MO HEALTHNET OVERSIGHT COMMITTEE
FEBRUARY 5, 2008
MEETING HANDOUTS

This packet contains the following information:

1. Family Healthcare Programs and Eligibility Requirements
2. MO HealthNet Covered Services Presentation
3. Components of Healthcare Home
4. Health Care Home
5. MO HealthNet Health Care Home Expansion
6. Biography of Dr. James Crane, Washington University School of Medicine, guest speaker
7. Reports made to and by the Oversight Committee
8. Biography of Daniel Kowalski, Director, Legislative Budget Office, guest speaker
9. MO HealthNet Expenditure Projections Presentation
10. Common Acronyms

Family Healthcare Programs

PROGRAM	SERVICES	ELIGIBILITY REQUIREMENTS
1. Title: MO HelthNet for Kids Note: This description includes both SCHIP and non-SCHIP children. SCHIP children are those with net family income above the following: • 185% FPL for children under age 1 • 133% FPL for ages 1- 5 • 100% FPL for ages 6 –18.	Healthcare coverage for children under 19 years of age. Coverage is provided through a Managed Care plan in some counties. SCHIP children whose gross income is over 150% FPL are not eligible for non-emergency medical transportation.	Under 19. SSN. Live in Missouri. US Citizen/Eligible Qualified Non-Citizen. Parent cooperates in obtaining medical support. Gross family income less than 300% of Federal Poverty Level (FPL) for household size. Children with net family income above the following must be uninsured: • 185% FPL for children under age 1 • 133% FPL for ages 1- 5 • 100% FPL for ages 6 –18. Children in families with gross income over 150% FPL cannot have access to affordable health insurance ($64 to $161/mo), family net worth must be less than $250,000 and the family must pay a monthly premium of between $12 and $294 based on family size and income. (The Premium schedule changes yearly July 1.)
2. Title: MO HealthNet for Families (MHF)	Healthcare coverage for families with income that does not exceed the July 16, 1996 AFDC (current Temporary Assistance) income limits. Coverage is provided through a Managed Care plan in some counties.	Eligible child under 19 in the home. SSN. Live in Missouri. US Citizen/Eligible Qualified Non-Citizen. Cooperate in obtaining medical support for the children. Net family income does not exceed the income limit for household size
3. Title: MO HealthNet for Pregnant Women	Healthcare coverage during pregnancy plus 2 months of postpartum following the month the pregnancy ends. Coverage is provided through a Managed Care plan in some counties.	Verified Pregnancy. SSN. Live in Missouri. US Citizen/Eligible Qualified Non-Citizen. Net family income does not exceed 185% FPL for household size (including unborn child).
4. Title: Extended Women's Health Services Note: This is a section 1115 waiver group.	Up to 12 months of women's health services for women who lose MO HealthNet healthcare coverage two months after a pregnancy ends. Coverage is limited to family planning, and testing and treatment of Sexually Transmitted Diseases.	Received MO HealthNet coverage due to pregnancy. Uninsured.

PROGRAM	SERVICES	ELIGIBILITY REQUIREMENTS
5. Title: MO HealthNet for newborns	Healthcare coverage through age 1. Coverage is provided through a Managed Care plan in some counties.	Mother was eligible for and received MO HealthNet when child was born. Newborn remains in mother's home.
6. Title: Transitional MO HealthNet	Provides healthcare coverage to a family for up 12 months, after the closing of MHF case. Coverage is provided through a Managed Care plan in some counties.	Received MHF 3 of last 6 months preceding ineligibility. Become ineligible for MHF due to employment, earned income, or loss of earned income disregards. Child under 19 in the home. Return quarterly reports to be eligible for the second 6 months. To be eligible for months 7 through 12, earned income minus childcare costs cannot exceed 185% FPL for household size.
7. Title: Extended MHF for Child Support Closings	Provides healthcare coverage to a family for 4 months, after the closing of MHF case due to increased child support. Coverage is provided through a Managed Care plan in some counties.	Received MHF 3 of last 6 months preceding ineligibility. Become ineligible for MHF due to receipt of or increased income from child support or alimony.
8. Title: Refugee Medical Assistance	Up to 8 months of healthcare coverage for recipients of the Refugee Assistance program. Coverage is provided through a Managed Care plan in some counties.	Admitted to U.S. as a refugee, an asylee, or a similar status. Eligibility is limited to the first 8 months in the United States. Ineligible for other MO HealthNet categories. SSN. Live in Missouri. Available resources of $1000 or less. If net income exceeds the Temporary Assistance limit for household size, must incur medical expenses to spenddown the limit. If an increase in earnings causes ineligibility, healthcare coverage continues until the end of the 8 month time limit.

MO HealthNet Eligibility for Persons who are Aged (age 65 and over), Blind, or Disabled, or Need Treatment for Breast or Cervical Cancer

PROGRAM	SERVICES	ELIGIBILITY REQUIREMENTS
MO HealthNet for the Aged, Blind, and Disabled (MHABD) Non-Spenddown	MO HealthNet Covered Services	• Social Security Number • Live in Missouri • US Citizen or Eligible Qualified Non-Citizen • Elderly (65 and over), Blind or Permanently and Totally Disabled • Available resources for elderly and disabled: Individual - less than $1000 Couple - $2000 or less • Real and Personal Property for blind: Individual - $2000 or less Couple $4000 or less • Net Income limit for Elderly and Disabled, 85% of the federal poverty level: Individual - $724, Couple - $970 • Net Income limit for Blind, 100% of the federal poverty level: Individual - $851, Couple - $1,141
MO HealthNet for the Aged, Blind, and Disabled (MHABD) Spenddown	MO HealthNet Covered Services that exceed the spenddown amount.	• All eligibility requirements are the same as MHABD non-spenddown, except there is no income maximum. • Each month meet a spenddown equal to the amount by which income exceeds the non-spenddown limit. The spenddown may be met by incurring medical expenses or paying in to MO HealthNet Division.

PROGRAM	SERVICES	ELIGIBILITY REQUIREMENTS
MO HealthNet Vendor Payments for care in a Nursing Facility, Institution for the Mentally Retarded, State Mental Hospital (age 65 or older), or Psychiatric Hospital (under age 22)	MO HealthNet covered services including payment to the nursing facility above the amount the resident is expected to pay.	• Requires nursing facility, IMR, or MHC level of care. • A resident is expected to pay all available income, except for medical insurance premiums and a $30 monthly personal needs allowance, to the nursing facility. However, allotment of income may allow for some or all of that spouse's income to be allotted to the community spouse or certain dependents. • Can't transfer property without receiving fair and valuable consideration, with some exceptions. • All other eligibility requirements are the same as MHABD non-spenddown, except that for a married couple (unless both institutionalized) available resources must be less than $1000 after Division of Assets.
Division of Assets (Prevention of Spousal Impoverishment)	Division of Assets provides a way to set aside a portion of a married couple's assets when one spouse enters a nursing facility and the other spouse remains in the community. It also applies when one spouse is eligible under HCB criteria.	• Married couple • A spouse resides in a MO HealthNet certified bed or in a hospital for at least 30 days and the other spouse resides in the community • The minimum spousal share of assets is $20,880 • The maximum spousal share of assets is $104,400, unless higher amount is set by an administrative hearing or court decision.
Elderly and Disabled Home and Community Based Waiver Program (HCB)	MO HealthNet covered services.	• Age 63 or over • Require nursing facility level of care • Certified by Dept. of Health and Senior Services to receive HCB waiver services • Maximum income limit of $1,113 for person needing HCB (adjusted annually) • Can't transfer property without receiving fair and valuable consideration, with some exceptions • All other eligibility requirements are the same as MHABD non-spenddown, except that for a married couple available resources must be less than $1000 after Division of Assets.

