MO HEALTHNET OVERSIGHT COMMITTEE
MAY 25, 2010

This packet contains the following information:

1. Bio of Emily Rowe, Manager, Income Maintenance Program, Family Support Division

2. MO HealthNet participation by eligibility category

3. Legislative Session and Budget Overview Presentation: Marga Hoelscher

4. MO HealthNet Comprehensive Review Final Report Presentation: The Lewin Group

5. MO HealthNet Comprehensive Review Program Integrity Presentation: The Lewin Group

Emily Rowe
Manager, Income Maintenance Program
Family Support Division

Emily Rowe is a Unit Manager for the Department of Social Services in the Income Maintenance Program and Policy Unit of the Family Support Division. In this position Ms. Rowe is responsible for the development and implementation of MO HealthNet eligibility policy in the State of Missouri based upon both Federal and State rules and regulations. Ms. Rowe has three years of experience in this position and has worked for the Department of Social Services, Family Support Division for twelve years. Ms. Rowe has a Bachelor of Arts degree in both psychology and biology from Drury University in Springfield, Missouri.

MoHealthNet Participation

	Participants as of March 2008	Participants as of April 2010 (Preliminary)	Change Since March 2008	Percentage of April 2010 Participants (Preliminary)	Current Income Eligibility Maximums (Shown as a Percentage of Federal Poverty Level)	Budgeted Participants by June 2010
Children	484,750	538,361	+53,611	60.4%	300%	550,910
Persons with Disabilities	147,208	163,670	+16,462	18.4%	85%	160,569
Custodial Parents	74,561	83,192	+8,631	9.3%	TANF level (approximately 19%)	76,778
Seniors	76,808	77,433	+625	8.7%	85%	79,111
Pregnant Women	28,301	28,919	+618	3.2%	185%	32,563
Total	811,628	891,575	+79,947			899,931
Women's Health Services	19,831	45,877	26,046		185%	63,622

Source: Missouri Department of Social Services, Family Support Division/MO HealthNet Division, Monthly Management Report

Budget Overview for MO HealthNet Oversight Committee

Presented by Marga Hoelscher, CPA MPA

Chief Financial Officer

May 25, 2010

Presentation Highlights

- FY 10 Current State Outlook
- FY 11 Revenue Forecast
- FY 11 Operating Budget
- FY 11 MO HealthNet Budget by Agency
- MO HealthNet Budget New Decision Items
- Cost Containment Legislation
- FY 11 MO HealthNet Budget Reductions

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Current State Outlook

FY 2010

FY 2010 State Revenues

- FY 2010 Original CRE was $7.764 billion

- Revised CRE for FY 2010 is $6.971 billion
  - 6.4% **decline** from the FY 2009 actual net collections.
  - Reduction of $480 million from prior year collections

