services as discussed above.

It is not clear how recipients will be able to use the card to "satisfy cost-sharing requirements." Will the State set up new accounts into which the participant can deposit funds and use the card like a debit card? Will the mere presentation of the card meet (or waive) Medicaid cost-sharing requirements? Will the cards be pre-loaded with points to help people make their co-payments or will the cards only satisfy cost-sharing if enough "health improvement" points are earned? Or will some other mechanism be employed?

V. COST-SHARING

A. Establishing a "Level of Co-payments" (§ 208.950.10(2):

SB 577 would require the State to establish a "level of co-payments" to be paid by HealthNet participants for services that are not federally mandated, including but not limited to prescription drugs. The legislation does not say *what level* of co-payments will be required, leaving that to the discretion of the MO HealthNet Division. This omission raises significant questions since the State already imposes co-payments for 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 the "level of co-payments" or what the increase would be.

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.[6] 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.

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 changes, particularly for people with very low-incomes.[7] The proposed 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. Financial Penalties for Emergency Room Use. (§ 208.950.10(8)).

The legislation would require the State to establish a "*sliding scale fee level of copays"* for *emergency visits* to a hospital. The original version of SB 577 authorized "vendors" to "establish a percentage of co-insurance" for non-emergency use of emergency rooms.

While the bill's former provisions authorized co-pays for *non-emergency* use of emergency room, the Substitute allows co-pays for use of emergency rooms *even when emergency room use is entirely appropriate.* The co-pay is only waived if the individual is "*admitted on an inpatient basis into the hospital*." This approach is inconsistent with the new co-payment options allowable under the DRA, which authorizes the State to impose co-payments for *non-emergency* use of emergency rooms in limited circumstances. Emergency care is otherwise exempt from co-payments under federal law.[8] Therefore, the current provision violates federal Medicaid law.

The DRA allows co-payments for "non-emergency" use of emergency rooms in limited circumstances. The DRA requires that in order for states to apply such financial penalties for emergency room use, Medicaid *beneficiaries must have access to available alternative non-emergency services*.[9] Moreover, if the State chooses to implement such cost-sharing, *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. [10]

In enacting these provisions, Congress recognized that individuals contacting the emergency room often do not have an alternative source of care available, 24-hours a day, 7-days a week and therefore should not be subject to cost-sharing for emergency room use without certain protections.

These federal provisions also interact with requirements under the Emergency Medical Treatment and Active Labor Act (otherwise known as EMTALA) for hospitals to screen all individuals seeking emergency care. Providers may be placed in a difficult position if they are expected to inform individuals of additional cost-sharing obligations after they have already examined the ER patient pursuant to EMTALA requirements and then either deny treatment if the Medicaid beneficiary does not have the funds to pay the co-insurance penalty or send the individual to another provider which they determine to be accessible for the patient.

It is very likely that the emergency room may determine that it is more cost-effective and medically appropriate to provide the prescription needed or treat the flu-like symptoms (without Medicaid reimbursement) rather than send the individual away without treatment at all because the individual is not able to pay the co-insurance.[11] The implementation of the proposal for cost-sharing for non-emergency use of ERs at the very least creates issues of concern for hospitals and medical providers, as well as Medicaid beneficiaries. And imposing cost-sharing for *actual* emergencies (unless there is an admission to the hospital) compounds these problems and violates federal law.

In contrast to these problems with such financial penalties, *proper implementation of the medical home concept* --- including ensuring the availability of providers 24/7 either through direct contact with provider offices or nurse triage lines, along with patient education regarding the availability of advice and health treatment options --- would be a more effective approach to reducing unnecessary emergency room visits.[12] As indicated below, the Committee Substitute's inclusion of a 24-hour nurse triage line is one positive step in this direction.

- **New Provision on Nurse Triage Lines**

The legislation would require all plans to establish a toll-free nurse health line that must be open 24 hours a day and staffed by licensed registered nurses. All calls would be confidential. All plans would be required to encourage their participants to call when experiencing symptoms and before they make appointments with a health care professional or visit an emergency or urgent care room. The nurses must assess symptoms and provide recommendations as to what services should be sought by the participant. The nurses may not provide a diagnosis or provide treatment.

This requirement is a positive addition that may well help Medicaid patients in seeking appropriate treatment and avoiding inappropriate emergency room use. It should be noted that under the bill's current wording, the individual will still be charged a co-payment *even if* the triage nurse recommends that the individual go to the emergency room for treatment, unless that individual is admitted to a hospital.