PROGRAM	**SERVICES**	**ELIGIBILITY REQUIREMENTS**
Missouri Children with Developmental Disabilities (Sara Lopez) Waiver	MO HealthNet covered services	• Under age 18 • US Citizen or Eligible Qualified Non-Citizen • Live in Missouri • Social Security Number • Certified by Dept. of Mental Health to receive waiver services • Child's income cannot exceed $1,113 per month • Available resources of child must be less than $1,000
Supplemental Nursing Care	Pays a monthly cash grant to eligible persons residing in a licensed residential care facility (RCF – maximum grant $156, ALF/RCF II – maximum grant $292), or non-Medicaid ICF/SNF – (maximum grant $390). A $30.00 personal needs allowance. MO HealthNet covered services.	• Age 21 or over • Income less than facility's base rate • If in Non-MO HealthNet ICF/SNF must need nursing facility level of care to receive highest grant. • All other eligibility requirements are the same as MHABD non-spenddown.
Blind Pension	Monthly cash grant of $575 State funded medical assistance which provides most MO HealthNet covered services.	• US Citizen or Eligible Non-Citizen • Live in Missouri • Cannot be eligible for or receiving SSI • Must be 18 or older • Have total property less than $20,000 (homestead is exempt) • Meet the state definition of blindness.
Supplemental Aid to the Blind	MO HealthNet covered services Monthly cash grant of $575 less any SSI received	• US Citizen or Eligible Qualified Non-Citizen • Live in Missouri • Social Security Number • Must apply for or receive SSI • Must be 18 or older • Have available resources that do not exceed $2,000 if single, $4,000 if married • Income of blind individual less than $688 a month • Meet the state definition of blindness.

PROGRAM	SERVICES	ELIGIBILITY REQUIREMENTS
MO HealthNet based on Section 1619 (a) of the Social Security Act	MO HealthNet covered services	• 1619 Status is determined by the Social Security Administration. ✓ Must continue to be blind or disabled. ✓ Continue to meet all SSI requirements other than earnings and receive SSI. ✓ Have earnings above substantial gainful activity amount but below federal benefit rate (SSI maximum grant). Must have received MO HealthNet in the month prior to gaining 1619 status.
MO HealthNet based on Section 1619 (b) of the Social Security Act	MO HealthNet covered services	• 1619 status is determined by the Social Security Administration. ✓ Must continue to be blind or disabled ✓ Must continue to meet all SSI requirements other than earnings. ✓ Not have sufficient earnings to replace SSI cash benefits, MO HealthNet benefits and publicly-funded personal or attendant care that would be lost due to the persons earnings. A threshold of $2,538 is utilized, but an individualized threshold can be calculated if earnings exceed $2,538. • Must have received MO HealthNet in the month prior to gaining 1619 status.
MO HealthNet for Women receiving Breast or Cervical Cancer Treatment	All MO HealthNet Covered Services. Coverage is NOT limited to cancer treatment.	• Social Security Number • Live in Missouri • US Citizen or Eligible Qualified Non-Citizen • Under age 65 • Screened for breast or cervical cancer by Missouri's Show Me Healthy Women (SMHW) Program (Note: The SMHW Program has income limits that must be met to get the screening.) • Need treatment for breast or cervical cancer • Uninsured or has health insurance that does not cover breast or cervical cancer treatment

PROGRAM	SERVICES	ELIGIBILITY REQUIREMENTS
QMB – Qualified Medicare Beneficiary	Pays Medicare Part B premium, in some cases Part A Pays co-payments and deductibles for Medicare approved services.	• US Citizen or Eligible Qualified Non-Citizen • Live in Missouri • Social Security Number • Must be receiving Part A Medicare • Have available resources less than $4,000 if single, $6,000 for a couple • Monthly income does not exceed 100% of FPL
SLMB – Specified Low Income Medicare Beneficiary	Pays Medicare Part B Premium only.	• Same as QMB, except monthly income does not exceed 120% of FPL.
QI – 1 Qualifying Individual	Pays Medicare Part B Premium only.	• Same as QMB, except monthly income does not exceed 135% of FPL.
Qualified Disabled and Working Individuals (QDWI)	Pays Medicare Part A Premium only.	• QDWI status is determined by the Social Security Administration ✓ Under age 65 ✓ Lost free Medicare Part A due to employment ✓ Remain disabled • Enrolled in Medicare Part A • Monthly income does not exceed 200% of FPL. • Have available resources less than $4,000 if single, $6,000 for a couple • US Citizen or Eligible Qualified Non-Citizen • Live in Missouri • Social Security Number

PROGRAM	SERVICES	ELIGIBILITY REQUIREMENTS

Ticket to Work Health Assurance (TWHA) Program	MO HealthNet covered services	• Eligibility requirements are the same as MHABD with some exceptions noted below.
		• Age 16 through age 64.
		• Employed with Social Security and Medicare taxes withheld.
		• Exclude medical savings accounts and independent living accounts for the participant up to $5,000/year each and earnings on such deposits.
		• Gross Income limit for TWHA is 300% of FPL Individual - $2,553.00, Couple - $3,423.00
		• Net Income limit for TWHA is 85% of FPL: Individual - $724, Couple - $970
		• The following are disregarded when determining net income limit for TWHA:
		  • All earned income of the disabled worker.
		  • The first $65 and one-half of the remaining earned income of a non-disabled spouse's earned income.
		  • A twenty dollar standard exemption.
		  • Health insurance premiums.
		  • A seventy-five dollar a month standard deduction for the disabled worker's dental and optical insurance when the total dental and optical insurance premiums are less than seventy-five dollars. If the total dental and optical insurance premiums exceed $75, allow the actual premium.
		  • All Supplemental Security Income (SSI) payments received.
		  • The first fifty dollars ($50.00) of the disabled worker's SSDI payments.
		  • A standard deduction for impairment-related employment expenses equal to one-half of the disabled worker's earned income. The disabled worker is entitled to this deduction even if the earned income is excluded from the gross income test as sheltered workshop income.