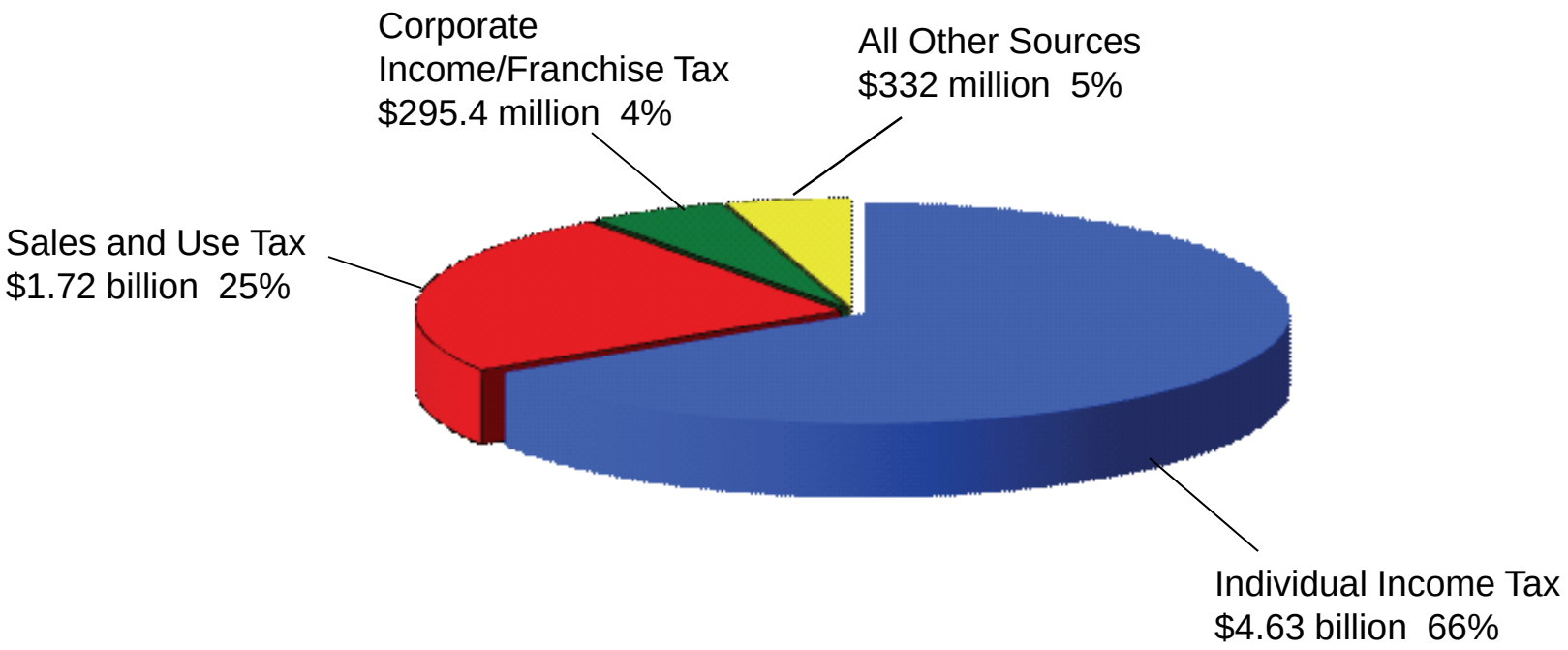
- As of April 30, 2010:
  - 11.7% **decline** from the FY 2009 actual net collections.
  - Refunds increased 12.8% from $1.04 billion to $1.17 billion
  - From $6.4 billion in FY 2009 to $5.7 billion in FY 2010

State Revenues

- FY 10 estimates of major revenue sources:
  - Sales and use tax collections **decrease** of 5.3%
  - Individual income tax collections **decrease** of 5.1%
  - Corporate income tax collections **decrease** of 17.5%

- FY 10 YTD as of April 30, 2010:
  - Sales and use tax collections **decrease** of 6.5%
  - Individual income tax collections **decrease** of 8.9%
  - Corporate income tax collections **decrease** of 8.3%

FY 2010 Revised CRE
Net General Revenue $6.97 Billion



General Revenue Growth Rates

Fiscal Year	% Growth
FY 2005	5.8%
FY 2006	9.2%
FY 2007	5.2%
FY 2008	3.7%
FY 2009	-6.9%
FY 2010*	-6.4%
FY 2011*	3.6%

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FY 2011

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Revenue Forecast FY 2011

- FY 2011 CRE is $7.22 billion
  - 3.6% **increase** over revised CRE
  - Increase of $252.3 million
  - Below FY 2008 collections of $8 billion and FY 2009 collections of $7.45 billion