VI. "PREMIUM OFFSET" PROGRAM (§ 208.202)

The Governor's budget included funding for a premium assistance or "offset program" for small businesses. SB 577 provides the enabling legislation for implementing such a program by authorizing the MO HealthNet Division to implement a "premium offset" program for making "standardized private health insurance coverage available to qualified individuals." This section of the bill is extremely vague, and it delegates very broad authority to the new HealthNet Division to design a new program and develop all of the important details. It is unclear whether the 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.

While very few details are provided, the MO HealthNet Division would be given broad authority to apply for waivers and state plan amendments needed to implement a premium assistance program (the original bill *required* the Division to apply for such waivers and state plan amendments). The program would be subject to appropriation 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 *and* the employee pay their share of the required premiums. Participants who receive the "standardized private health insurance coverage" would not entitled to any Medicaid "wrap around" services to fill-in the gaps in their private coverage.

The program appears to be geared towards premium assistance for purchasing employer-sponsored coverage (under which state and federal Medicaid payments would be used to pay the health premiums with specific employers). These programs have generally had very low participation in other states.[13] Some questions include:

(1) Who are the "qualified individuals?" Would the program apply to existing Medicaid beneficiaries or would it be an expansion of coverage? What are the income and resource eligibility requirements for the new program?

The only eligibility requirement described is that the person must *be without insurance for an entire year* before being eligible for the program. This requirement is a rather stringent limitation on program participation for people who may have no other access to health insurance. Such a provision would 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. A preferable approach to discourage "crowd out" of employer coverage would be less harsh for uninsured people.

(2) Would there be *any* standards for the Medicaid benefits package?

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

(4) Would 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.

(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? Such programs tend to focus on small business or employers with 50 employees or less.

(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 get the savings from the existing Medicaid program to pay for this program?

These questions are left to the discretion of the State agencies. The efficacy of such a program will depend on these and other details not included in SB 577.

The Committee Substitute includes a new provision, which states that "*absent employer participation, a qualified employee, or qualified employee and qualified spouse, may directly enroll in the MO Health Net premium assistance program.*" It is not clear what this means. Will there be a new state-administered 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 the legislation envision? Does the bill intend to allow individuals 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 there would still need to be some type of employer "participation" under this model. This new provision could certainly be revised so that its intent and meaning are made clear.

VII. "HEALTH IMPROVEMENT" PLANS

SB 577 introduces a new concept not previously included in the Governor's budget or in the Departments' HealthNet Recommendations. It requires Medicaid recipients to enroll in one of "three types of health care delivery models called "Health Improvement Plans."

A. Three options for health care delivery (§§ 208.950.1 and 208.950.2)

SB 577 would give all Missouri Medicaid recipients a "*choice"* of participating in one of three types of "health improvement plans." All three models would be required to offer a "health advocate" to the Medicaid beneficiary. All Medicaid recipients would be required to enroll in one of the three types of health improvement plans, including recipients who are aged, blind or disabled.

The **"risk bearing" plan** essentially means capitated managed care similar to that currently employed in Missouri's MC+ program for parents, children and pregnant women.[14]

The **Administrative Services Organization** (ASO) plan is a form of managed care that is not capitated and provides health care on a fee-for-service basis, but the private entity is "at risk" in that its fees will be reduced if savings and quality targets set by the State are not met. (§ 208.950.9).[15]

The third plan, the **"state care management point of service program,"** is defined as a "*system of health care delivery administered by the department of social services.*" This broad definition could well mean providing the same fee-for-service Medicaid option that is provided under the current system or some other delivery system defined at a later date.

It could also be interpreted to mean a primary care case management system such as that now provided on a voluntary basis in Missouri's chronic care improvement program for individuals with specific diseases or health conditions.[16] This definition should be clarified.

The bill mandates competitive bidding for the managed care contracts for both the risk-based and ASO models, with preferences for Missouri-based vendors and prior experience. (§ 208.950.10). Three-year contracts are subject to annual savings and quality targets determined by the Department and which include consumer and provider satisfaction levels. For the risk-bearing entities, contracts shall require "per diem" reductions or other financial penalties if quality targets specified by the Department of Social Services are not met (a new provision in the Substitute). ASOs will have their fees reduced if savings and quality targets are not met. There will be at least quarterly reporting of participant and provider quality and satisfaction indicators. These indicators include, but are not limited to, complaints, prompt payment of providers, call center statistics, and denials of care, to be determined by the department. Participant call centers will be established for recipients to receive questions about the programs and refer participants to appropriate state offices. Individuals in managed care who do not choose a primary care provider will have a provider chosen for them.