MO HealthNet Eligibility for Persons who are Aged (65 and over), Blind, or Disabled, or Need Treatment for Breast or Cervical Cancer

Program	Individual Monthly Income Limit	Couple Monthly Income Limit	Individual Asset Limit	Couple Asset Limit
MO HealthNet for the Aged, Blind, and Disabled (MHABD) Non-Spenddown	Elderly/Disabled $724 Blind $851	Elderly/Disabled $970 Blind $1,141	Elderly/Disabled $999.99 Blind $2,000.00	Elderly/Disabled $2,000 Blind $4,000.00
MO HealthNet for the Aged, Blind, and Disabled (MHABD) Spenddown	Incurred Medical Expenses reduce income to $724 for Elderly/Disabled or $851 for Blind	Incurred Medical Expenses reduce income to $970 for Elderly/Disabled or $1,141 for Blind	Elderly/Disabled $999.99 Blind $2,000.00	Elderly/Disabled $2,000 Blind $4,000.00
Nursing Facility Vendor Payments	Available income paid for cost of care	N/A	$999.99	$2,000, or Division of Assets
Supplemental Nursing Care	Less than the facility's base rate	N/A	Elderly/Disabled $999.99 Blind $2,000.00	Elderly/Disabled $2,000 Blind $4,000.00
Home and Community Based Waiver	$1,113	N/A	$999.99	$2,000, or Division of Assets
Blind Pension	N/A	N/A	$20,000 Total Property	$20,000 Total Property
Supplemental Aid to the Blind	$688	N/A	$2,000	$4,000
1619 (a) and 1619 (b)	$2,538	N/A	$2,000	$3,000
MO HealthNet for Women receiving Breast or Cervical Cancer Treatment	N/A-SMHW screening has income limits	N/A	N/A	N/A
Qualified Medicare Beneficiary	$851	$1,141	$4,000	$6,000
Specified Low Income Medicare Beneficiary	$1,021	$1,369	$4,000	$6,000
QI-1 - Qualifying Individual	$1,149	$1,541	$4,000	$6,000
Qualified Disabled Working Individuals	$1,702	$2,282	$4,000	$6,000

INCOME GUIDELINES
FOR MO HealthNet for Kids (MHK), MO HealthNet for Families (MHF) AND TEMPORARY ASSISTANCE

NUMBER OF PERSONS	TEMPORARY ASSISTANCE			MO HEALTHNET FOR FAMILIES	NON-CHIP MO HEALTHNET FOR KIDS AGES 6-18	NON-CHIP MO HEALTHNET FOR KIDS AGES 1 - 5	NON-CHIP MO HEALTHNET FOR KIDS UNDER AGE 1 & MO HEALTHNET FOR PREGNANT WOMEN	MO HEALTHNET FOR KIDS CHIP GROUPS (UNINSURED CHILDREN) THROUGH AGE 18			
	Gross Max.	Eligibility Test (Full Need St)	Net Income Limit/Max. (% of Need Std)	NET INCOME MAX	NET INCOME MAX	NET INCOME MAX	NET INCOME MAX	GROSS INCOME MAX			
								FEDERAL POVERTY LEVEL			
	185% of Cons Std	Cons. Std.	Grant Amt		100% of Federal Poverty Level	133 % of Federal Poverty Level	185% of Federal Poverty Level	NO-COST 150%	PREM 185%	PREM 225%	PREM 300%
1	727	393	136	136	851	1132	1575	1277	1575	1915	2553
2	1254	678	234	234	1141	1518	2111	1712	2111	2567	3423
3	1565	846	292	292	1431	1904	2648	2147	2648	3220	4293
4	1832	990	342	342	1721	2289	3184	2582	3184	3872	5163
5	2078	1123	388	388	2011	2675	3721	3017	3721	4525	6033
6	2307	1247	431	431	2301	3061	4257	3452	4257	5177	6903
7	2538	1372	474	474	2591	3446	4794	3887	4794	5830	7773
8	2755	1489	514	514	2881	3832	5330	4322	5330	6482	8643
9	2971	1606	554	554	3171	4218	5867	4757	5867	7135	9513
10	3186	1722	595	595	3461	4603	6403	5192	6403	7787	10383
11	3402	1839	635	635	3751	4989	6940	5627	6940	8440	11253
12	3619	1956	675	675	4041	5375	7476	6062	7476	9092	12123

Temporary Assistance:
If under gross income limit, deduct child care expenses and $90 work standard and compare to consolidated standard.
If under the consolidated standard, income after allowable deductions, must be under the net income limit to be eligible.

MO HealthNet for Pregnant Women and Non-CHIP Children :
Deduct childcare expenses and $90 for each wage earner from gross income-compare to poverty level.

MO HealthNet for Families:
Gross income, minus the first $50 of child support, must be under the Temporary Assistance gross income maximum.
If under the gross income limit, deduct child care expenses, the first $50 of child support and $90 for each wage earner from gross income - must be under MHF Net Income Max to be eligible.

CHIP groups:
Gross income must be under maximum. There are no deductions.
Premiums for families with gross income above 150% FPL up to and including 225% FPL are 4% of monthly income between 150% and 185% of the FPL for the family size plus 8% of monthy income between 185% and 225% of the FPL for the family size.
Premiums for families with gross income above 225% FPL up to and including 300% FPL are set at 5% of 225% FPL for the family size, not to exceed $282.

** Transitional MO HealthNet eligibility (for the second six-month period of eligibility) is determined by subtracting childcare expenses from earned income and comparing the result to 185% of the current federal poverty level.

Components of Healthcare Home

- Access and Communication
  - Has written standards for patient access and patient communication
  - Uses data to show it meets standards for patient access and communication
- Patient Tracking and Registry Functions
  - Uses data system for basic patient information (mostly non-clinical data)
  - Has clinical data system with clinical data in searchable data fields
  - Uses the clinical data system
  - Uses paper or electronic-based charting tools to organize clinical information
  - Uses data to identify important diagnoses and conditions in practice
  - Generates lists of patients and reminds patients and clinicians of services needed (population management)
- Care Management
  - Adopts and implements evidence-based guidelines for three conditions
  - Generates reminders about preventive services for clinicians
  - Uses non-physician staff to manage patient care
  - Conducts care management, including care plans, assessing progress, addressing barriers
  - Coordinates care/follow-up for patients who receive care in inpatient and outpatient facilities
- Patient Self-Management Support
  - Assesses language preference and other communication barriers
  - Actively supports patient self-management
- Electronic Prescribing
  - Uses electronic system to write prescriptions
  - Has electronic prescription writer with safety checks
  - Has electronic prescription writer with cost checks
- Test Tracking
  - Tracks tests and identifies abnormal results systematically
  - Uses electronic systems to order and retrieve tests and flag duplicate tests
- Referral Tracking
  - Tracks referrals using paper-based or electronic system
- Performance Reporting and Improvement
  - Measures clinical and/or service performance by physician or across the practice
  - Survey of patients' care experience
  - Reports performance across the practice or by physician
  - Sets goals and takes action to improve performance
  - Produces reports using standardized measures
  - Transmits reports with standardized measures electronically to eternal entities
- Advanced Electronic Communications
  - Availability of Interactive Website
  - Electronic Patient identification
  - Electronic Care Management Support

Source: NCQA Proposed Standards

Health Care Home

A health care home provides quality, coordinated health care focused on wellness. It enables both health professionals and participants to address health concerns before they become catastrophic. The choice of a health care home can be made by the participant, considering their own unique health care needs. The health care home serves as the participant's home base for health care, where health professionals know the participant's medical and health history, and can recommend care, early detection and preventative services to improve wellness.

The quality, coordinated health care provided by a health care home relies on health care professionals having access to a participant's health information, and the ability to share that information with other professionals caring for the participant. MO HealthNet allows health care providers to access information about their participant patients through a web-based electronic health record tool. This tool includes information about a participant's health history, including diagnosis information, medical procedures, and prescription drug history. It also allows providers to submit electronic prescriptions, request pre-certification for imaging procedures, and request pre-certification for some durable medical equipment items.