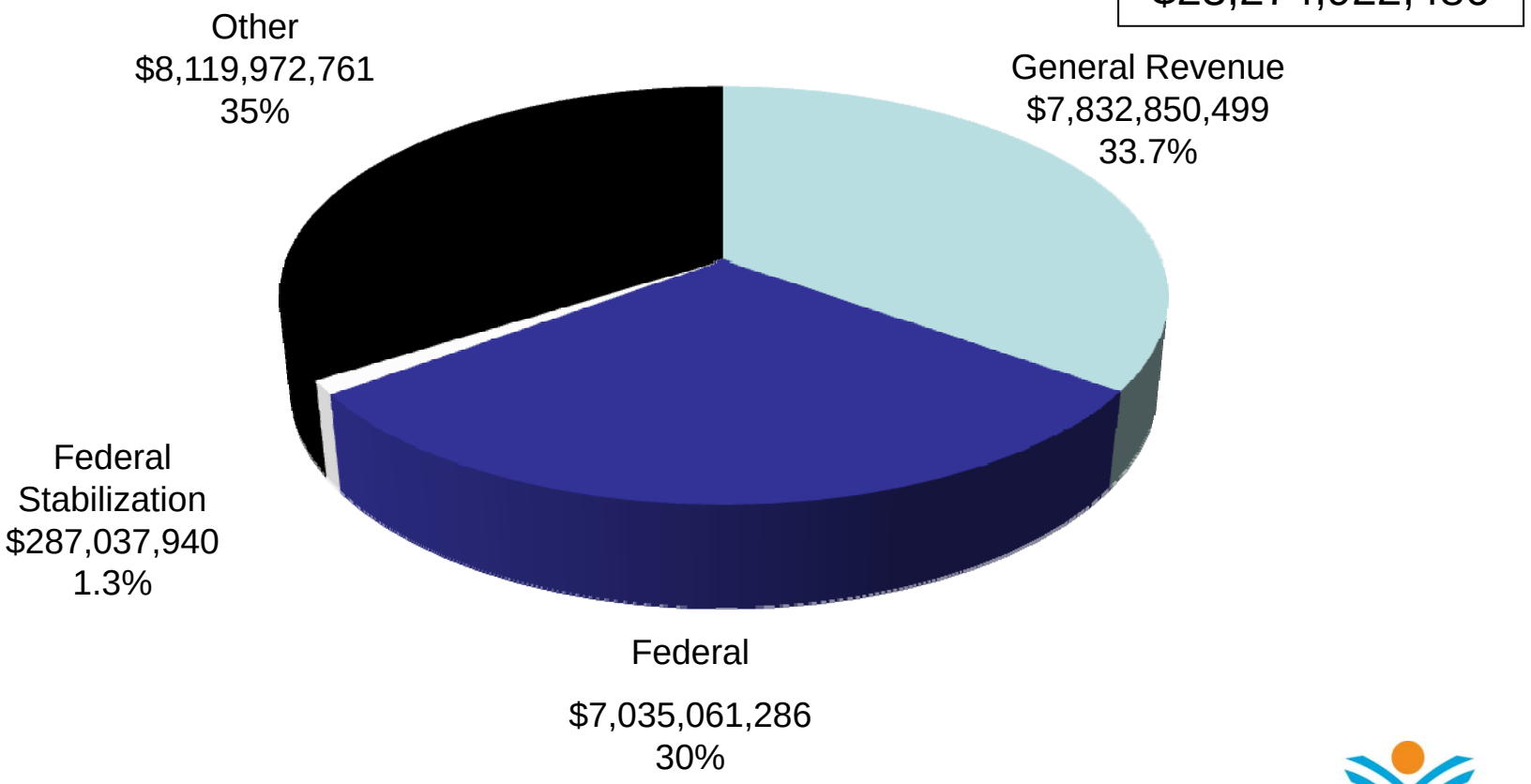
- FY 11 CRE assumes Missouri economy improves:
  - Sales and use tax collections **increase** of **2.7**%
  - Individual income tax collections **increase** of **3.7%**
  - Corporate income tax collections **increase** of **19.2%**

FY 2011 Total Operating Budget

Sources of Funds – TAFP

All Funds

$23,274,922,486



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TOTAL MEDICAID ALL AGENCIES
FY 2011 TAFP

	FY 2011 Core and New Decision Items-TAFP			
	GR	**FED***	**OTHER***	**TOTAL**
Elementary and Secondary Education	$0	$500,000	$2,945,254	$3,445,254
Mental Health	$234,365,191	$436,064,609	$19,166,523	$689,596,323
Health and Senior Services	$195,006,057	$337,398,032	$450,001	$532,854,090
Social Services	$1,106,690,950	$3,350,754,913	$2,098,483,133	$6,555,928,996
Total	$1,536,062,198	$4,124,717,554	$2,121,044,911	$7,781,824,663

