

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

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# The Transformation of Missouri Medicaid to **MO HealthNet**

## Executive Summary

- As a result of legislative action, Missouri is embarking on the most comprehensive update to the Medicaid program since its inception nearly 40 years ago.
- Based on recommendations from the Medicaid Reform Commission Report, **the new program will focus on:**
  - **Wellness**
  - **Prevention**
  - **Improved health outcomes**
  - **Individual responsibility**
  - **Evidence-based practice**
  - **Technology**
  - **Efficient program operations**
- In 2005, prompted by rapidly increasing Medicaid expenditures and program growth, the Missouri General Assembly passed legislation to help safeguard the sustainability of the program. It provided a June 30, 2008, sunset for Medicaid and created the Medicaid Reform Commission to review the program and make recommendations for reform.
- The Medicaid Reform Commission held public hearings and issued a report focused on nine critical areas for transformation.
- Governor Matt Blunt directed the executive agencies to study the Medicaid Reform Commission's recommendations and bring forward a plan to implement the recommendations and transform Medicaid.
- Missouri is continually examining ways to be proactive in patient care, technology and the efficient operation of the Medicaid program. Lessons learned through recent Medicaid innovations have helped shape the new, improved program components.
- **The executive agencies' working group proposes that the Medicaid program be transformed from a payer for services to a model program for the provision of high-quality health care focused on wellness.** This report contains 14 Medicaid transformation recommendations for Governor Blunt's consideration that reflect leading edge approaches in patient care, patient outcomes and health care financing:
  - **Recommendation 1:** Transform Missouri's Medicaid program to **MO HealthNet**.
  - **Recommendation 2:** Transform the Division of Medical Services to the **MO HealthNet Division** to become an authoritative leader in the provision of quality health care as well as health care financing.
  - **Recommendation 3:** Engage **MO HealthNet** participants with a health care home and health care home coordinator focusing on the health and wellness of individuals.

- **Recommendation 4:** Engage **MO HealthNet** participants in a health risk assessment.
- **Recommendation 5:** Develop a plan of care among the **MO HealthNet** participant, their health care coordinator and allied health professionals to improve health care status and encourage healthy behavior.
- **Recommendation 6:** Assist **MO HealthNet** parents who are not receiving temporary cash assistance to achieve independence. Modeled on Welfare Reform agreements, **MO HealthNet** independence agreements will be developed to help participants achieve improved health outcomes and self reliance.
- **Recommendation 7:** Provide opportunity for **MO HealthNet** participants to access other Medicaid-eligible services beyond the **MO HealthNet** benefit package. Participants may accrue credits by taking part in an approved list of healthy behaviors and use the credits for Medicaid-eligible services through **MO HealthNet Plus**.
- **Recommendations 8 and 9:** Recognize the critical role of health care home providers who embrace the principles of the **MO HealthNet** program. Health care home providers are active contributors and integral to the success of **MO HealthNet** and the improved health status of participants. Health care home providers will have access to improved technology, incorporate evidence-based practice, engage participants in health risk assessments and partner with participants to improve health outcomes. In recognition of the critical role of health care home providers, the working group recommends **(8)** physician-related reimbursement be increased (a potential way to do this is to move toward aligning reimbursement with Medicare rates) and **(9)** pay for performance measures be implemented to support providers for contributing to the health of **MO HealthNet** participants.
- **Recommendation 10:** Expand strategies that reduce waste, fraud and abuse and emphasize fiscal accountability through an efficient use of systems.
- **Recommendations 11-14:** Reduce the number of uninsured Missourians. In 2005, the Census Bureau estimated 691,000 Missourians were uninsured. Strategies to increase health insurance availability include: **(11)** small employer premium offsets, **(12)** extending **MO HealthNet** coverage to workers with disabilities, **(13)** extending **MO HealthNet** coverage to youth aging out of the foster care system and **(14)** redefining affordability for MC+ for Kids (SCHIP).

# The Transformation of Missouri Medicaid to **MO HealthNet**

## I. The Charge

The Medicaid Reform Commission was created under Senate Bill (SB) 539 and Senate Concurrent Resolution 15 to make recommendations for reforming, redesigning and restructuring the Medicaid system. The Commission held public hearings and issued recommendations.

Governor Matt Blunt directed the executive agencies (Departments of Social Services, Health and Senior Services and Mental Health) to study the Medicaid Reform Commission's recommendations and bring forward a plan for implementing the recommendations and transforming the existing Medicaid program. In keeping with the Medicaid Reform Commission's recommendations, this report lays out the executive agencies' vision, tenets and transformation approach. It incorporates leading edge strategies in improving health care outcomes and in health care financing. *(Please see Appendix A for a summary of all options which have been under consideration.)*

The executive agencies' working group included a large dynamic group of people from varying disciplines from the Governor's Office and the Departments of Social Services, Health and Senior Services and Mental Health. This provided a cadre of experts throughout the process of developing recommendations to transform Medicaid. *(Please see Appendix B for a list of contributors.)*

# The Transformation of Missouri Medicaid to MO HealthNet

## II. Medicaid Today

**History** – Missouri is embarking on the most comprehensive update to the Medicaid program since its inception nearly 40 years ago.

Medicaid, authorized by federal legislation to provide health care access to low-income persons who are age 65 or

over, blind, disabled or members of families with dependent children, began in Missouri in 1967. Since 1967, legislative options and mandates have expanded the categories of eligibility to include Medicaid coverage for children and pregnant women in poverty, refugees and children in state care. Medicaid is jointly financed by both United States and Missouri taxpayers, and is administered by the state of Missouri through the Division of Medical Services (DMS), a division within the Department of Social Services (DSS).