The legislation would establish an Oversight Committee on Health Improvement Plans. The Committee consists of members of the Missouri Senate and House of Representatives, consumer representatives appointed by the Governor, health care providers appointed by the Governor, "advocates of health care" appointed by the Governor, and the Directors of the Departments of Social Services, Mental Health and Health and Senior Services (§ 208.955.1). The bill sets out requirements for these Committees to meet, review data, and report findings on the Program. By July 1, 2013, the Committee must issue findings to the General Assembly on the "success and failure of the health improvement programs" and recommend whether to discontinue any of the programs. (208.955.3)

The Department of Social Services will evaluate all three models annually based on cost, quality, health improvement, health outcomes, social and behavioral outcomes, health status, customer satisfaction, use of evidence-based medicine and use of best practices, and will submit the annual evaluation to the Oversight Committee. (§ 208.950.5). The legislation does not indicate whether there will be an independent evaluation of the program.

B. Plans Required to Partner with FQHCs, RHCs, and CMHCs (§ 208.950.10(9))

All "programs" (presumably this means all "health improvement plans") must contract with federal qualified health centers (FQHCs), rural health clinics (RHCs) and community mental health centers (CMHCs) if there are FQHCs and CMHCs within a 30-mile radius of these plans "to ensure availability of care." This requirement is sound in that these entities already provide health care to low-income people in many areas of the

state, and it makes sense to allow Medicaid beneficiaries to have continued access to these clinics if they are enrolled in some type of managed care plan.

C. The MO HealthNet Division (formerly the Division of Medical Services) will be a "Third Party Administrator" (§ 208.950.2)

SB 577 specifically provides that beginning no later than July 1, 2008, the new MO HealthNet Division shall function as a "third party administrator," providing all Medicaid recipients with a choice of health improvement plans.

A third party administrator (TPA) is typically more of a fiscal intermediary serving as another's financial agent, by processing claims, providing services, and issuing payments for insurance companies, publicly-funded programs or employers with self-funded health insurance plans. Under the current Medicaid program, however, the Division of Medical Services has far more responsibility than a typical TPA in that it is charged with ensuring compliance with federal law by the State and organizations with which it contracts, including compliance with the rights of Medicaid beneficiaries, and general oversight of the program. The wording of the legislation at least raises questions as to whether the legislation intends for the Division of Medical Services to relinquish any of these oversight functions.

Given the large amount of money involved and the importance of the program, it would not make sense to restrict the Agency's role in this way. There must be very strong oversight of contracted entities to ensure that the State is getting value for its dollars and that beneficiaries are getting necessary health care services.[17] Moreover, the designation of the MO HealthNet Division as a TPA does not seem to square with the need for a State role in monitoring recipient compliance with the healthy behavior and lifestyle requirements of the Health Improvement Program.

D. Elderly and Disabled Beneficiaries are enrolled on an "Opt-Out" Basis (§ 208.950.12)

SB 577 states that elderly and disabled residents will be enrolled in health improvement plans on an "opt-out" basis. This provision appears to mean that such individuals would be automatically enrolled in a "health improvement plan" and then would have to choose to "opt-out." This component raises a number of questions. First, it is not clear how these individuals would receive their health care if they do "opt-out" since the only available service delivery mechanisms in the new MO HealthNet program are the three types of "health improvement plans."

The "opt-out" terminology is often used to describe beneficiary rights in Medicaid "managed care." For example, disabled children have the right to "opt-out" of Missouri's current Medicaid managed care program after they are assigned to participate. It is unclear whether the legislature intends for elderly and disabled beneficiaries to be *assigned* to capitated managed care plans or ASOs if they do not choose this type of health care delivery system. The State would clearly need a federal waiver to enroll

dually eligible Medicaid individuals (individuals who receive Medicaid and Medicare) and then allow them to "opt-out" later on.

Enrolling dual eligibles in managed care presents a range of issues, including whether it is appropriate to enroll "dual eligibles" (who receive a majority of their services and their prescription drugs through Medicare). Moreover, placing the burden on elderly and disabled beneficiaries to "opt-out" rather than having them "opt in" to a plan could limit their choices, if they are not clearly educated as to the choices available to them or have not retained an advocate to help them navigate the system.

There are significant questions that should be answered as the process moves forward.