**Federal and other fund totals include $178.6 million in appropriations for CSTAR and ADA that are counted in both DMH and DSS budgets. New appropriations in the DSS budget were needed to support a change in the way the CSTAR and ADA programs were financed. The change did not result in new CSTAR and ADA services.*

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New Decision Items – Truly Agreed and Finally Passed

	FY 2011 New Decision Items-TAFP			
	GR	**FED**	**OTHER**	**TOTAL**
Elementary and Secondary Education	$0	$0	$0	$0
Mental Health	$9,293,143	$12,049,375	$375,228	$21,717,746
Health and Senior Services	$19,360,016	$28,895,687	$0	$48,255,703
Social Services	160,462,991	$385,309,847	$296,686,699	$842,459,537
Total	$189,116,150	$426,254,909	$297,061,927	$912,432,986

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MO HealthNet - FY 2011 DSS New Decision Items

*Italics Revised thru the budget process.	TAFP
Cost-to-Continue Medicaid Programs	*$228,531,269*
MHD Caseload Growth	*$97,263,971*
Managed Care GR Tax Replacement	$7,443,750
Pharmacy PMPM Increase	*$41,088,509*
Pharmacy Clawback	*$0*
FMAP Adjustment	$44,208,303
Medicare Premium Increases	$21,748,045
Hospice Rate Increase	$220,621
IGT Safety Net Increase	$20,654,549
Ambulance Reimbursement Methodology and Tax FTE	$2,958,188
IGT DMH	$178,630,216
Increase FRA Authority	$63,329,394
Fund Switch to FRA	*$36,800,000*
Pharmacy Reimbursement Authority	$88,082,722
Fund Switch to Life Sciences and Senior RX	*$11,500,000*
DSS NDI Total	$842,459,537

CCR HCS SCS SB 842, 799 & 809 (Schmitt)

	Estimated GR Impact
Reprice Medicare Part B Crossover Claims (Hospitals)	$8,000,000
DMH Hospital Provider Tax	$6,500,000
Medicaid Third Party Collections (Subrogation)	$1,000,000
Third Party Assessment for In-home Providers	$3,600,000
In-home Provider tax	$0
Equalize Optometrist and Physicians Rates	$0
Telephony with a 2015 date for CDS and in-home Services	$0

CCR HCS SCS SB 1007 (Dempsey)

	Estimated GR Impact
Reprice Medicare Part B Crossover Claims (Hospitals)	$8,000,000
DMH Hospital Provider Tax	$6,500,000
Medicaid Third Party Collections (Subrogation)	$1,000,000
Third Party Assessment for In-home Providers	$3,600,000
Requires Notification of In-Home Services	$0
Transfers TB Responsibility to DHSS from University	$0
Telephony with a 2015 date for CDS and in-home Services	$0
In-home Provider Tax	$0

Other Cost Containment Initiatives In Process of Implementing

	Estimated State Savings
Medicare Part A Repricing (Nursing Facility)	$12,000,000
Increase Generic Utilization (Pharmacy)	$1,456,200
MAC Pricing for Specialty Drugs (Pharmacy)	$3,000,000
Better Manage High Cost Clients (Pharmacy)	$5,424,622
Eliminate Dual Eligibles from CCIP	$3,567,690
Enhance Third Party Liability Efforts	$3,786,120
Manage Imaging Benefits (CT Imaging, MR Imaging, and Ultrasounds)	$3,900,000
Restructure Outpatient Methodologies (Hospitals)	$7,600,000
FRA Replacement of GR	$36,800,000

More Actions Needed

- Estimated Additional Reductions of $350 million

- Three Main Factors:
  - Money-saving legislation did not pass
  - Revenue collections continue to fall
  - Assumptions that may not materialize
    - ❑ Caseload growth

- Announcements in June

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HEALTH CARE AND HUMAN SERVICES POLICY, RESEARCH, AND CONSULTING - **WITH REAL-WORLD PERSPECTIVE**.