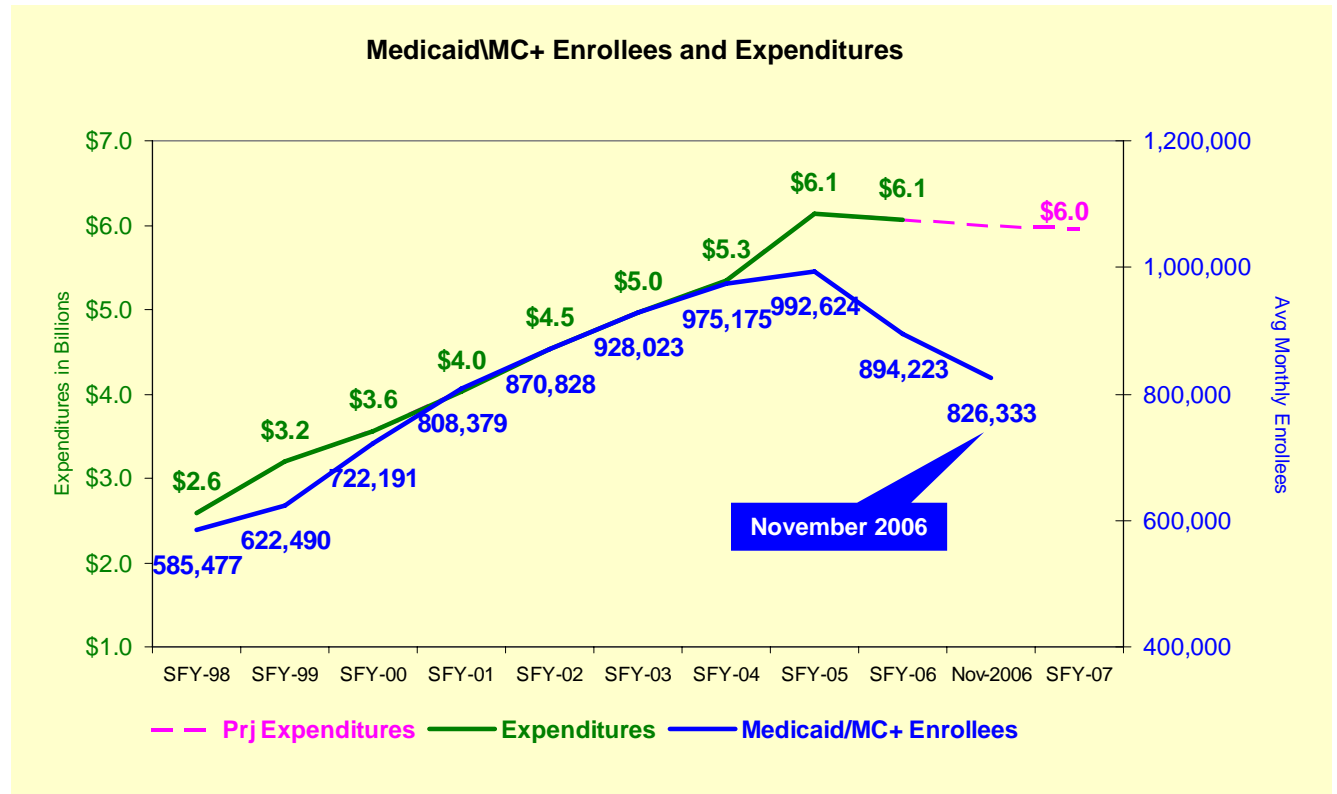
**Senate Bill 539 and the General Assembly's Medicaid Reform Commission** – In 2005, prompted by rapidly increasing Medicaid expenditures and program growth, the Missouri General Assembly passed legislation which:

- Provided a June 30, 2008, sunset on the current Medicaid program;
- Created the Medicaid Reform Commission to review the current Medicaid program and make recommendations for reform; and,
- Made changes to ensure sustainability of the program.

The Medicaid Reform Commission, comprised of members of the Missouri House and Senate, as well as *ex officio* members from DSS, Health and Senior Services (DHSS) and Mental Health (DMH), met during the summer and fall of 2005 and issued its report in December 2005. The Commission's report focused on nine areas:

- Establishing a health care environment that fosters wellness and prevention emphasizing personal responsibility for behaviors related to health care;
- Exploring the expansion of coordinated care to other areas of the state and other Medicaid groups;
- Increasing provider participation and satisfaction;
- Emphasizing the importance of using technology for electronic health records, e-prescribing, telemonitoring and telemedicine;
- Encouraging state departments to collaborate on mental health care issues;
- Examining opportunities to control long term care costs;
- Continuing and expanding upon opportunities to utilize evidence-based practices related to prescription drugs, while exploring efforts to contain pharmacy costs;
- Improving the availability of quality health care; and,
- Providing access to health care based on need rather than eligibility category.

**Current Medicaid program** – In SFY-2006 annual expenditures were \$6.1 billion and just over 826,000 Missourians are currently enrolled in the program. The changes enacted in SB 539 were successful in safeguarding the sustainability of the Medicaid program by bending the expenditure trend. However, the relationship of the purchase of services to health care outcomes was a challenge requiring further deliberations. Developing a system that focuses on improving health care outcomes and ensuring the future of the program is the foundation for recommendations offered by both the Reform Commission and this report.



The table, (*below*), summarizes current program eligibility and services.

<b>Mandatory and Optional Medicaid\MC+ Eligibles and Services</b>			
<b>Mandatory Eligibles</b>		<b>Mandatory Services</b>	
<ul style="list-style-type: none"> <li>• Old Age Assistance Up To Supplemental Security Income (SSI) Maximum</li> <li>• Medical Assistance for Families</li> <li>• Permanently and Totally Disabled Up To SSI Maximum</li> <li>• Aid to the Blind Up To SSI Maximum</li> <li>• Medicaid for Pregnant Women &lt;= 133% of Poverty</li> <li>• Qualified Medicare Beneficiaries</li> <li>• Medicaid for Children Ages 6-18, &lt;= 100% of Poverty</li> <li>• Medicaid for Children Ages 0-6, &lt;= 133% of Poverty</li> <li>• Refugees</li> <li>• Foster Care</li> <li>• Homeless Dependent Neglected Children</li> <li>• Newborns of Current Medicaid-Enrolled Women</li> </ul>		<ul style="list-style-type: none"> <li>• Nursing Facilities</li> <li>• Hospitals</li> <li>• Physician-Related</li> <li>• EPSDT</li> <li>• Home Health</li> <li>• Non-Emergency Medical Transportation</li> <li>• Lab and X-Ray Services</li> <li>• Federally Qualified Health Clinics and Rural Health Clinics</li> <li>• Family Planning</li> </ul>	
<b>Optional Eligibles</b>		<b>Optional Services</b>	
<ul style="list-style-type: none"> <li>• Aid to the Blind Above SSI Up To 100% FPL</li> <li>• Blind Pension</li> <li>• Youth in the Custody of Division of Youth Services</li> <li>• Child Welfare Services (Not Title XIX or IV-E Eligibles)</li> <li>• Children in the Custody of Juvenile Court (Not Title XIX or IV-E Eligibles)</li> <li>• MC+ for Kids (SCHIP)</li> <li>• Medicaid for Children Under Age 1, Between 133%-185% of Poverty*</li> <li>• Medicaid for Pregnant Women &gt; 133% of Poverty, But &lt;= 185% of Poverty</li> <li>• Missouri Children with Developmental Disabilities (MOCDD)</li> <li>• Presumptive Eligibility</li> <li>• Women With Breast or Cervical Cancer</li> <li>• Seniors Above SSI Maximum Up To 85% of FPL</li> <li>• Permanently and Totally Disabled Above SSI Max. Up To 85% of FPL</li> <li>• 1115 Waiver - Uninsured Women's Health</li> </ul> <p><i>*Mandatory as long as the state covers children under Title XXI (SCHIP).</i></p>		<ul style="list-style-type: none"> <li>• Dental**</li> <li>• Pharmacy</li> <li>• Nursing Facilities for Children</li> <li>• Personal Care</li> <li>• Podiatry**</li> <li>• Clinic Services</li> <li>• Rehabilitation and Specialty (Including Hospice, Optical, Durable Medical Equipment)**</li> <li>• Mental Health Services</li> <li>• ICF/MR</li> <li>• State Institutions</li> </ul> <p><i>**Some services are available only to individuals in a category of assistance for children, pregnant women, the blind or nursing facility residents.</i></p>	