The types of providers and entities currently serving as health care homes for MO HealthNet participants include, but are not limited to:

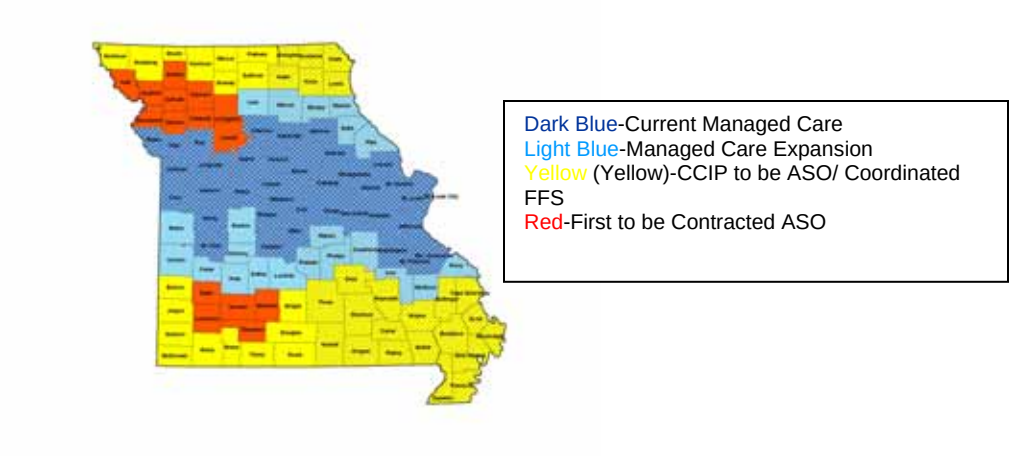
- Primary Care Providers
- Specialty providers who provide comprehensive patient management (i.e., oncologists, renal (dialysis) centers)
- Community Mental Health Centers
- Federally Qualified Health Centers
- Rural Health Clinics
- Nursing Facilities
- Hospice
- Managed Care Organizations
- Targeted Case Management providers
- MRDD (habilitation) centers

Average Monthly Enrollment, Oct 2007		829,472	
Additional Enrollees in SFY-2008			
Foster Care Children from 18 to 21	970		
MC+ for Kids (S-CHIP)	13,519		
Ticket to Work	1,930		
Total New Enrollees in SFY-2008		16,419	
Estimated Enrollment			845,891
Enrollees that Currently have a Health Care Home:			
Current Enrollees in Managed Care	349,391		
Managed Care Expansion Projected Enrollees	39,000		
SFY-2008 Estimated Enrollees in Managed Care	8,680		
Women's Health Services Enrollees	17,054		
Nursing Home Residents	24,395		
Hospice Participants	1,518		
Mental Health Case Managed Participants	42,427		
Chronic Care Improvement Program (CCIP) Enrollment	110,000		
Total Enrollees that Currently have a Health Care Home		592,465	
Participants who need a Health Care Home			253,426

MO HealthNet Health Care Home Expansion

Goal

When fully implemented, MO HealthNet will be comprised of three types of health improvement plans per SB577, i.e., risk bearing coordinated care, Administrative Service organizations (ASO) without total risk and coordinated fee for service. The goal is for every MO HealthNet participant to have a health care home.



Proposed Process

- Continue the statewide rollout of CCIP (Chronic Care Improvement Program) [except in Springfield and St. Joseph]
- Do a request for proposal (RFP) for ASO models in the Springfield and St. Joseph catchment areas for all populations (including the chronically ill)
- Use the current CCIP vendor to identify the balance of the fee for service population and do a first level electronic risk assessment
- The Division will help them identify a healthcare home
- Work toward an incremental phase in of ASO management of all populations (including the chronically ill) in the fee for service counties of the state over the next two years.
- The current CCIP contract will expire as the chronically ill are included in ASO management for all populations within a given geographic area.

Overall Considerations

- Retain claims processing; encounter data is less robust than paid claim data for analysis and reporting.
- Maintain single electronic provider tool in order to avoid confusion, reduce uptake, or send conflicting coordination messages.
- Increase the number of lives for bidders in less densely populated geographic areas to minimize per member cost.

James P. Crane, MD

James P. Crane, MD, is the associate vice chancellor for clinical affairs and professor of obstetrics and gynecology and of radiology at Washington University School of Medicine. He also is chief executive officer of the school's faculty group practice, which ranks as the third-largest academic medical practice in the United States.

Dr. Crane was named the medical school's first associate vice chancellor for clinical affairs in 1991. Early in this new role, he led the effort to create a clinician-teacher pathway for clinically oriented faculty. He also led the planning of the Center for Advanced Medicine, a 710,000-square-foot ambulatory care facility that offers patient-centered, multidisciplinary care.

Dr. Crane oversees several clinical practice support operations and works with the 14 clinical department chairs and 1,045 faculty physicians to coordinate clinical program development and to make the school's clinical enterprise more efficient and responsive to the needs of patients and referring physicians.

In the greater community, Dr. Crane is actively involved in efforts to eliminate health disparities and improve access to care for the uninsured. He serves on the board of the St. Louis Regional Health Commission and is past chair of the St. Louis Health Care Network, a newly created organization bringing together the area's major safety-net institutions.

MO HealthNet

Provider Enrollment

February 5, 2008

Judith Muck, MPA
Deputy Division Director
MO HealthNet Division

Enrollment Statistics

- There are approximately 38,303 MO HealthNet enrolled providers.
- There are 60+ provider types.
- Each day there are 40 to 50 new provider applications
- Each day there are 80 to 90 updates.
- Each Medicaid program has different enrollment requirements.
- An investigation of the provider's professional background will be conducted pursuant to 13 CSR 70-3.020.

Do Providers Have to Enroll?

- Providers must be enrolled in the MO HealthNet program to provide medical services.
- Providers agree to accept MO HealthNet payment as payment in full.
- Participants enrolled in Managed Care access services through the health plan's provider network.
- The health plan network may include providers not enrolled in the fee-for-service program.

Where are the MO HealthNet Provider Enrollment Applications located?

- Provider applications are available via the web and must be completed while on the Internet.
- This site contains applications and requirements for enrollment.
- Information for current providers is also available for those who may need to change an address or make other changes.
- Contact the Provider Enrollment Unit at providerenrollment@dss.mo.gov.

Web Resources

Contact Resources

- Providers may contact one of the following Interactive Active Voice Response System (IVR) telephone numbers for MO HealthNet program assistance:
  - 573/635-8908
  - 573/751-2896
  - Help on proper claim filing instructions, claims resolution and disposition, and participant eligibility file problems.
  - The IVR provides answers to such questions as participant eligibility, last two check amounts, and claim status using a touch-tone telephone.
- Written inquiries are also handled by the Provider Communications Unit and can be mailed to the following address:
  - *Provider Communications Unit*
    P.O. Box 5500
    Jefferson City, MO 65102-5500

More Contact Resources

Infocrossing Healthcare Services, Inc. *Help Desk: 573/635-3559 E-mail : internethelpdesk@momed.com (For Electronic Billing Assistance):* help with the required electronic claims format, network communication, assistance with billing Web site and other simple help tips.

Third Party Liability *573/751-2005* Report injuries sustained by MO HealthNet participants, problems obtaining a response from an insurance carrier, or unusual situations concerning third party insurance coverage.