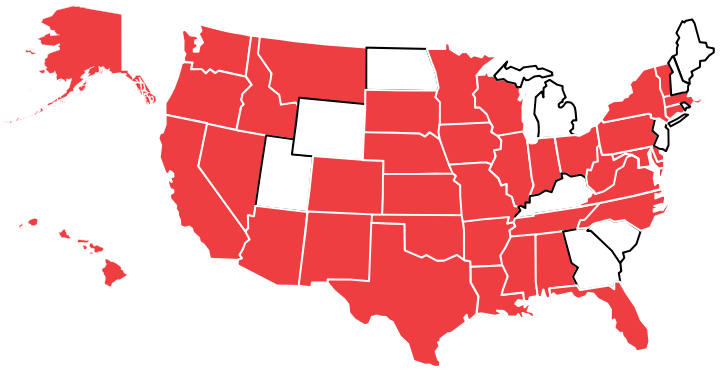
MO HealthNet Comprehensive Review

Oversight Committee Presentation

May 25, 2010

The Lewin Group - Who We Are

- The Lewin Group, founded in 1970, is a premier national health care and human services policy research and consulting firm
- Our clients are federal, state and local agencies, legislatures, and commissions that oversee and operate Medicaid, public health, mental health, aging, HIV/AIDS, human services and insurance programs
- Lewin was purchased by Ingenix, a wholly-owned subsidiary of UnitedHealth Group, in 2007
- Throughout its history, The Lewin Group has maintained firm principles to preserve the integrity and editorial independence of our work. These principles are strongly supported by both Ingenix and UnitedHealth Group.



Red represents states with which Lewin has worked since 2000

"The Lewin Group is the gold standard of health policy analysis..."

- The Wall Street Journal, October 17, 2008.

Introductions

- Kathy Kuhmerker –
  - Managing Director at The Lewin Group
  - Former New York State Medicaid Director
  - More than 20 years with the New York State Division of Budget

- Jim Teisl -
  - Senior Consultant at The Lewin Group
  - Former Policy Manager for Ohio Medicaid
  - Former Senior Consultant at Greater New York Hospital Association

Lewin's Comprehensive Review – Current Status

Lewin began its comprehensive review of the Missouri Medicaid program in September 2009 to identify opportunities for potential cost savings and operational improvement

Project Deliverables

Deliverables that have been completed:

- Review of MO HealthNet Pharmacy Program
- Short-term Cost Containment Opportunities
- Short-term Long Term Care Opportunities
- Clinical Services Area Review (including Hospitals, CCIP, DME, and Hospice)
- High Cost Beneficiary and High Volume Provider Analysis
- Non-Emergency Medical Transportation Review
- Final Assessment Report (including Metrics and Dashboards and Longer-term Long Term Care Recommendations

- We have also completed a review of MO HealthNet Program Integrity operations
- Our scope of work excluded analyses of Medicaid managed care or hospital reimbursement systems
  - While some deliverables touch upon these important areas, we did not conduct a thorough review
  - Both are important topics for MO HealthNet to review and consider carefully

Final Report Focus Areas

Program Organization & Management

MO HealthNet Operations: Current State Observations

- Medicaid administration is organized by type of service divided across agencies – a siloed structure with divided accountability
- Low staffing levels in some areas limit effectiveness
- Contractor reliance can lead to redundancy across contractors and limited (or highly concentrated) institutional knowledge
- Limited current use of performance measurement and reporting capabilities

Coordinating Authority

A Coordinating Authority Could Improve Operational Efficiency and Coordination (1/2)

- Overview of revised structure:
  - Overall responsibility for Medicaid oversight would ideally be a cabinet-level position with authority over all aspects of the program
  - A unified Medicaid department is an option, but most states have opted to coordinate Medicaid functions across different agencies
  - DSS may want to consider integrating eligibility policy and oversight functions with MO HealthNet
  - Ongoing systems integration efforts are critical to enhancing program coordination