**Current initiatives** – The Medicaid program has been seeking out innovation and researching leading edge technologies, strategies and ways to improve. Below are several initiatives currently underway to advance patient care, maximize technology and improve program operations. Lessons learned through these initiatives have informed transformation:

- Part of transforming Medicaid involves realigning the Division of Medical Services. This means a significant shift from the division functioning as a payer for services to a model that places program development and clinical policy decision making on equal footing with strong and efficient financial oversight. DMS recently reorganized into two sections to emphasize the clinical and financial aspects of the program.
- Chronic Care Improvement Program (CCIP) improves patient care and achieves cost savings through an enhanced primary care case management program incorporating the tenets of disease management, care coordination and case management into a patient-based risk assessment model. The goals are to improve health care quality for patients with chronic illnesses and disease complications and reduce costs.
- CyberAccess™ is an electronic, web-based tool to assist providers by incorporating Medicaid paid medical and pharmacy claims into a patient profile. Providers are able to assess a patient's utilization of services, including medications and services provided by other providers, and medication coverage and limitations allowing for coordination and management of care.
- SmartPA™ uses a highly-sophisticated clinical rules system in conjunction with drug and medical claims data to help pharmacists determine the appropriateness of dispensing certain medications. It streamlines the prior authorization process for all stakeholders – physicians, allied health professionals and participants. It adjudicates prior authorizations in real time.
- Smart MedPA™ technology was implemented in July 2006 based upon SmartPA™ to process pre-certifications for Computed Tomography (CT) and Magnetic Resonance Imaging (MRI) of the chest.
- Evidence-based practice is the conscientious, explicit and judicious use of current best evidence in making decisions about individual patient care. It is an underpinning for policy development that is acceptable to providers and other stakeholders. It integrates individual clinical expertise with the best available external clinical evidence from systematic research. The application of the evidence-based medicine principles is extended to all professions associated with health care, including purchasing and management. Examples utilized by DMS include the:
  - Prior Authorization Committee
  - Dental Committee
  - Transplant Committee
  - Non-Pharmaceutical Mental Health Prior Authorization Committee
  - Medical and Technical Advisory Committee
  - Durable Medical Equipment Committee
  - Drug Utilization Review Board
  - Licensed In-House and Contract Clinicians
  - University of Missouri-Kansas City School of Pharmacy's Drug Information Center
  - Oregon Health and Science University's Center for Evidence Based Policy Drug Effectiveness Review Project and Medicaid Evidence-Based Decisions Project
- Web-based medication price posting is being developed to share the usual, customary and reasonable (UCR) charge for prescription drugs with consumers so that they may comparison shop across pharmacies.
- Consolidation of drug purchases with other high-volume, government drug purchasers is currently under development.
- A Long Term Care Insurance Partnership program is being considered to encourage the purchase of long term care insurance while encouraging appropriate use of Medicaid.

- Missouri has been selected by the Center for Health Care Strategies (CHCS) to participate in the Pay for Performance Purchasing Institute. Participants will receive technical assistance from CHCS and other collaborators in areas such as developing incentive structure, choosing measures and engaging providers.
- Through the Deficit Reduction Act of 2005, Missouri has applied for transformation grant funding for these areas:
  - CCIP is an enhanced primary care case management program utilizing an integrated web-based plan of care with mechanisms to encourage patient self care and establishment of a medical home. Provider pay-for-performance and participation incentives are included.
  - A Medication Risk Management (MRM) program targeting patient adherence with treatment of Metabolic Syndrome, incentivizing pharmacists to educate and monitor patients using an electronic web-based tool.
  - A provider web portal that allows providers to prescribe electronically; view their patient's medication, diagnosis and procedure history; select appropriate preferred medications; and electronically request drug prior authorizations and medical procedure or equipment pre-certifications for their patients.
  - A reduction of expenditures for outpatient drugs through a real-time claims editing tool which uses clinical and preferred drug criteria and educates prescribers about the relative cost of therapeutically-equivalent drugs through a fiscal advisory posted on the web.
  - A Primary Care Home Initiative in the St. Louis region designed to ensure the sustainability of health care for patients most in need while reducing the growth of Medicaid spending.
  - A project that uses health information analytic tools to improve health care outcomes of Medicaid patients with severe mental illnesses and co-occurring medical disorders. It addresses three problems that contribute to poor patient health outcomes and the associated high health care costs: prescribing practices that are inconsistent with evidence-based recommendations, patients who do not take medications as prescribed (non-adherence) and medical and behavioral caregiver fragmentation of treatment.
  - An enhancement of the estate recovery capabilities by establishing connectivity to databases available through the Office of State Courts Administrator and county collectors' offices.
- The Missouri Mental Health\Medicaid Partnership is a collaboration between DMS and DMH. Health data analytic tools and evidence-based interventions are used to target high-risk Medicaid patients with severe mental illnesses and co-occurring chronic physical health disorders to improve health outcomes. The process:
  - Educates clinicians about medication prescribing practices consistent with best-practice guidelines;
  - Alerts clinicians and case managers to patients who fail to refill medications in a timely fashion; and,
  - Provides behavioral and physical health clinicians with patient health profiles and clinical recommendations for better health care quality and coordination.