E. Exemption for Beneficiaries to continue with current providers (§ 208.950.6)

The legislation provides an exemption from capitated managed care or administrative services organizations for individuals whose current providers are not enrolled in the managed care network. (Unlike the "opt-out" provision, this exemption is not limited to elderly and disabled beneficiaries.) However, *it is not clear why this option is needed if participants are intended to have a "choice" of delivery systems.* If the legislature intends that recipients will *not* have a choice of health care delivery systems, then there are other reasons for exemptions from capitated managed care, other than the fact that the individual's current provider is not included in the managed care network. The lack of available specialists or the plan's inability to accommodate an individual's disability may also be reasons for exemptions from managed care.

F. Phased-in Enrollment: Enrollment in the new "Health Improvement Plans" would be phased in as follows:

- **Enrollment of Parents and children:** Enrollment of parents and children who are not already in Medicaid managed care would begin on July 1, 2008 and be completed July 1, 2009.

- **Aged, Blind and Disabled individuals:** One-half of elderly blind and disabled recipients would be enrolled in the plans by July 1, 2009, but all individuals would be enrolled by July 1, 2013.

G. Discussion of the Managed Care Provisions

The new "health improvement program" will apply to all Medicaid beneficiaries. While the current version appears to afford recipients a *choice* of health improvement plans (i.e., health care delivery systems), it would clearly expand managed care as a delivery system for elderly and disabled beneficiaries – at least on a voluntary basis. Some of the language regarding "opt-out" and "exemptions" at least *implies* that managed care may be required rather than offered merely as a choice.

In particular, *caution is needed in approaching the issue of Medicaid managed care for elderly and disabled beneficiaries*. There is still not enough evidence to say conclusively whether Medicaid managed care for those with disabilities hurts, helps, or has no substantial effect on their access to health care or on the quality of care that they receive.[18] 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.

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.[19] The Missouri Medicaid Reform Commission noted the "fear amongst the advocates for the disabled and mentally ill" that "care will be rationed, not managed. *There is some basis for that fear*."[20] 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.[21] 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.[22]

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 are 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 heath needs and very low income as well as the lack of adequate performance assessment standards."[23] 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."[24]

In fact, *managed care for these populations, done correctly, could cost more money than fee-for-service Medicaid.*[25] Because people with disabilities are a "severely underserved population, effective assessment, care planning, and case management may greatly *increase* their use of services."[26] 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.[27] Therefore, Missouri should proceed cautiously, if at all, in expanding managed care to elderly and disabled beneficiaries. If the State moves forward in this area, more specificity is needed to evaluate the efficacy of such a proposal. Some of the specific questions are the following:

(1) **Will there be adequate networks** to serve elderly and disabled individuals in a managed care setting?

(2) **Will managed care plans be equipped to provide specialized health care services for people with disabilities?** Will there be adequate numbers of specialists to serve individual with chronic and disabling conditions? Will the plans have to ensure that their network providers' facilities are wheelchair accessible, including parking doorways and restrooms? Will plans have special equipment such as exam tables that can be raised and lowered?

(3) **What benefits will be included in managed care?** In the current Missouri managed care system for parents and children, many of the most specialized and high-cost services are *carved out* of mandatory managed care (which means they are still provided and paid for by the State on a fee-for-service basis). How will plans provide these services to people with disabilities? Will these services be carved out?

(4) **What kinds of consumer protections will be in place for seniors and people with disabilities?** Even if the program is "voluntary," managed care plans certainly will market their services to elderly and disabled beneficiaries, and it will be critical for consumer protections to be in place before anyone is enrolled. The legislation leaves most of these consumer protections for a later date, through agency regulations or the negotiations between the State and managed care plans. Will there be a role for consumers and their representatives in any agency rulemaking or negotiations governing managed care for seniors and people with disabilities?

(5) **What will be the grievance and appeal mechanisms?** *Will there be Ombudsman services* for these beneficiaries (as proposed in prior Missouri Medicaid managed care legislation)? What will be the mechanisms for participants to disenroll from health plans, with or without cause? Under what circumstances can plans disenroll participants? How will the State ensure that plans do not discriminate on the basis of disability? Will there be standards for waiting times and accessibility of services (e.g., geographic accessibility of providers)?

(6) **Would managed care be limited to acute care services or would long-term care be included as well?** Obviously managed "long-term care" is very different from coordinating acute care through capitated managed care plans. While the legislation may not actually intend that long-term care be included in the new system, *the literal language of the legislation would appear to make all Medicaid services, including nursing home services, part of the new Health Improvement (i.e., managed care) program.*[28] Because such a substantial portion of the Medicaid expenditures for seniors and people with disabilities is for long-term care, the scope of managed care is an important question.[29] Certainly, Missouri providers, beneficiaries, consumers, and state officials should know at the outset whether long-term care services would be subject to bidding by risk-based managed care plans and administrative services organizations, not to mention the savings and quality indicators for evaluating the provision of "managed long-term care."

