MO HEALTHNET OVERSIGHT COMMITTEE MEETING

January 29, 2013
1706 E. Elm Street
Jefferson City, MO

MINUTES

Members in Attendance:
Margaret Benz
Gerard Grimaldi
Brian Kinkade
Rep. Keith Frederick
Rep. Jeanne Kirkton (via phone)
Kecia Leary
Timothy McBride
James McMillen
Joe Parks
Mark Sanford
Sen. Rob Schaaf
Ingrid Taylor
Susan Wilson for Joseph Pierle

Members Absent:
DHSS Representative
Sen. Joseph Keaveny
Bridget McCandless
Carmen Parker Bradshaw

DSS Staff in Attendance:
Ian McCaslin, MHD
Andrew Bond, MHD
Darin Hackmann, MHD
Erin Heine, MHD
Samar Muzaffar, MHD
Karen Purdy, MHD
Paul Stuve, MHD
Emily Rowe, FSD
Rebecca Woelfel, DSS

Others in Attendance:
Meghan Elledge, Law Missouri
Ashley Berg, Heartland Regional Medical Center
Julie Batz, Missouri Senate
Carson Smith, House of Representatives
Emily O'Laughlin, House of Representatives
Geoffrey Oliver, Legal Services of Eastern Missouri
Mary Schantz, MO Alliance for Home Care
Megan Burke, Paraquad
Steve Renne, MO Hospital Association
Jim Burns, Centers for Medicare and Medicaid Services
Kim Covert, HealthCare USA
Angela Schulte, Home State Health Plan
Leanne Peace, MO Kidney Program
Kimberly Brandt, Wipro
Diane Twehous, Wipro
Dave Sproat, Bristol Myers

WELCOME/INTRODUCTIONS/MINUTES – Dr. Tim McBride, Vice Chair, called the meeting to order at approximately 12:00 noon. Minutes of the November 13, 2012 meeting were approved as submitted. Dr. McBride paid tribute to Dr. Corinne Walentik, Chair of the Oversight Committee, who passed away December 6, 2012. The family has suggested donations to Nurses for Newborns.

With the passing of Dr. Walentik, the MO HealthNet Oversight Committee Chair position became open. Dr. Tim McBride was nominated to be Chair. The nomination was seconded and unanimously approved by voice vote. Dr. James McMillen was nominated for the Vice Chair position. The nomination was seconded and also unanimously approved by voice vote.

DIRECTOR'S UPDATE – Dr. Ian McCaslin, Director-MO HealthNet Division, announced that Alan Freeman has been named as the new Director of the Department of Social Services (DSS). Mr. Freeman brings to DSS a background in health care including CEO of Grace Hill Community Health Center. The appointment is subject to confirmation by the Missouri Senate. Another transition in personnel

occurred with the resignation of Marga Hoelscher as Deputy Division Director. Ms. Hoelscher accepted a position as Director of Accounting for the State Senate. Julie Creach has been named as Interim Deputy Division Director. Andrew Bond is Chief Financial Officer.

MO HEALTHNET ENROLLMENT BY ELIGIBILITY CATEGORY– Summarizing the handout, Emily Rowe, Family Support Division, reported that participants as of December 2012 totaled 879,120. The chart reflected that of the 879,120, 60.9% are children, 18.5% are persons with disabilities; 9.0% custodial parents, 8.6% seniors defined as individuals 65 or older; and 3% are pregnant women. Of the 535,660 children enrolled, approximately 70,011 are enrolled in the Children's Health Insurance Program (CHIP).

In addition, 60,484 women are receiving services through the Women's Health Services program. This category is reported separately as benefits for this group of eligibles are limited to family planning services, not the full MO HealthNet benefit. A higher federal match is received for these services.

Managed care enrollment as of December 2012 totaled 422,046. A graph depicting enrollment in each region by health plan was also shared. The managed care program provides services to only children, pregnant women, and low income parents in select counties. If an individual is in one of these eligibility categories and lives in a managed county, enrollment in managed care is mandatory, with certain exceptions and opt out opportunities.

As a result of questions regarding cost savings for managed care, it was reported that the last analysis on cost was conducted in 2010 by Mercer, the state's actuary. The study, which was driven by encounter data, was framed in the context of what the relative cost would be to provide services in the absence of managed care. The conclusion was a 3% savings in the managed care program, a $38 million impact versus fee-for-service at the time of the study. The 3% savings is the national average for a mature managed care program such as that in Missouri Medicaid. The assumptions utilized did not include decreased utilization in the managed care program. Savings are achieved through increased access in urban areas, the pricing power of service in academic teaching centers, with the bulk of savings due to better care management, avoidable hospital bed days, reduction in the use of emergency departments, and quicker connection to high risk patients. The committee requested the data from the study be shared. There are numerous studies regarding outcomes through managed care programs. This national literature will also be shared with committee members.