- DMH has received a Mental Health Transformation Grant to provide a comprehensive, seamless system that:
  - Utilizes evidence-based practices,
  - Integrates physical and mental health at the service delivery level,
  - Establishes local investment and ownership of services, and,
  - Creates a unified system across the department that incorporates multiple funding streams.
- DMH, in collaboration with DSS and DHSS, has submitted an application for a Money Follows the Person Rebalancing Grant. If awarded, this grant will enable Missouri to make home and community-based service options more widely available.

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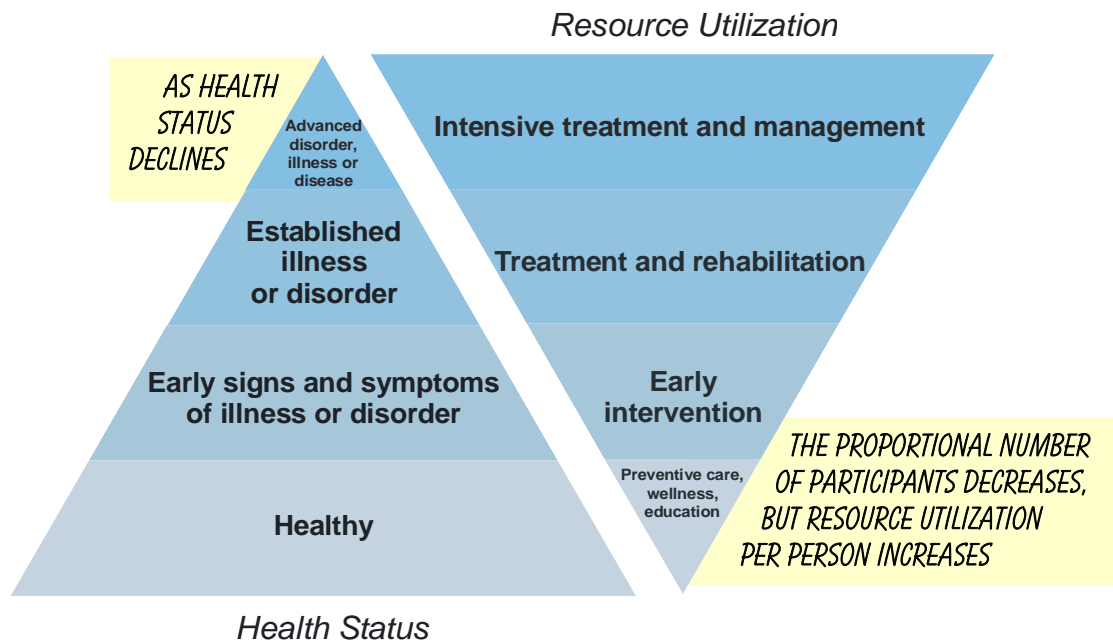
### III. Transformation

**Vision - The executive agencies' working group proposes that the Medicaid program be transformed from a payer for services to a model program for the provision of high-quality health care focused on wellness.**

**Tenets** – These basic principles provide a framework for transforming Medicaid. A transformed Medicaid system will:

- Heighten the focus on **improving health outcomes** through emphasis on participant education and encouragement of healthy individual behaviors. Through a **health risk assessment** and a **plan of care**, participants will be guided in health education and management of health status. Recognizing the importance of balancing **wellness and prevention** with treatment, a series of programs will be available to support healthy behavior.
- Transform the role of recipients of health care into increasingly engaged **participants**. As appropriate, participants will be provided opportunities to increase their health literacy and become active partners with their **health care home** in improving and maintaining their health.
- Transform the role of **providers** by encouraging evidence-based practice coupled with leading edge technology to strengthen health care outcomes. A key component will be linking evidence-based performance measures to financial incentives for health care home providers.
- Promote **independence** for parents not receiving temporary cash assistance through provisions focused on employment and training similar to Welfare to Work.
- Deliver services and supports in the **home and community** wherever possible. These settings allow for choice, flexibility and individualized care in the least restrictive environment.
- Promote a program that is **efficiently and effectively** operated. This includes being a prudent purchaser of health care and continued efforts to contain **waste, fraud and abuse**.
- Reduce the **uninsured** population through the following potential strategies: offering transitional care for foster care children and workers with disabilities, leveraging small employer-sponsored health insurance and redefining affordability provisions for CHIP children.

**MO HealthNet** – From historical data and experience in managing complex health care programs, the working group knows resource utilization is strongly related to the severity of physical, behavioral and disability issues. This basic relationship is illustrated below. As one goes from minimal health, behavioral or disability issues to severe stages of disease, illness or disorder in the health status triangle, the number of participants progressively declines, while resource utilization significantly increases. This suggests if Medicaid invests in participants' health, Missouri can affect resource utilization and ultimately overall costs.



Building from this premise, while maintaining current eligibility criteria, policy guidelines and service levels, the executive agencies' working group proposes to revolutionize the Medicaid program by conceptually changing the program to increase wellness and prevention and emphasize active participation.

To reflect this transformation, Missouri's Medicaid program would be replaced by a new **MO HealthNet** system and the Division of Medical Services would become the **MO HealthNet Division**.

**MO HealthNet Participants – One of the most important transformation concepts for recipients is the increased focus on engaging participants in their health care.** The elements of transformation related to participants include:

- **MO HealthNet participants will have a health care home** with its primary focus being the wellness of the individual. A health care home is not bricks and mortar, nor is it directed by a specific type of provider. Rather, a health care home provides comprehensive, coordinated physical and behavioral health. It is a partnership among the patient, their family and their caregivers to assure medical, behavioral and psychosocial needs are addressed. The goal of the health care home is to assist patients and their support system with accessing primary care services, coordinating referrals and obtaining specialty care. Additionally, the health care home encourages 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. The following are examples of services or functions that are features of a health care home:

*THE GOAL OF THE HEALTH CARE HOME IS TO ASSIST PATIENTS AND THEIR SUPPORT SYSTEM IN ACCESSING PRIMARY CARE SERVICES, COORDINATING REFERRALS AND OBTAINING SPECIALTY CARE.*

- Periodic updating of a plan of care which maximizes patient independence and is consistent with the health risk assessment;
- Updating of the clinical care considerations; and
- Fulfilling the expectations that access should be both sufficiently monitored and reasonable in relationship to the level of emergent need.