Provider Education *573/751-6683* provider training on proper billing practices as well as MO HealthNet programs and policies education. Any scheduled training workshops are posted on the MHD provider page

More Contact Resources

- MO HealthNet Exceptions
  - Life-Threatening Emergency Requests Only: 1-800-392-8030
  - Non-Emergency Requests Fax Number: 573/522-3061
  - Call for emergency requests or
  - fax non-emergency requests for essential medical services or an item of equipment that would not normally be covered.
- Pharmacy Help Desk, Drug Prior Authorization, and Diabetic Supply Prior Authorization Process: *1-800-392-8030 Fax Number: 573/636-6470*
  - Call this number to obtain overrides to point of sale pharmacy claims that are rejecting because of clinical edits, such as "Refill Too Soon" and "Step Therapy".
  - Prior authorization for certain drugs or diabetic supplies can also be obtained at this number.
- Psychology Help Desk: *1-866-771-3350; fax number 1-573/635-6516*
- Clinical Services: *1-573/751-6963*

Discussion

- Questions?

Reports made to the Oversight Committee

- The Oversight Committee will receive and review the five-year rolling MO HealthNet forecast prepared by the Legislative Budget office.
    - *SB 577, Section 208.955.2(10) and Section 1*
        - After studying the report, the Committee will consider ways to maximize the federal drawdown of funds, study the changing demographics of the state and MO HealthNet participants, and consider steps needed to prepare for increasing numbers of participants due to aging baby boomers.
- The Oversight Committee will receive an annual report from the Department of Health and Senior Services regarding the implementation of DHSS's plan developed to address a system of coordinated health care services available an accessible to all people. This program is referred to as DHSS's Primary Care Resource Initiative for Missouri program (PRIMO).
    - *SB 577, Section 191.411*
- The Oversight Committee will receive a report from the Department of Social Services within 6 months of July 1, 2008, summarizing the findings of an independent survey commissioned by the Department to examine key health care delivery system indicators.
    - *SB 577, Section 208.950.5*
- The Oversight Committee will receive a report for its review from the Department of Social Services that evaluates and compares all health improvement plans on the basis of cost, quality, health improvement, health outcomes, social and behavioral outcomes, health status, customer satisfaction, use of evidence-based medicine, and use of best practices.
    - *SB 577, Section 208.950.2*
- The Oversight Committee is also charged with reviewing participant and provider satisfactions reports; reports from other states on the relative success or failure of various models of health delivery; data from health risk assessments, and results of the public process input into the design, development, and implementation of health improvement plans.
    - *SB 577, Section 208.952.1*

Reports made by the Oversight Committee

- The Oversight Committee must decide how to analyze and present the data reported by the Department of Social Services on participant and provider satisfaction, other states' experiences, health plan comparisons, financial impact, studies of provider access, and results of public input so that this information is accessible and useful to consumers, providers, and public officials. The Committee is required to report significant findings of this analysis to the General Assembly and the Governor ***at least annually, beginning January 1, 2009.***
    - *SB 577, Section 208.952.1(8)and (9)*

- The Oversight Committee must issue a report with its findings on the success and failure of health improvement plans and recommendations as to whether or not any health improvement plan should be discontinued to the General Assembly by July 1, 2011
    - *SB 577, Section 208.955.3*
- The Oversight Committee must conduct a study to determine whether an office of inspector general should be established. The study should include a survey of experiences of other states that have created a similar office.
    - *SB 577, Section 208.955.2(11)*
- The Oversight Committee must develop and report to the Governor and General Assembly on or before January 1, 2008, on recommendations related to the expenditure of funds from the Healthcare Technology Fund. The committee's considerations should include a review of the current status of healthcare information technology adoption in the state, addressing issues related to the adoption of interoperable healthcare information technology, evaluating costs, identifying private or public/private partnerships to fund efforts to adopt interoperable systems, exploring the use of telemedicine to improve access, and recommending best practices or policies to promote the adoption of interoperable healthcare information technology.
    - *SB 577, Section 208.978*

Daniel Kowalski

Dan Kowalski currently serves as the founding Director of the Legislative Budget Office, an independent, non-partisan budget analysis unit within the Joint Committee on Legislative Research. Dan also is a consultant to the Committee for a Responsible Federal Budget, a bipartisan, non-profit organization committed to educating the public about issues that have significant fiscal policy impact.

Prior to his February 2007 appointment with the Missouri General Assembly, Dan served for eight years on the Budget Committee staff of the United States House of Representatives. In his position as the Director of Budget Review, Dan was intimately involved in the formulation and enforcement of Congress' budget resolutions.

Dan also worked for four years at the Congressional Budget Office as a Principal Analyst in the Projections Unit, and for seven years at the Finance Committee of the New York State Senate as a tax analyst. He began his career in government with the New York City Department of Finance.

Dan holds a Master of Public Policy degree from the John F. Kennedy School of Government at Harvard University and a Bachelor of Arts degree from St. John's College in Annapolis, Maryland.

MO HealthNet Expenditure Projections Fiscal Years 2009 - 2013

Legislative Budget Office

Joint Committee on Legislative Research

February 5, 2008

Background

- SB 577 requires the Legislative Budget Office to annually prepare a rolling 5-year forecast.
- Projections were completed and distributed as required last month.
- Estimates are based on:
  1. Current law and policy;
  2. Trends in claims data for the period January 2004 through October 2007; and
  3. Trends in state population for calendar years 2007 – 2014.

Enrollment and Expenditure Projections

- SFY 2008 MO HealthNet spending expected to grow by 8.1 percent. Expenditures total $6.1 billion to serve 842,000 persons.
- Under current law, SFY 2009 spending growth moderates to 6.5 percent. Eligible population reaches 849,000 and costs exceed $6.4 billion.
- Over 2009 – 2013, MO HealthNet spending totals $37 billion. Annual expenditure growth averages 6.8 percent while enrollment growth averages 0.7 percent.

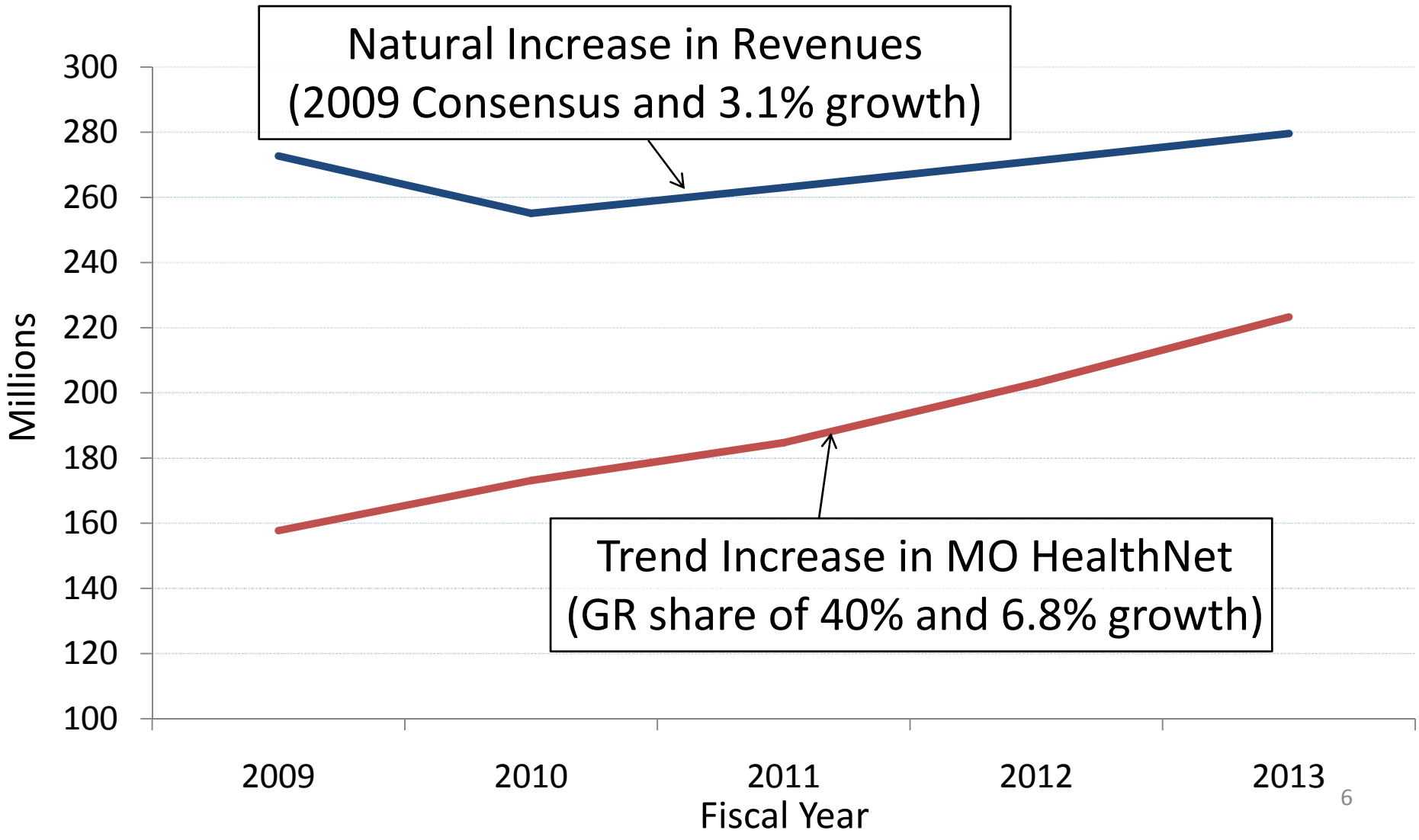
Enrollment and Expenditure Projections (cont.)