DEPARTMENT OF SOCIAL SERVICES BUDGET – Brian Kinkade, Deputy Director, Department of Social Services, presented a summary document of the SFY 2014 Governor's recommendation for health care expansion. Funding for the expansion is included in the Departments of Social Services, Mental Health, and Health and Senior Services. Any health care expansion would require action from the General Assembly.

The document details the additional groups that would be included in an expansion. It is estimated that a total of nearly 260,000 additional lives would be covered in the categories of parents below 138% of the Federal Poverty Level (FPL), childless adults below 138% FPL, and medically frail adults below 138% of the FPL. Associated costs were also reviewed. The expansion would be funded 100% with federal funds for the first three years, FY14-FY16. Beginning in FY17 state contribution would begin at a gradual rate until FY20 when state share would be 10%. There are individuals currently covered who, if an expansion is pursued, would qualify for coverage under the expanded health plan, thus shifting costs from the 60/40 or 0% match rate to 100% federal match. Identifying those groups represents a savings of state general revenue. Those groups affected are detailed on the summary document.

Request was made to revise the summary document to show subsequent years. The committee also requested a break down by department of the general revenue savings anticipated in the Medicaid expansion.

There have been studies conducted on the economic impact of a health care expansion. Potential new revenues may result in an increase in personal income tax as a result of new staff employed or sales tax as a result of equipment purchases. The potential for new revenues may also come with the ability to suspend current tax credits available to insurance companies for premiums to the high risk pool. The cost to the state would be avoided if participants in the high risk pool had access to health care.

The increased participation by children shown on the summary is not directly related to the expansion. Rather, it is anticipated that discussions regarding the expansion will spark families to ask about coverage for children currently eligible but not enrolled with Medicaid. Assumptions are geared to be conservative in terms of capturing full cost of participants.

With regard to health care benefits for the expansion population, the federal law gives options. For the analysis, assumption was made that the new populations would receive a benchmark package – including, at a minimum, hospitalization, doctor, pharmacy, mental health – but probably not the full Medicaid benefit package. The benefit package as well as the delivery system structure are areas for legislative discussion.

Substantial discussion, including multiple views, continued on various issues such as the impact on the Department of Corrections population, potential of insurance companies increasing their rates due to the addition of high risk pool individuals, rates of provider reimbursement, the health insurance exchange, and loss of disproportionate share (DSH) funding to hospitals. The Committee discussed their role in the process and requested additional information at the next meeting.

MO HEALTHNET DIVISION BUDGET UPDATE – Andrew Bond, MO HealthNet Division Director of Finance, provided an overview of the MO HealthNet Division budget. A map depicting the 2012 average monthly MO HealthNet participation showed that 148.7 people participate per 1,000 Missourians. Highest participation is found in the southeast region of the state. Enrollment from January 2000 to July 2012 was reviewed. Eligibility groups and associated expenditures were graphed, noting that in SFY 2012 seniors and persons with disabilities comprised more than 27% of the enrollees, yet accounted for nearly 66% of MO HealthNet expenditures. The Governor's recommended budget for Medicaid expenditures over all agencies – Departments of Social Services, Elementary and Secondary Education, Mental Health, and Health and Senior Services -- was reviewed. Major decision items in the Governor's SFY 2014 budget recommendation were also outlined. It was noted that the state is working with the Centers for Medicare and Medicaid Services (CMS) to gain approval of the primary care rate increase state plan amendment.

PUBLIC COMMENTS – Leanne Peace, Missouri Kidney Program, voiced continued concerns regarding the negative impact on the chronically ill of the spenddown changes. She presented the process is cumbersome for patients and staff; there is a lack of clarity between offices; and a failure to process information timely.

Meghan Elledge, Legal Aid of Western Missouri, echoed the breakdown of communication related to the spenddown changes, despite the implementation of the call center. She stated that phone calls to the

call center are not returned. Inconsistent information is provided. Ms. Elledge offered their assistance with the process.

Commenters noted that a webinar was conducted in July 2012, but an additional webinar and on-line tools would be beneficial.

Written comments from Paraquad regarding continuing problems with the spenddown process were distributed to Committee members.