Key to the health care home will be the health care coordinator's facilitation. The selection of a health care coordinator will be based on the participant's predominant diagnoses (both physical and behavioral), their relative disease progression and their treatment needs. Health care coordinators will have the appropriate level of training based on the identified needs of each patient. Routine follow up with the patient regarding their perception of their health care status and the services they receive will be an aspect of the health care home. The work group recommends contracting with an enrollment specialist to help participants select a health care home.

*THE HEALTH CARE HOME IS FACILITATED BY A HEALTH CARE HOME COORDINATOR.*

- **Participants engage in a health risk assessment.** Once a participant is linked to a health care home, a health risk assessment can be done. Health risk assessments are designed to identify the probability and early detection of chronic conditions. For best results, it is recommended both the participant and the provider jointly complete the health risk assessment.
- **Participants and their providers partner to develop a plan of care.** Through the health risk assessment, participants along with their health care home will identify healthy behaviors, establish strategies for better health care outcomes and a plan of care focused on wellness and prevention. A participant will then be linked with appropriate providers and programs.

*PARTICIPANTS WILL WORK WITH THEIR PROVIDER TO COMPLETE A HEALTH RISK ASSESSMENT.*

*PARTICIPANTS AND THEIR PROVIDER WILL DEVELOP A PLAN OF CARE.*

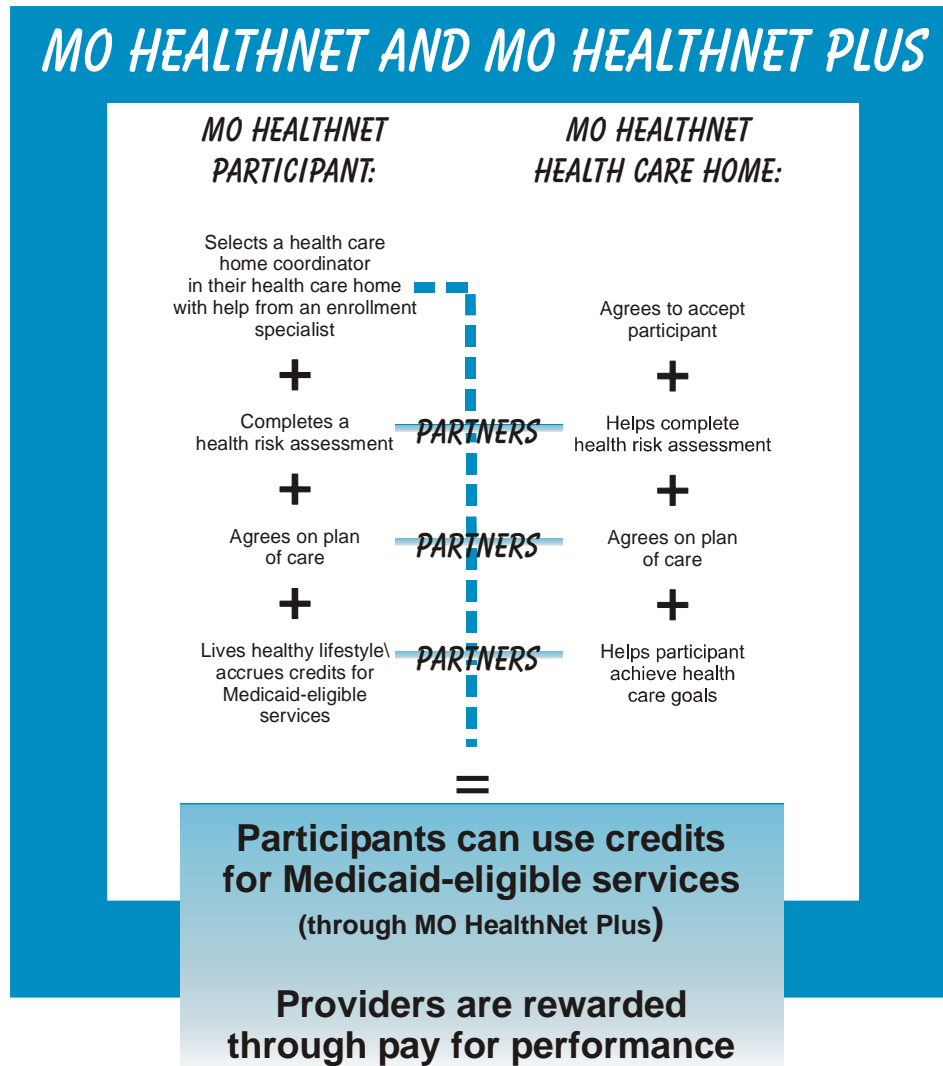
- **MO HealthNet parents work toward independence.** Participant agreements are a component of transforming Medicaid for parents. Modeled on Welfare Reform agreements, these **MO HealthNet** independence agreements will be developed to assist participants in achieving better health care outcomes and moving toward self reliance. It is suggested that independence agreements be offered as a pilot to a targeted group of parents not receiving temporary cash assistance who are **MO HealthNet** participants.

**Health Care Home Providers** – Health care home providers who embrace the principles of the **MO HealthNet** program are integral to its success. Transformation means health care home providers become active contributors to **MO HealthNet** participants' health care outcomes. Elements of transformation related to providers include:

- **Participant medical information** – A web-based tool called CyberAccess™ provides electronic prescribing, diagnosis data, patient medical history, ability to receive alerts, selection of appropriate medications and a means to request drug and medical prior authorizations. This will give the health care home provider a wealth of information to assist in managing and coordinating patient care.
- **Evidence-based practice** – Best practice information and evidence-based information will be available to health care home providers to assist them in effective health status management activities with their patients.
- **Health risk assessments** – Health care home coordinators work with participants to assess health risks. Assessments will be used to develop a plan of care that both the participant and their health care home agree upon.
- **Reimbursement and pay for performance** – Health care home provider participation is vital to the success of the **MO HealthNet** program. To provide the necessary services to participants, a strong health care home provider network is needed. Rates must support attracting and retaining an adequate number of health care home providers. One way of improving rates would be to move toward aligning physician-related reimbursement rates with Medicare.

There should be a relationship between the quality of care provided and reimbursement for services delivered. To recognize the important role of health care home providers, the working group suggests a pay for performance program. Pay for performance programs link evidence-based performance measures to financial incentives. Initially, pay for performance incentives should be limited in scope, focusing on health care home providers who are caring for multiple patients enrolled in the Chronic Care Improvement Program. The number of health care home providers should be increased as the program matures by providing incentives that make participation in pay for performance attractive to them. Pay for performance will be based on documentation of adherence to evidence-based care and treatment guidelines in a patient's plan of care. Baselines that are unique to the individual's health care status will be established.