- Growth in enrollment is expected to be fastest in the Southwest, and slowest in St. Louis.
- Old Age Assistance is projected to be the fastest growing eligibility group.
- Growth in both the aged population and claims payments is most rapid in the Kansas City and Northeast regions.
- Managed care premiums fastest growing service category. In 2013, almost $1 out of every $5 spent on the program will go to managed care.

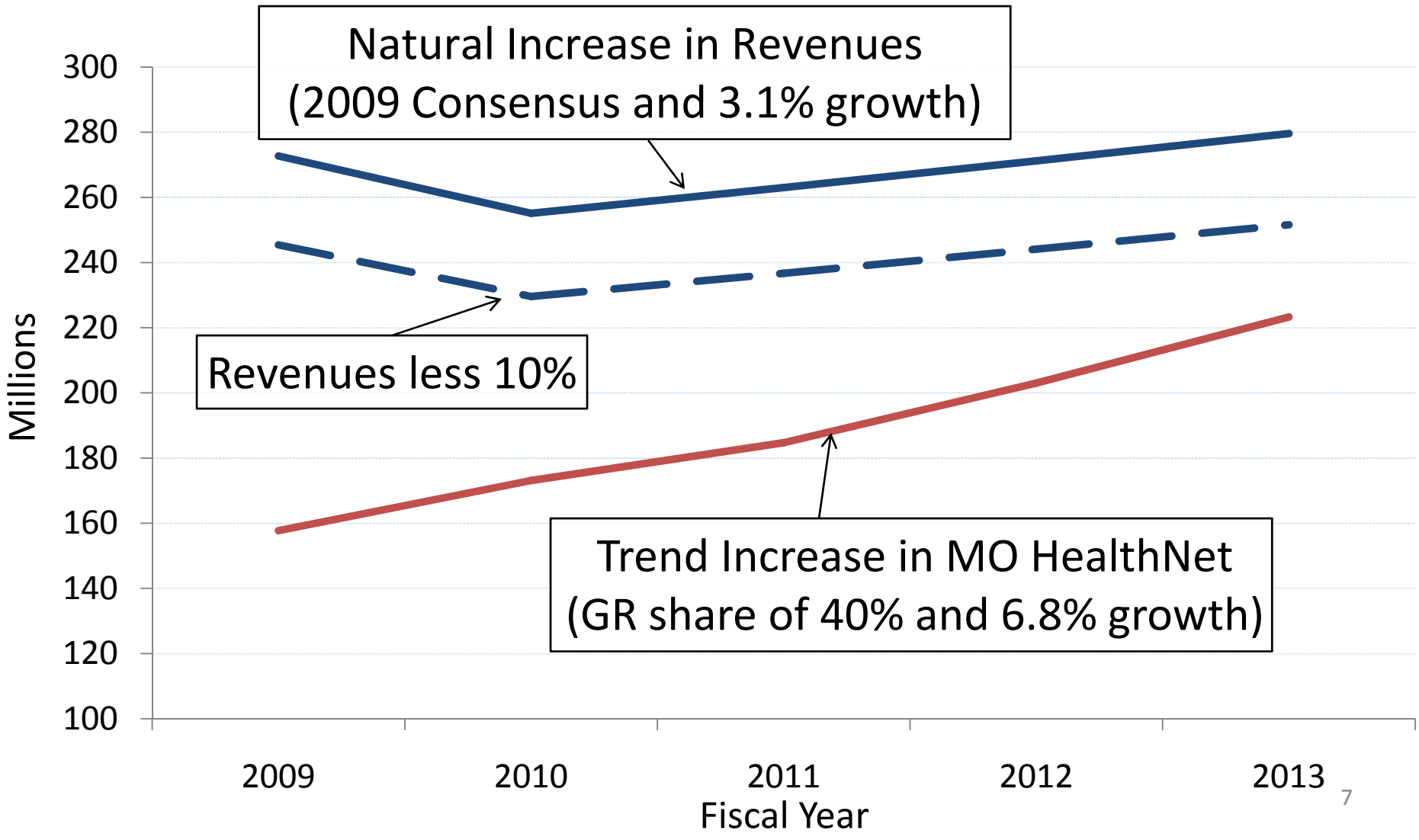
Financial Need Going Forward

- Projected growth in MO HealthNet expenditures exceeds historical growth rates in General Fund revenues. MO HealthNet spending threatens to crowd out other spending.
- Current legislative proposals to dedicate portions of natural revenue growth to transportation infrastructure makes situation worse, as do proposals to expand the MO HealthNet program.
- Revenue growth alone may not preclude the need for difficult fiscal choices in future years.