In response to questions from Committee members, Family Support Division staff indicated a collective agreement that spenddown is a difficult program from all perspectives, but a very important one. A regional approach had been initially developed to handle spenddown cases, but the agency is now trying to centralize the process to allow more consistency. Information on specific cases was requested.

DENTAL RATE COMPARISON – In follow-up from the November 2012 meeting, Paul Stuve, PhD, Quality Manager-MO HealthNet Division, provided additional dental information to include children under the age of two. The presentation included maps depicting the location of dental providers in both the fee-for-service and managed care programs. Managed care regions and the corresponding health plans were reviewed. Preventive and treatment services were compared between the managed care and fee-for-service programs. Orthodontics were not considered due to billing differences. It was noted that approximately 3,000 children under the age of two are receiving preventive dental services from dentists. This number does not include dental care for these children being provided during EPSDT screenings. Utilization rates for both preventive and treatment services by age group were also reviewed. Based on claims data information in SFY 2012, the utilization rate of preventative services in the fee-for-service program was 39.5% compared to 46.4% in the managed care program. The utilization rate of treatment services for the same time period was 20.1% in the fee-for-service program compared to 21.9% in managed care. A review of medical records was not conducted during the study; information was based on claims data only.

A discussion of dental services continued, including treatment for tooth abscesses in the emergency department and inclusion of dental services in the Affordable Care Act.

MMIS REPROCUREMENT – Darin Hackmann, MO HealthNet Division Information Systems Director, explained that MMIS – Medicaid Management Information System – is the state mechanized claims processing and information retrieval systems. It touches every aspect of the operation of the MO HealthNet program, but not eligibility and enrollment. An overview of the various components of MMIS were outlined. Of note, over 96 million claims are processed annually through the MMIS, with payments in excess of $6 billion. Average claim processing time is .58 days with over 99% of claims submitted electronically.

Wipro Infocrossing, Inc. has provided services as the MMIS Fiscal Agent since 1988. The current contract can be extended through June 30, 2017. Functions of the fiscal agent were reviewed to include MMIS operation and development, call centers, managed care enrollment broker, clinical authorizations, and provider manuals.

A second system of the overall Missouri MMIS is the Clinical Management Services and System for Pharmacy Claims and Prior Authorization (CMSP). CMSP functions include adjudication of clinical and pharmacy claims, prior authorizations and precertifications, and the CyberAccess web portal. CMSP is

operated by Xerox Heritage, LLC (formerly ACS Heritage). This contract too can be extended through June 30, 2017.

With both contracts expiring June 30, 2017, MMIS reprocurement is required by state and federal law. Enhanced federal match is available for the process if federal guidelines and procedures are followed. The first step in the process is a Medicaid Information Technology Architecture self assessment – a benchmark as to how automated the system is. MMIS alternatives for the procurement were discussed to include (1) continue with the existing system with upgrades; (2) a total system replacement; or (3) a hybrid approach under which portions of the existing system are replaced with commercial off the shelf solutions. A contractor for the self assessment has been selected and approval from CMS is pending. Remaining steps in the procurement process were outlined as well as the cost and timelines for a total replacement of the MMIS.

Discussion ensued on the effect of the federal insurance exchange and Medicaid expansion on the MMIS.

MONEY FOLLOWS THE PERSON – Julie Juergens, Project Director, provided an overview of the Olmstead Decision which spawned funding for the Money Follows the Person demonstration grants authorized under the Deficit Reduction Act of 2005. Missouri's grant was approved in January 2007 and was initially set to expire in 2011. The Affordable Care Act extended funding through 2016 and allows four additional years to 2020 to spend awards. Objectives of the demonstration were reviewed and include transitioning people who are elderly and/or disabled and currently reside in nursing facilities or habilitation centers to home and community based services. Eligibility criteria was reviewed as well as examples of qualified housing under the demonstration. A breakdown of individuals transitioned to community services since inception of the grant was provided. Medicaid waivers and state plan services available were outlined. Assistance with one-time expenses, up to $2,400, to set up a home in the community is available for individuals transitioning out of nursing facilities. Assistance with transition is a multi-agency effort, coordinated by staff within the Departments of Social Services, Mental Health, and Health and Senior Services. A very important part of the demonstration is the quality of life surveys which are completed prior to discharge and repeated at both one and two years post transition. The required federal reporting and evaluations were also shared. Questions raised during the presentation included dental services for individuals who have transitioned into the community and general oversight of their care. Cost comparisons between nursing home placement and the Money Follows the Person program were given.

ADJOURN – Dr. McBride adjourned the meeting at 3:50 pm. Next meeting is April 9, 2013.