(7) **How would the system work for dual eligibles** who receive many of their health care services *and* their prescription drugs *through Medicare*? The legislative provisions apply to all elderly and disabled beneficiaries, including dual eligibles, but the legislation does not discuss how the new system would work for them.[30] 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.[31] There are serious questions involved in establishing a Medicaid managed care program for individuals who receive so much of their care, as well as their prescription drugs, through the *Medicare* program.[32]

(8) **What will be the "guaranteed savings level" referenced in the bill and how will such savings be achieved?** (§ 208.950.8) The fiscal note to the legislation assumes that "savings of at least 5% can consistently be achieved through managed care."[33] What will be the "profit limitations" referenced in the bill? In particular, how will guaranteed savings be achieved for elderly and disabled beneficiaries, given the high costs of health care for such beneficiaries?[34] How will the ASOs meet their "savings targets" so that their vendor fees are not reduced? There is a legitimate concern that immediate savings cannot be achieved for this population without compromising access to care.[35] In fact, 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.[36] As the Medicaid director of the Arizona Medicaid program recently noted, "it is a very short-sighted strategy to establish 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."[37] (Arizona's Medicaid program is probably the most experienced of any with regard to Medicaid managed care).

For these reasons, MCOs could well choose to deny services or cut reimbursement in order to meet guaranteed savings targets.[38]

(9) **Will mental health care be provided through managed care plans** (whether the ASO or capitated model)? Will mental health services be carved out? Providing mental health care through a managed health care model presents special concerns, particularly for individuals with severe mental illness that would need to be addressed.[39] The Senate Committee Substitute carves out *one* category of mental health services --- rehabilitative mental health and alcohol and drug abuse services that are provided by a mental health or alcohol and drug abuse professional.[40] However, this change does not resolve whether other types of mental health services will be provided by the plans or "carved out" and provided on a fee-for-service basis.

(10) **What types of waivers will be requested?** SB 577 requires the Department of Social Services to request waivers, if needed, for implementation of an administrative services organization (ASO) model, but such waivers would clearly be required if the Agency mandates enrollment in a capitated managed care model for people with disabilities. (§ 208.950.3).

(11) **Will there be a choice of plans** for individuals enrolled in capitated (risk-based) managed care?

(12) **Would key stakeholders, including persons with disabilities and disability advocates, be involved** in the planning and design of the program?

(13) Would persons with disabilities be able to receive their primary care from a specialist (and have that specialist serve as their "health care home")?

(14) **Under what circumstances will seniors and people with disabilities be able to "opt-out" of managed care?** Will there be any protections against auto-assignment of elderly and disabled individuals to managed care plans? Will they be assigned to plans that include their current primary care physicians or specialists? Will these individuals be educated about how to choose a plan and avoid being assigned to a plan that may not meet their needs?

As a recent study noted, "it is important to recognize that auto-enrollment can disrupt ongoing provider-patient relationships and treatment regiments [sic] (a fact that has been in evidence in the Medicare Part D auto-enrollment process in the case of dual eligibles)."[41] It is "likely that some plans are going to be better equipped to treat patients with certain diagnoses than others, or that beneficiaries are going to be able to access certain plans more readily than others . . . Accordingly , it would be desirable to have an auto-enrollment procedure that takes into account provider history, geographic location, treatment needs and other factors that enhance a beneficiary's ability to access care."[42]

Even if the State continues to provide a *choice* of delivery systems, many of these 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.

VIII. OTHER ISSUES ADDRESSED IN SB 577

A. Coverage for Children "Aging out" of foster care (§208.151.1(26): The legislation implements the Governor's proposal to provide coverage to children "aging out" of foster care, an initiative estimated to help 970 such children. 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.

The expansion of Medicaid coverage for this group of needy children would be a beneficial improvement to the Missouri Medicaid program.

B. Health Technology Fund (§ 208.975):[43] SB 577 would create a "Healthcare Technology Fund" administered by the Department of Social Services. Subject to

appropriation by the General Assembly, the fund will be used to promote technological advances to improve patient care, decrease administrative burdens and increase patient and provider satisfaction. This bill also sets out a variety of technological improvements for which the fund may be used.