Annual Increase in MO HealthNet and General Fund Revenues



Annual Increase in MO HealthNet and General Fund Revenues



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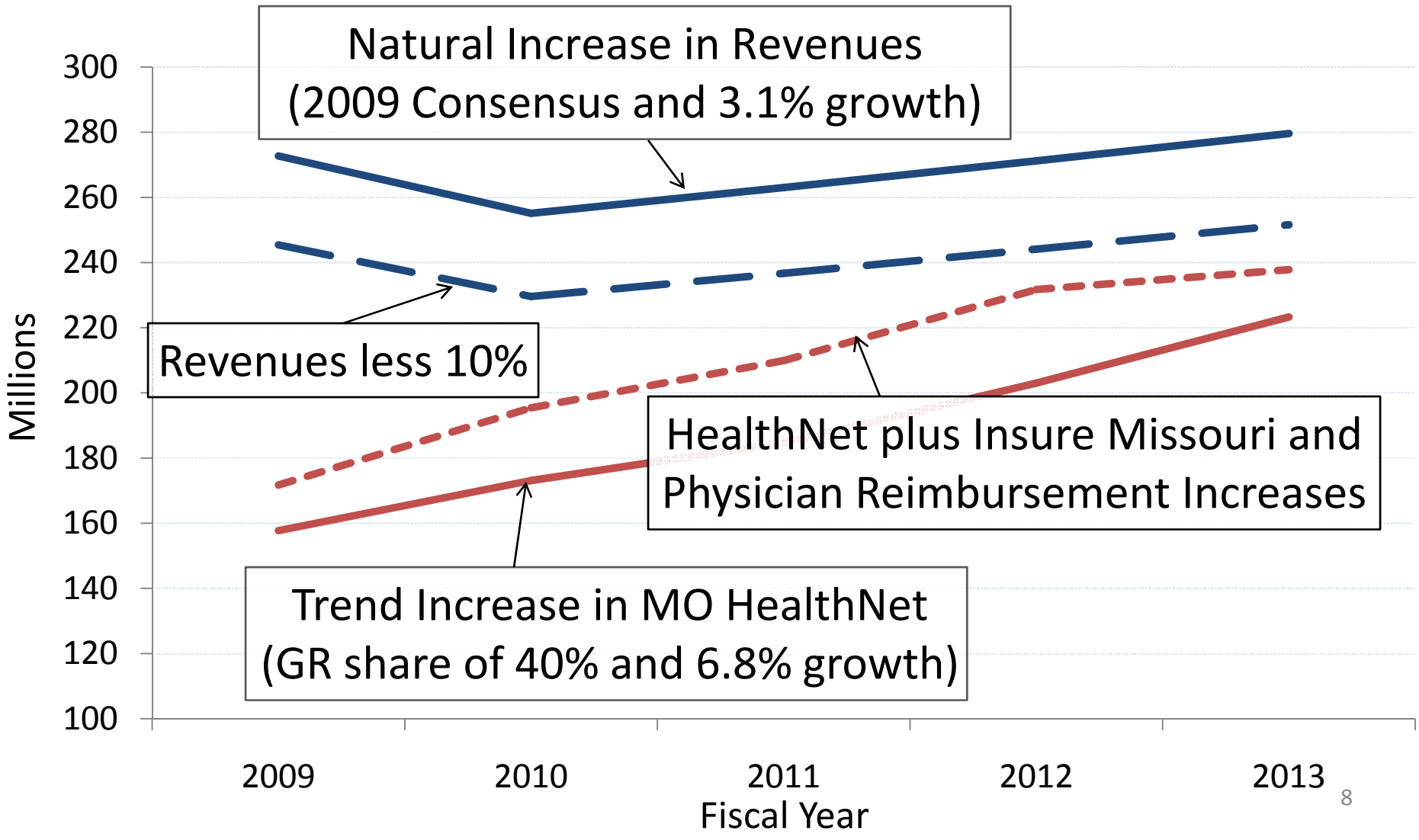
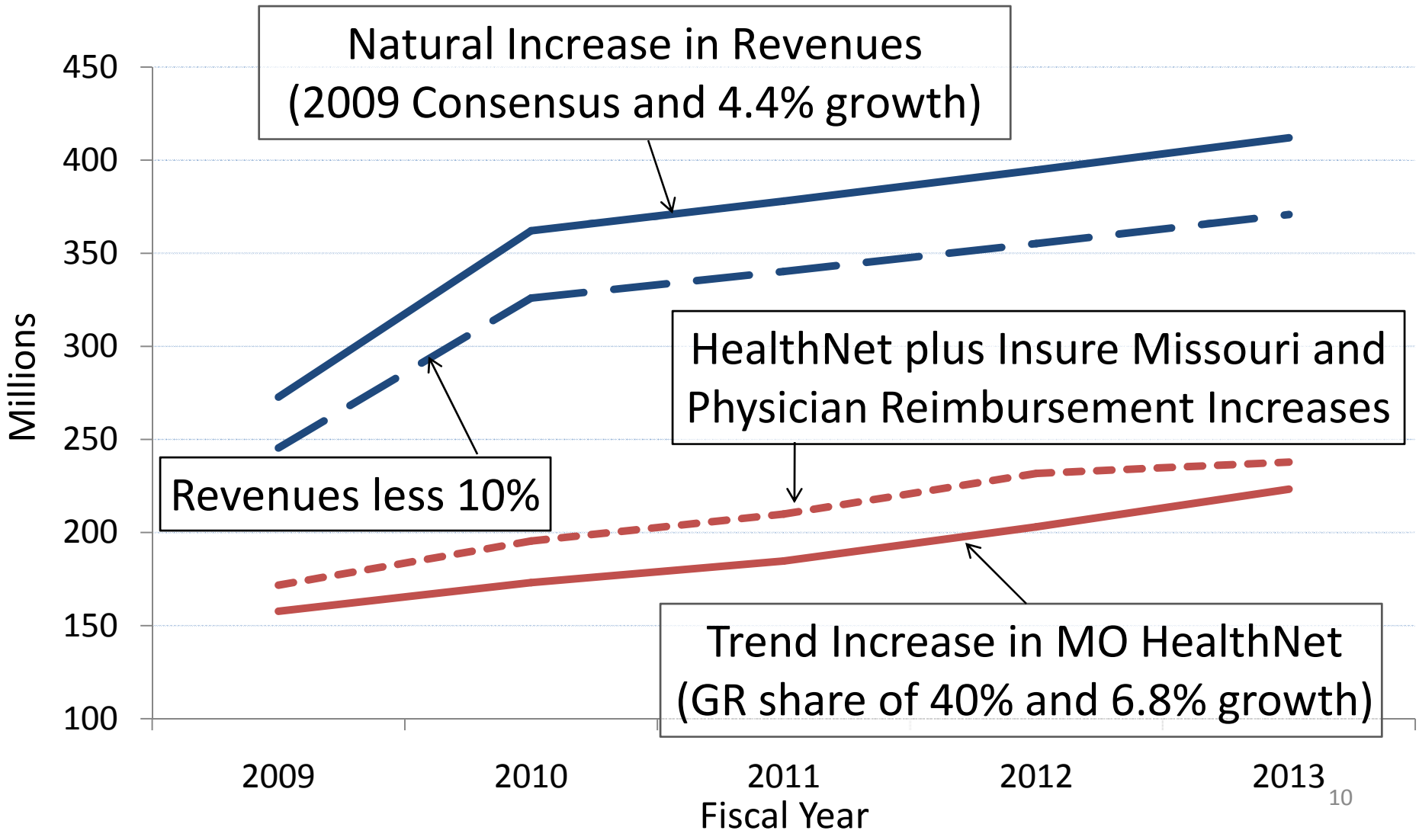


Risks

- **Upside:** Revenue growth consistently exceeds the 10-year average of 3.1%.
- **Downside:** Projections implicitly assume that the state economy stays the same as the base year.
  - Current weakness in the US economy suggests this assumption may prove unrealistic.
  - Prolonged slowdown in Missouri economy could simultaneously reduce revenue growth and increase participation in the MO HealthNet program.