**MO HealthNet Plus** – Participants in **MO HealthNet** have the opportunity to access Medicaid-eligible services beyond the **MO HealthNet** benefit package. Through **MO HealthNet** participants can accrue credits by taking part in healthy behaviors to improve their health status. A list of approved activities will be made available to participants.



Examples of ways credits can be accrued would include keeping all primary care appointments, quitting smoking, following a plan of care, etc.

In the year after credits are accrued, participants can use their credits for Medicaid-eligible services through **MO HealthNet Plus**. For example, an adult may use their credits on dental care.



**Waste, Fraud and Abuse** – The working group suggests that **MO HealthNet** continually expand efforts to reduce waste, fraud and abuse. Focus areas include:

- **Electronic fraud and abuse detection system** – Through a comprehensive and versatile array of electronic data mining and visualization tools, billing schemes such as false claims, procedure unbundling and duplicate billing can be uncovered. The program's electronic fraud and abuse detection system is an integral part of finding and deterring fraud; it should be expanded.
- **Provider education** – Currently, provider education occurs through the DSS on-line web site. Manuals, bulletins and hot tips of the week are all educational opportunities. Through development of a specific web site component, providers and participants should receive educational materials related to waste, fraud and abuse.
- **Advertise fraud hotlines** – A marketing plan, including further development of web site capabilities and taglines, should be utilized to promote the use of hotlines for reporting fraud.
- **Increase audit coordination** – By coordinating resources and working together, the audit outcomes for DSS, DMH and DHSS can be maximized to detect and deter fraud, waste and abuse of the **MO HealthNet** program.
- **Ensuring appropriate prescribing and participant use of controlled substances** – The working group proposes a three-pronged approach:
  - First, establish a panel of "lock-in" prescribers who have a proven record of appropriate prescribing patterns for controlled substances. Lock-in prescribers would be trained to identify substance abuse and patient falsification. They would be compensated for the additional administrative burden attached to controlled substance users.
  - Second, focus on participants who misuse controlled substances by requiring participation in substance abuse assessment and treatment intervention if indicated. Participants declining the assessment or treatment would be allowed a seven-day prescription two times per month and remain in lock-in status.
  - Third, limit participants in clinical case management for chronic pain to controlled substances from only one provider. Prior authorization for visits to a pain management provider and submission to periodic testing to determine pain medication compliance would be required.
- **False Claims Act** – The working group recommends enacting a False Claims Act as described in the Federal Deficit Reduction Act of 2005.
- **Long Term Care Insurance Partnership Program** – One mechanism that would encourage the purchase of long term care insurance, while encouraging appropriate use of Medicaid, is the creation of a long term care insurance partnership program. Under these partnership programs, individuals who purchase long term care insurance plans and deplete the benefit available under that plan may retain a certain amount of assets and still qualify for Medicaid, provided they meet all of the other eligibility criteria. While legislation already exists in Missouri, the federal government until recently limited these partnerships to Indiana, Connecticut, California and New York; however, the Deficit Reduction Act of 2005 included provisions authorizing any state to create a long term care insurance partnership.

**Technology** – Another vital element of transformation is maximizing the use of technology. Technology touches almost every aspect of transformation and it is interspersed throughout this report.

- CyberAccess™, SmartPA™ and Smart MedPA™ have all been mentioned, but their importance warrants reiterating. They are integral parts of the fee for service program management and Chronic Care Improvement (CCIP) program. We recommend the lessons learned through CCIP and the application of technology be applied to the entire **MO HealthNet** population.

**Uninsured** – In 2005, the Census Bureau estimated 691,000 Missourians were uninsured. We offer these strategies for consideration to help reduce the state's uninsured population:

- Implement a premium offset to small employers for employees below 200% of the federal poverty level. The proposal is to provide an incentive to build upon the employer-sponsored health insurance model and provide health insurance to low-income employees. Approximately a third of the cost of the program would be from state general revenue and matching federal funds. These funds would be used to leverage the remaining 2/3 from employers and their employees.
- Extend **MO HealthNet** coverage to an estimated 1,800 workers with disabilities. Workers would qualify if they have net income below 85% of the federal poverty level and gross income below 250% of the federal poverty level. For earnings to count, they must be subject to Social Security taxation.
- Offer transitional health care to youth aging out of foster care. Currently foster care youth, aged 18-21, who leave the custody of the Children's Division are unable to access or may not qualify for Missouri Medicaid. These young adults may no longer have available health care services or medications necessary to maintain a successful level of functioning. Youth leaving foster care at age eighteen often need supports, including health care, to transition to a successful adulthood. Offering transitional coverage would impact approximately 1,000 young adults.
- Reduce the affordability provision for the State Children's Health Insurance Program (SCHIP). Currently children who qualify for MC+ for Kids must lack access to affordable health insurance. Affordable insurance has been defined as the cost of premiums at or below 9% of the median income level for a family of three for each income group. The working group proposes that the affordability provision be revisited to potentially reduce the test as follows:

<b>Income as a percentage of federal poverty:</b>	<b>Affordability redefined as:</b>	<b>Suggested affordability guideline per month for a family of three:</b>
Over 150-185%	1% of family income	\$21 ( <i>currently \$209</i> )
Over 185-225%	3% of family income	\$77 ( <i>currently \$255</i> )
Over 225-300%	5% of family income	\$156 ( <i>currently \$375</i> )

Redefining affordability in this way would allow an estimated 13,800 uninsured children to participate.

**Seniors and Persons With Disabilities** – There are a number of issues surrounding care for the elderly and persons with disabilities, including the mentally ill, that have implications for **MO HealthNet**; however, they also affect a much larger population.

DHSS administers home and community-based programs that allow seniors and adults with disabilities to remain in their home and community for as long as possible before considering, or in lieu of, placement in an institutional setting. To reduce or delay institutionalization, a wider range of care options that provide supportive services could be developed.