C. Long-term Care Partnership Program (§ 208.690): This proposal 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 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.[44] 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.[45]

D. Promoting "in-home care" (§ 208.950.10(4)): The bill would also require that there be "mechanisms in place" to promote and determine the appropriate use of in-home care for participants prior to admission to custodial skilled nursing facilities. However, as indicated below, the legislation is silent with regard to changing the incentives for nursing home care as opposed to receiving care in the community. It is unclear whether the inclusion of this provision means that the legislation intends to switch to a "managed long-term care system" as opposed to the current fee-for-service system for long-term care.

E. 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.[46]

F. "Pay-for-Performance" (§ 208.153.2): The legislation authorizes the Department of Social Services to establish a "pay-for-performance" program "subject to appropriations by the General Assembly." The Governor has proposed to pay providers based on results rather than the provision of certain tests and treatments.[47] SB 577 would *require* risk-bearing managed care organizations and administrative services organizations to participate in a "pay for-performance" system while providers in the state-administered (Point-of- service) model may participate in the program. If funds are not appropriated, these two types of managed care organizations 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. 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.

IX. MEDICAID ISSUES THAT ARE NOT ADDRESSED IN SB 577

There are a number of other key Medicaid issues that are not addressed by the proposed Senate legislation. Some of these are considered in the Governor's budget or other legislation while others are not addressed at all. Among the issues that SB 577 does not cover are the following:

- **Provider Reimbursement Rate Increases not included:** As indicated in previous discussions, the Governor's budget includes some funding for increases in provider reimbursement, a significant improvement for the Medicaid system. This recommendation is not included in SB 577 and presumably will be addressed through the Budget process.

- **Medicaid Coverage for Workers with Disabilities and SCHIP "affordability" changes are not included:** The Governor proposed funding to implement a new program for workers with disabilities and to restore some of the children who have lost coverage as a result of the stringent affordability test in Missouri's SCHIP program. These restorations are not included in this legislation and will likely be included in separate legislation. The Missouri House of Representatives has already passed separate legislation that would implement a new program for disabled workers (HB 39).[48]

- **Medicaid Coverage and Services are not restored:** The legislation does not restore the cuts in eligibility for more than 100,000 Missouri Medicaid recipients who lost coverage in 2005. Nor does it restore health care *services* to the over 300,000 low-income Missourians who lost Medicaid coverage of medically necessary health care services which help to prevent illnesses and ameliorate the impact of their disabilities. The legislation could enable some Medicaid recipients to earn back a few of these services if recipients comply with the behavioral requirements established by the State. As indicated above, therapy and comprehensive day rehabilitation services could be available to some beneficiaries under certain limited conditions.

- **Discrepancies in Medicaid Coverage Unaddressed** (§ 208.152.2) The legislation does not address discrepancies created by the 2005 cuts to Medicaid services under which a wide array of medically necessary services such as hearing aids, canes, catheters, crutches, some breathing equipment, hospital beds, 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.

- **Long-Term Care Incentives:** The proposal does not address the current disincentives to move people from institutionalized care into home and community-based care. As a result of more restrictive criteria for long-term care services adopted in 2005 and the inability to receive certain medically necessary services in the community when these services are available in a nursing home, the current system encourages individuals to enter or remain in institutionalized care.

CONCLUSION

SB 577 is the enabling legislation for the Governor's "HealthNet" proposal and provides a mechanism for implementation of the "health care home" concept. The legislation does not restore coverage to groups that lost Medicaid coverage or services 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 adds a new component, the "health improvement plan," which raises a number of questions and leaves broad discretion to the Department of Social Services to develop the contours of the new program.

Endnotes

[1] In making these changes, the legislation mistakenly changes the name of the federal Medicaid Agency, "the Centers for Medicare and Medicaid Services" to the "Centers for Medicare and MoHealthNet Services." § 208.152.4.

[2] See American Academy of Pediatrics, National Center on Medical Home Initiatives for Children with Special Needs, http://www.medicalhomeinfo.org/

[3] In describing the health advocates' responsibilities, SB 577 uses the terms "patient" and "participant" interchangeably.

[4] The Governor's proposed budget includes $32.6 million ($12.1 million state, $20.5 federal) for health risk assessments for Missouri Medicaid recipients that would then be used to create a "plan of care" for those individuals. Five million dollars ($2.5 million state, $2.5 million federal) would be spent on enrollment brokers to help individual choose a "Health Care Home." The legislation's fiscal note appears to disregard the cost of all of these additional "health advocate" responsibilities. See Committee on Legislative Research, Oversight Division, Fiscal Note for SB 577.