Annual Increase in MO HealthNet and General Fund Revenues



COMMON ACRONYMS

ABD	Aged, Blind, and Disabled
ACM	Administrative Case Management
ADHC	Adult Day Health Care
ADL	Activities of Daily Living
AFDC or ADC	Aid to Families of Dependent Children [Now known as Temporary Assistance for Needy Families (TANF)]
ASO	Administrative Service Organization
AVR	Automated Voice Response
BAFO	Best and Final Offer
BCCT	Breast and Cervical Cancer Treatment
BNDD	Bureau of Narcotics and Dangerous Drugs
CAHPS	Consumer Assessment of Health Plan Survey
CCIP	Chronic Care Improvement Program
CD	Children's Division
CDC	Centers for Disease Control
CFR	Code of Federal Regulations
CIL	Center for Independent Living
CLIA	Clinical Laboratory Improvement Amendments

CMHC	Community Mental Health Center
CMN	Certificate of Medical Necessity
CMS	Centers for Medicare and Medicaid Services
COA	Category of Aid
COB	Coordination of Benefits
CON	Certificate of Need
COS	Category of Service
CPR	Comprehensive Psychiatric Rehabilitation
CPS	Division of Comprehensive Psychiatric Services
CPT-4	Current Procedural Terminology – 4th edition
CSR	Code of State Regulations
CSTAR	Comprehensive Substance Treatment and Rehabilitation
CY	Calendar Year
CYBER	CyberAcess® Web-based tool providing health care providers with access to patient data.
DBF	Division of Budget and Finance
DCN	Departmental Control Number
DERP	Drug Effectiveness Review Project
DESE	Department of Elementary and Secondary Education
DFS	Division of Family Services (renamed Family Support Division in 2003)
DHHS	Department of Health and Human Services
DHSS	Department of Health and Senior Services
DIRECT CARE PRO	Web based tool that teams providers to complete available interventions for patient care

DME	Durable Medical Equipment
DMH	Department of Mental Health
DMS	Division of Medical Services (renamed MO HealthNet Division 2007)
DOS	Date of Service
DOSE OPT	Dose Optimization
DRA	Deficit Reduction Act
DRU	Drug Rebate Unit
DSH	Disproportionate Share
DSM	Disease State Management Diagnostic and Statistical Manual of Mental Disorders (e.g. DSM-IV-TR) 4th Edition Text Revision
DSS	Department of Social Services
DUR	Drug Utilization/Use Review
ED	Emergency Department
EHI	Electronic Health Information
EHR	Electronic Health Record
eMOMED	MO HealthNet Web portal
EMR	Electronic Medical Record
EOB	Explanation of Benefits
EOMB	Explanation of Medicare Benefits
EPSDT	Early Periodic Screening, Diagnosis, and Treatment
EQRO	External Quality Review Organization
ER	Emergency Room
FA	Fiscal Agent

FACES	Family and Children's Electronic Services
FAMIS	Family Assistance Management Information Systems
FF	Federal Funds
FFP	Federal Financial Participation
FFS	Fee for Service
FFY	Federal Fiscal Year
FMAP	Federal Medical Assistance Percentage
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
FRA	Federal Reimbursement Allowance
GR	General Revenue
HBM	Health Benefits Manager
HCBS	Home and Community Based Services
HCPCS	Healthcare Common Procedure Coding System
HCY	Healthy Children and Youth Program (EPSDT)
HEDIS	Health Plan Employer Data & Information Set
HIT	Health Information Technology
HIPAA	Health Insurance Portability and Accountability Act
HIPP	Health Insurance Premium Payments
HMO	Health Maintenance Organization
ICF	Intermediate Care Facility
IFB	Invitation for Bid
IFOX	Infocrossing Healthcare Services (MHD fiscal agent)

IRU	Institutional Reimbursement Unit
ITSD	Information Technology Services Division
IVR	Interactive Voice Recognition
JCAHO	Joint Commission of Accreditation on Hospitals of Healthcare Organizations
LOC	Level of Care
LPHA	Local Public Health Agency
LTC	Long Term Care
MA	Medical Assistance
MC+	Medical Assistance Program for Low Income Families, Pregnant Women, and Children (changed to MO HealthNet)
MCFRA	Managed Care Federal Reimbursement Allowance
MCM	Medical Case Management
MCO	Managed Care Organization
ME Code	Medical Eligibility Code
MFCU	Medicaid Fraud Control Unit
MHD	MO HealthNet Division
MHF	MO HealthNet for Families (formerly Medical Assistance for Families)
MHK	MO HealthNet for Kids
MMIS	Medicaid Management Information Systems
MoRx	Missouri Rx Plan
MPW	MO HealthNet for Pregnant Women
MR/DD	Mentally Retarded/Developmentally Disabled
NCQA	National Committee Quality Assurance

NDC	National Drug Code
NEMT	Non-Emergency Medical Transportation
OA	Office of Administration
OIG	Office of Inspector General (DHHS)
PA	Prior Authorization
PACE	Program for All Inclusive Care for the Elderly
PARM	System Parameters
PASARR	Preadmission Screening and Annual Resident Review
PBM	Pharmaceutical Benefits Manager
PC	Personal Care
PCCM	Primary Care Case Management
PCP	Primary Care Physician Primary Care Provider
PDL	Preferred Drug List
PDP	Prescription Drug Plan
PHI	Protected Health Information
PIP	Performance Improvement Project Physician Incentive Plan
PMPM	Per Member Per Month
PPO	Preferred Provider Organization
PR	Program Relations Provider Relations
PTD	Permanently and Totally Disabled
QA&I	Quality Assessment and Improvement

QMB	Qualified Medicare Beneficiary
RA	Remittance Advice
RCF	Residential Care Facility
RFP	Request for Proposal
RHC	Rural Health Clinic
Rx	Prescription
SAO	State Auditor's Office
SCHIP	State Children's Health Insurance Program
SDAC	School District Administrative Claiming
SFY	State Fiscal Year
SLMB	Specified Low-Income Medicare Beneficiary
SMART PA	Web based decision rules engine (Pharmacy)
SMART MED PA	Web based decision rules engine (Medical/DME Pre-certifications)
SPA	State Plan Amendment
SURS	Surveillance and Utilization Review Subsystem
TANF	Temporary Assistance for Needy Families
TCM	Targeted Case Management
TEFRA	Tax Equity and Fiscal Responsibility Act
TEMP	Temporary MO HealthNet During Pregnancy (Presumptive Eligibility)
TOS	Type of Service
TPL	Third Party Liability
TWHA	Ticket to Work Health Assurance Program
U/C	Usual and Customary

UM	Utilization Management
VFC	Vaccines for Children
WIU	Welfare Investigation Unit

Title XIX:
Sec. 1901. **[**42 U.S.C. 1396**]** For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care.

Section 1915(b) of the Social Security Act lists when the Secretary of Health and Human Services may waive requirements of Section 1902 of the Social Security Act -- such as statewide effectiveness (1902(a)(1)) -- to allow a state to undertake listed options.

Section 1915(c) of the Social Security Act allows the Secretary of Health and Human Services to issue a waiver so that a state plan may include Home and Community Based Services as "medical assistance."

"Amount payable under the Social Security Act" means payments by the Federal Department of Health and Human Services to beneficiaries, providers, intermediaries, physicians, suppliers, carriers, states, or other contractors or grantees under a Social Security Act program, including:

Title XXI
Sec. 2101. **[**42 U.S.C. 1397aa**]** (a) Purpose.—The purpose of this title is to provide funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner that is coordinated with other sources of health benefits coverage for children.