- **Single point of entry** – Information is often the most important resource for Missouri residents, families or caregivers needing long term care. Without knowledge about existing services and resources to help an individual stay in their own home, many struggle without help or prematurely enter more restrictive care settings. A single point of entry system would provide a user-friendly access for current, comprehensive information and assistance. The 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.
- **Integration of the health care home with community-based service authorization** – Home and community-based service authorization could be integrated into the health care home concept, health risk assessment, provider participation, nurse visits and primary case management or CCIP, if applicable, to develop a thorough plan of care.
- **State plan personal care program** – Redesign the state plan personal care program to enhance services, reduce administrative burden, improve quality and establish consistent care planning based on the individual needs of the elderly and disabled citizens in Missouri.
- **Nurse visits for participants of home service** – Make semi-annual nurse visits available to all home care participants to assess the appropriateness and quality of home and community-based services. Nurse visits would provide valuable medical and functional information to be integrated with data maintained by the health care home.
- **Waiver redesign** – Redesign the Aged and Disabled Waiver and the Independent Living Waiver to eliminate the institutional bias and expand and redesign the service package to further promote and enhance community living as an alternative to nursing home placement.
- **Assisted living** – Develop an Assisted Living Waiver to include assisted living and caregiver homes as a means to provide additional alternatives to institutionalization. Assisted living would provide community-based services for individuals in need of protective oversight who meet nursing home level of care.

DMH establishes policies, standards and quality outcomes for prevention, education, habilitation, rehabilitation and treatment of Missourians challenged by mental illness, substance abuse\addiction and developmental disabilities. Missouri's Medicaid program currently supports vital services for individuals with developmental disabilities; serious mental illness or emotional disorders; and women, children and youth with alcohol and drug abuse problems who require public mental health services. As the mental health authority for Missouri, DMH supports **MO HealthNet** by articulating the clinical and programmatic standards of care for treatment of mental illness, substance abuse and developmental disabilities. DMH assists in implementing and maintaining these standards to assure that participants receive evidence-based, quality treatments and services and that a comprehensive array of services and supports for individuals and families challenged by mental illness, substance abuse and developmental disabilities are available.

Providing public mental health services is complicated:

- Funding is spread across DMH, Medicaid and a wide variety of state and local public agencies.
- A significant number of individuals who require mental health services are ineligible for Medicaid.
- Problems exist in duplication and gaps in services.

To address these issues, DMH is leading an initiative to comprehensively transform public mental health into a system that is unified, accountable and comprehensive. To accomplish this transformation, additional federal Medicaid waivers may be required.

**MO HealthNet Legislation** – To have **MO HealthNet** in place prior to June 30, 2008, the working group recommends **legislation in the 2007 session** which might include the following:

- Establishing **MO HealthNet**
- Establishing **MO HealthNet Plus**
- Removing the sunset on Medicaid concurrently with implementation of the new program
- Implementing a False Claims Act
- Extending transitional coverage to youth aging out of foster care
- Providing coverage for qualifying workers with disabilities
- Redefining affordability provisions for SCHIP children
- Implementing a Small Employer Premium Offset program

**MO HealthNet Budget Estimates** – To implement the model described within this document the following are estimates for budgetary support:

**Estimated Budget for State Fiscal Year 2008 (2007 Session)**

- An enrollment specialist to help participants select a health care home and a health care home coordinator (≈\$1.0 million general revenue investment)
- Expand CyberAccess™ to include the majority of providers serving the fee for service **MO HealthNet** population (≈\$6.0 million general revenue investment)
- Pay for performance for the Chronic Care Improvement Program (≈\$2.9 million general revenue investment)
- Reimbursing health care home coordinators to work one-on-one with participants to complete the health risk assessment (≈\$12.0 million general revenue investment)
- A pilot project to move 5,000 parents not receiving temporary cash assistance from **MO HealthNet** to independence (≈\$3.0 million general revenue investment)
- Increase physician-related services rates to Medicare rates over time (≈\$111.0 million general revenue investment with the understanding that this could not be accomplished in one year)
- Coverage for youth aging out of the state's foster care system (≈\$0.7 million general revenue investment)
- Coverage for qualifying workers with disabilities (≈\$7.6 million general revenue investment)
- Adjusting the affordability provision for SCHIP children (≈\$4.5-\$5.0 million general revenue investment)

**Estimated Budget for State Fiscal Year 2009** (2008 Session)

- **MO HealthNet Plus** benefits for participants using credits earned in SFY-2008 (≈\$5.0-\$20.1 million general revenue investment)
- State share of the Small Employer Premium Offset program (up to \$20.0 million general revenue investment)

**Estimated Budget for State Fiscal Year 2010** (2009 Session)

- Expand Chronic Care Improvement Program pay for performance plan to the general **MO HealthNet** population (≈\$3.9 million general revenue investment)

**Savings** – The state's experience with managed care has shown that through coordinating care a savings of at least 5% can consistently be achieved. By implementing the transformational model recommended by the Medicaid Reform Commission and the executive agencies' working group, it is estimated the following savings can be achieved:

- In SFY-2009, ≈\$22.6-\$45.2 million in annual savings associated with the chronically ill is expected.
- In SFY-2010, ≈\$58.5 million in annual savings is expected from improving health care outcomes to the broader **MO HealthNet** population.

## Appendix A

The executive agencies' working group knows that transforming Medicaid is ongoing. While many of the ideas listed below are recommended, this appendix chronicles the broader work of the group and may serve as a springboard for further discussion.