[5] The Missouri Departments of Social Services, Mental Health and Health and Senior Services, *The Transformation of Missouri Medicaid to MO HealthNet: Recommendations Offered by the Departments of Social Services, Health and Senior Services and Mental Health*, December 7, 2006 (available at: http://www.dss.mo.gov/mis/mcdtransform.pdf)

[6] 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 ("MFH Report"); 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 ("Adverse Events"). 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.

[7] 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 Deficient 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.

[8] 42 U.S.C. § 1396o(a)(2)(D).

[9] Deficit Reduction Act of 2005, Section 6043(a), amending Section 1916A of the Social Security Act.

[10] *Id.*

[11] Federal EMTALA provisions provide as follows:

§ 1395dd Examination and treatment for emergency medical conditions and women in labor

> (a) Medical screening requirement. In the case of a hospital that has a hospital emergency department, if any individual … comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical diagnosis, the hospital must provide for an appropriate medical screening examination within the capability for the hospital's emergency department, including ancillary serves routinely available to the emergency department to determine whether or not an emergency medical condition … exists.

[12] There is, in fact, some evidence that educational and behavioral strategies, such as reminders and positive reinforcements, can increase the likelihood that patients follow treatment instructions and reduce emergency room visits. Judith Solomon, *West Virginia's Medicaid Changes Unlikely to Reduce State Costs or Improve Beneficiaries Health*, Center on Budget and Policy Priorities, May 31, 2006, at 5 (and citations therein). Several studies suggest that when physicians and patients work together to set treatment goals, health-related behavior may improve more than when the physician simply tells them what to do. *Id.*

[13] *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.

[14] The risk-bearing or capitated plans will 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 may choose to subcontract pharmacy management to the state. § 208.950.8.

[15] 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. § 208.950.9. 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.

[16] 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 (COPE), diabetes, cardiovascular disease and Gastroesophageal Reflux Diseases (GERD). Division of Medical Services, Provider Bulletin, Vol. 29, No. 22, January 16, 2007. Patients are invited to participate based on a "risk assessment" tool, and participation is voluntary. 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. Providers will receive incentive payments for actively participating in CCIP. These "pay-for-performance" measures have not yet been established.

[17] For discussion of the substantial administrative investment needed to effectively operate Medicaid Managed care programs, see Statement of Jeffrey Crowley, M.P.H., Senior Research Scholar, Health Policy Institute, Georgetown University, Medicaid Managed Care Roundtable, Before the Special Committee on Aging, United States Senate, September, 13, 2006, at 5-6. Crowley further notes that the future success of Medicaid managed care depends on the adequacy of capitation rates and *the ability of state and federal governments to monitor access and quality*. *Id.* at 2.

[18] *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 ("Medical Lessons Report"), at 6.

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

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

[21] 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 will be 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

[22] 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 entirely on a fee-for-service basis.

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

[24] *Id.*

[25] 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.*

[26]*Id.* (emphasis added).

[27] 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).

In contrast, $400 million in federal funds and over $115 million in FRA funds are spent on "hospital services," with the remainder coming from other sources of state match. These figures are very comparable to other recent state Medicaid budgets. Moreover, FY 2007 estimates from the Missouri Hospital Association indicated that *"only" $9.2 million in general revenue was allocated to in-patient and outpatient hospital spending for people with disabilities in Missouri's current fee-for-service Medicaid program.* Missouri Hospital Association, *Projected General Revenue By Category State Fiscal Year 2007 Elderly and Disabled* (based on information provided by the Missouri Department of Social Services, Division of Medical Services). In contrast, more than $106 million in general revenue was projected for nursing home care for elderly and disabled beneficiaries. *Id.*

These data do not leave much room for additional savings by reducing general revenue spending on hospital utilization.

[28] For example, SB 577's proposed section 208.950.8 provides that the risk-based plans would ensure the coverage of services as prescribed under Section 208.152 of Missouri law – all of the Medicaid services. There is no exception from risk-based plans for nursing home care under SB 577. While there was very little discussion of long-term care at the Senate hearing on SB 577 (and the nursing home industry did not testify on this legislation), the current version of the legislation would include long-term care as part of the new system.

[29] For a review of the issues involved in managed long-term care, and examples of managed LTC programs, see Paul Saucier and Wendy Fox-Grage, *Medicaid Managed Long-Term Care, AARP Public Policy Institute*, Issue Brief Number 79 (2005)

[30] While many states enroll some of their disabled beneficiaries in managed care, this is not the case for elderly recipients, except for more limited demonstration programs that are voluntary in nature, like the Missouri PACE program. Most elderly beneficiaries cannot be enrolled in mandatory capitated managed care for the majority of their medical services because they are either "dual eligibles" (eligible for Medicaid and Medicare), or are qualified Medicare beneficiaries.

In testimony before the former Missouri Interim Committee on Cost-containment, *the Missouri Association of Health Plans did "not recommend including long-term institutionalized Medicaid beneficiaries in managed care.*" Report of the Interim Committee on Medicaid Cost and Containment, January 27, 2004, at 26. The Committee also noted that "[e]nrolling the aged and disabled in Medicaid managed care can be complicated by dual eligibles [people eligible for both Medicare and Medicaid]." *Id.* States cannot manage Medicare spending or service delivery without a Medicare demonstration waiver and often are challenged by having control over only a limited number of services for dual eligibles." Enrollment of these "dual eligibles" and other groups of elderly and disabled such as qualified Medicare beneficiaries would clearly require a federal waiver from CMS.

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

[32] While there are a variety of 'integrated systems" for Medicaid and Medicare recipients, this is a highly complex area. The Medicare services that dual eligibles receive do not blend seamlessly with one another. Karen Tritz, *Integrating Medicare and Medicaid Services Through Managed Care*, Congressional Research Service, June 27, 2006. The programs often have different eligibility requirements or scope of coverage for the same (or similar) services. The integrations of Medicaid and Medicaid can occur through various contractual arrangements between the federal and state government and the managed care plan. In some case, the state requires that a Medicaid managed care plan also becomes a Medicare-approved plan and develops a contractual relationships or agreements with CMS to coordinate both the Medicare and Medicaid requirement. In other cases, the managed care plan initiates the integrated Medicare and Medicaid program without a coordinated effort by CMS and the state. Id. at CRS-4 to CRS-5.

Most of these programs are voluntary. In fact, *Medicare managed care plans* are *entirely* voluntary for the beneficiaries. Some of these programs for dual eligibles involve integration of long-term care with primary and acute care, which does not appear to be the intent of SB 577. Id. at CRS-13 to CRS-15.

[33] Committee on Legislative Research, Oversight Division, Fiscal Note for SB 577, March 6, 2007.

[34] 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.

[35] 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.

[36] *Id.* 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.

[37] Senator Smith's Medicaid Roundtable Testimony of Anthony Rodgers, Director, Arizona Health Care Cost-Containment System, September 13, 2006.

[38] Blue Cross Blue Shield of Kansas City recently cut reimbursement for its Medicaid product to address a financial shortfall under Missouri's current MC+ managed care program. That product provides coverage to a healthier population of Medicaid beneficiaries than would be brought into the new "health improvement" plans. See Letter from Wayne Burge, Vice President, Provider Contracting and Reimbursement, Blue Cross Blue Shield of Kansas City, to Blue-Advantage Plus Allied and Ancillary Providers, March 1, 2007. It is reasonable to anticipate that Medicaid care plans could respond to the need to meet "guaranteed savings targets" for a high-cost population by making similar cuts in provider reimbursement.

[39] For further discussion of these issues, see Joel Ferber and James Frost, *Expanding Medicaid managed care to Elderly and Disabled Beneficiaries: Preliminary Observations about Senate Bill 1123*, March 30, 2006 (and citations therein). *See also* Cynthia Claassen et al., "Psychiatric Emergency Service Use After Implementation of Managed Care in a Public Mental Health System," *Psychiatric Services*, Vol.56, No.6 June 2005:pp 691-698 (noting an increase in police-accompanied emergency room visits, suggesting that increasing numbers of patients with mental illness in need of treatment were coming to the attention of law enforcement officials after managed care was implemented).

[40] Mo Rev. Stat. §§ 208.950.8; 208.152.1(15)(c). These services include home and community-based preventative, diagnostic, therapeutic, rehabilitative, and palliative interventions rendered to individuals in an individual or group setting by a mental health or alcohol and drug abuse professional. These services are provided pursuant to an agreement between the Department of Mental Health and the Department of Social Services, which certifies its expenditures for these services to the Division of Medical Services, renamed the MO HealthNet Division. This revision extends the current practice in the existing MC+ Medicaid managed care system, under which Community Psychiatric Rehabilitation program is managed by the Department of Mental Health, instead of the Medicaid managed care plans.

[41] Rosenbaum et al., supra at 19.

[42] *Id.*

[43] The Substitute version moves this provision into Chapter 208 of the Missouri Revised Statutes.

[44] The legislation also require 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.

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

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

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

[48] For additional information about HB 39, see Joel Ferber and James Frost, *Missouri Medicaid For People With Disabilities: MAWD, Medicaid Spenddown, Healthnet And HB 39*, February 16, 2007.