Focus Area	Option Summary	
<b>1. Wellness and Prevention</b>	1.1	Encourage health risk assessments be completed by each participant and their health care home coordinator. Health risk assessments are designed to identify the probability and early detection of chronic conditions and help establish a plan of care. For best results, it is recommended both the participant and the health care home coordinator jointly complete the health risk assessment.
	1.2	Expand the Missouri Tobacco Quitline (1-800-QUIT-NOW). The Quitline offers telephone counseling and resource materials to assist individuals who want to quit smoking. The Quitline can assist: (1) tobacco users in any stage of readiness to quit, (2) pregnant smokers, (3) smokeless tobacco users, (4) former smokers seeking relapse prevention support, and (5) health care providers wanting assistance with patient treatment.
	1.3	Incentivize providers and participants so <b>MO HealthNet</b> children receive healthy child immunizations through Early Periodic Screening, Diagnosis and Treatment (EPSDT).
	1.4	Reduce the affordability provision for MC+ for Kids children. Affordable insurance has been defined as the cost of premiums at or below 9% of the median income level for a family of three for each income group. The working group is proposing that the affordability provision be revisited to reduce the impact on low-income families.
<b>2. Transforming the Roles of Participants and Providers</b>	2.1	Structure <b>MO HealthNet</b> independence agreements to assist parents not receiving temporary cash assistance in achieving better health care outcomes and moving toward self reliance.
	2.2	Encourage all <b>MO HealthNet</b> participants have a health care home with its primary focus being the wellness of the individual. Current programs include Chronic Care Improvement Program, Primary Care Case Management, Disease Management and Care Management.
	2.3	Attract and retain an adequate number of health care home providers by improving physician-related reimbursement rates. Reward providers for improving the health of <b>MO HealthNet</b> participants through pay for performance.
	2.4	Identify providers with the best outcomes at the best price, using a five-star system, to provide consumers and decision makers with data to make informed choices.
	2.5	Encourage continued collaboration between the Division of Medical Services and Department of Mental Health on the Missouri Mental Health/Medicaid Partnership. Health data analytic tools and evidence-based interventions are used to target high-risk Medicaid patients with severe mental illnesses and co-occurring chronic physical health disorders to improve their health outcomes.
<b>3. Evidence-Based Practice</b>	3.1	Extend evidence-based practice and the principles of evidence-based medicine to all professions associated with health care, including purchasing and management. Evidence-based medicine is the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research. Recent samples are SmartPA™ and Smart MedPA™. The state should continue to collaborate with external resources to supplement work done to date on evidence-based practices.
	3.2	Promote evidence-based mental health practices through integrated dual diagnosis treatment, assertive community treatment, supportive employment and transformation initiatives.
	3.3	Encourage collaboration among state departments in assuring programs meet standards of care established by the Department of Mental Health.
<b>4. Efficiency and Effectiveness of Medicaid</b>	4.1	Transform the Division of Medical Services to the <b>MO HealthNet Division</b> and transform Medicaid to the <b>MO HealthNet</b> .
	4.2	Expand the electronic fraud and abuse detection system. Through a comprehensive and versatile array of electronic data mining and visualization tools, billing schemes such as false claims, procedure unbundling and duplicate billing can be uncovered.
	4.3	Develop a specific web site component where providers and participants should receive educational materials related to waste, fraud and abuse.
	4.4	Coordinate resources so the audit outcomes for the Departments of Social Services, Mental Health and Health and Senior Services can be maximized to detect and deter fraud, waste and abuse of the <b>MO HealthNet</b> program.
	4.5	Promote the use of hotlines for reporting fraud. A marketing plan, including further development of web site capabilities and taglines, should be utilized.
	4.6	Reduce inappropriate prescribing and participant abuse of controlled substances.
	4.7	Enact a False Claims Act as described in the Federal Deficit Reduction Act of 2005.
	4.8	Establish the Office of Program Integrity within Department of Mental Health, to prevent and detect fraud and abuse, increase audit capacity, procurement and oversight of contractors including reviews and audits.



Focus Area	Option Summary	
5. Greater Independence\ Mental Health	5.1	Increase availability of services and supports not covered by Medicaid. Examples include employment, housing, respite care and wraparound services.
	5.2	Increase integration of primary care and basic behavioral health care by incentivizing with an enhanced rate for integrated settings. In addition, the use of mental health case management\ community support has been found to lower the need for hospitalization and increase the adherence to office visits and medication.
	5.3	Expand home and community-based services in lieu of institutionalization.
6. Greater Independence\ Delayed Institutionalization for Seniors and People with Disabilities	6.1	Develop a single point of entry system that should provide a user-friendly access point for current, comprehensive information and assistance related to long term care. The 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.
	6.2	Integrate home and community-based service authorization into the health care home concept, health risk assessment, provider participation, nurse visits and primary case management or Chronic Care Improvement Program (CCIP), if applicable, to develop a thorough plan of care.
	6.3	Redesign the state plan personal care program to enhance services, reduce administrative burden, improve quality and establish consistent care planning based on the individual needs of the elderly and people with disabilities in Missouri.
	6.4	Make semi-annual nurse visits available to all home care participants to assess the appropriateness and quality of home and community-based services. Nurse visits would provide valuable medical and functional information to be integrated with data maintained by the health care home.
	6.5	Redesign the Aged and Disabled Waiver and the Independent Living Waiver to eliminate the institutional bias by expanding and redesigning the service package to further promote and enhance community living as an alternative to nursing home placement.
	6.6	Develop an Assisted Living Waiver to include assisted living, adult foster care and caregiver homes as a means to provide additional alternatives to institutionalization. Assisted living would provide community-based services for individuals in need of protective oversight who meet nursing home level of care.
7. MO HealthNet Plus	7.1	Extend opportunities for <b>MO HealthNet</b> members with healthy behaviors to earn credits to access additional Medicaid-eligible services beyond the <b>MO HealthNet</b> benefit package.
8. Personal Responsibility - Long Term Care	8.1	Develop a Long Term Care Insurance Partnership program to encourage people to finance long term care by purchasing insurance and ultimately protecting assets while still qualifying for Medicaid.
	8.2	Research a Harbor Older Missourians Estates (HOME) program, which is similar to 401(k) programs, where individuals and/or employers establish a savings account using pre-tax payroll deductions and state match to create an account to be used for long term care. This would protect family assets in the years when individuals are most likely to need long term care.
	8.3	Educate participants and their families about how the state's Medicaid recovery efforts affect them and their responsibilities to contribute to care.
	8.4	Limit exclusion of annuities to those making payments to an institutionalized beneficiary.
9. Technology	9.1	Explore establishing a centralized web portal that would serve as a central hub interacting with other data systems to allow users easier access to participant data without direct inquiry into multiple state systems.
	9.2	Use Modified National Correct Coding which is an edit system developed by the Center for Medicare and Medicaid (CMS) to address correct coding methodologies and control improper coding leading to inappropriate payment.
	9.3	Expand the utilization of CyberAccess™ to encompass more <b>MO HealthNet</b> participants, providing access to patient information by incorporating Medicaid paid medical and pharmacy claims into a patient profile.
	9.4	Explore the creation of electronic health records.
	9.5	Explore opportunities to expand the use of telemedicine.
10. Uninsured Strategies	10.1	Share Medicaid medication pricing with consumers to allow Missourians to comparison shop for prescriptions in their community.
	10.2	Incentivize small employers who offer health insurance to employees through premium offsets and leveraging state and federal funds.
	10.3	Provide transitional <b>MO HealthNet</b> coverage for young adults aging out of foster care system.
	10.4	Offer <b>MO HealthNet</b> coverage to workers with disabilities.
	10.5	Pilot a community mental health center/federally qualified health center collaboration.



## Appendix B

Listed below are the individuals that contributed to work in this report:

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