A Coordinating Authority Could Improve Operational Efficiency and Coordination (1/2)

- Rationale for change:
  - Currently, budget and policy decisions are coordinated by the State Budget Office, as that is the first place all Medicaid information comes together
  - Each agency with Medicaid oversight and operational responsibilities has its own circle of stakeholders
  - Effective management of the Medicaid program requires the balancing of program and financial priorities for a diverse and vulnerable set of populations
    - A coordinating authority would have the broader perspective and ability to balance interests necessary to achieve most efficacious use of limited State resources

A Coordinating Authority Must Be Given the Resources and Authority to Succeed

- Such an approach will require legislation, appropriations and a process by which the structure and specific authority designations are defined and implemented
  - Responsibility and authority of existing agencies will need to be realigned
  - This process will require a dedicated project team to work with State leaders to refine objectives, clarify mission, and establish work plan for accomplishing realignment
- Sufficient funding must be appropriated for staff levels that allow for work to be driven by the coordinating body, rather than relying on the individual departments

Insufficient authority to compel coordination relegates these bodies to "facilitators" with little ability to effect real change

Regardless of Decision on Coordinating Authority, Responsibility for Institutional LTC and HCBS for the Aged Should be Realigned within the Same Agency

- Current arrangement fragments accountability and impedes planning and coordination
  - Currently, MHD budgets for and oversees nursing facility services and DHSS budgets for and oversees HCBS for older adults and people with disabilities
  - LTC and HCBS services for older adults are part of the same care continuum and should be planned for and budgeted in a unified manner
- If realignment is not done, the level of interagency collaboration and coordination needs to increase significantly beyond where it is today
- Development of a Medicaid coordinating authority would also have to consider alignment of Medicaid-funded services currently administered by DMH

Medicaid Medical Director

Hire a Full-Time Medical Director for the MO HealthNet Program

- Federal regulations require each Medicaid program to have a Medical Director - MO's Medicaid Director is a physician and also functions as the Medical Director
- A Medical Director should have the ability to relate directly to the provider community, coupled with strong policy capability and vision
- Increasing national emphasis on quality of care, electronic health records, health information exchanges, and coordinated care strategies increases the need for a full-time Medical Director
- Without ongoing clinical responsibilities, the Medicaid Director would be able to focus exclusively on strategic planning and day-to-day program administration

Quality Oversight Should be a More Prominent Focus of MO HealthNet Activities

- Quality assessment and improvement is dispersed throughout the organization
  - Managed care quality overseen by a small staff within MO HealthNet Operations
  - Other quality activities conducted by program staff (e.g., clinical services)
- Quality assessment and improvement activities should be enhanced by
  - Elevating overall responsibility to a higher level in the organization
  - Including both managed care and fee-for-service delivery modes
  - Ensuring interfaces with appropriate program staff
- Full-time Medical Director should lead Medicaid quality oversight efforts

Performance Metrics

Implement Series of Metrics & Management Dashboards

- Ultimate goal should be instant electronic access to current metrics
  - Managers and staff at different levels would have specific access permissions
  - Automated electronic dashboards would allow users to "drill-down" to underlying data
  - Data would be compiled from a variety of sources including the data warehouse, eligibility system, and financial management system
- Interim goal is the establishment of a concise set of metrics for senior leaders
  - We recommend that key metrics be compiled monthly and displayed graphically in an executive dashboard
  - Initial set of recommended metrics (included in the following slides) should be reviewed by MO HealthNet leadership and refined as needed
  - Format and comprehensiveness of dashboard metrics should be reviewed annually
- Additional program-specific metrics should be used by program managers responsible for day-to-day operations

We Propose Performance Metrics in the Following Seven Categories

- Expenditures
- Enrollment
- Program Integrity
- Long-Term Care
- Care Management
- Contractor Performance
- Special Projects

Several examples are provided on the following slides

Expenditures – Actual vs. Projected (excluding administrative costs)

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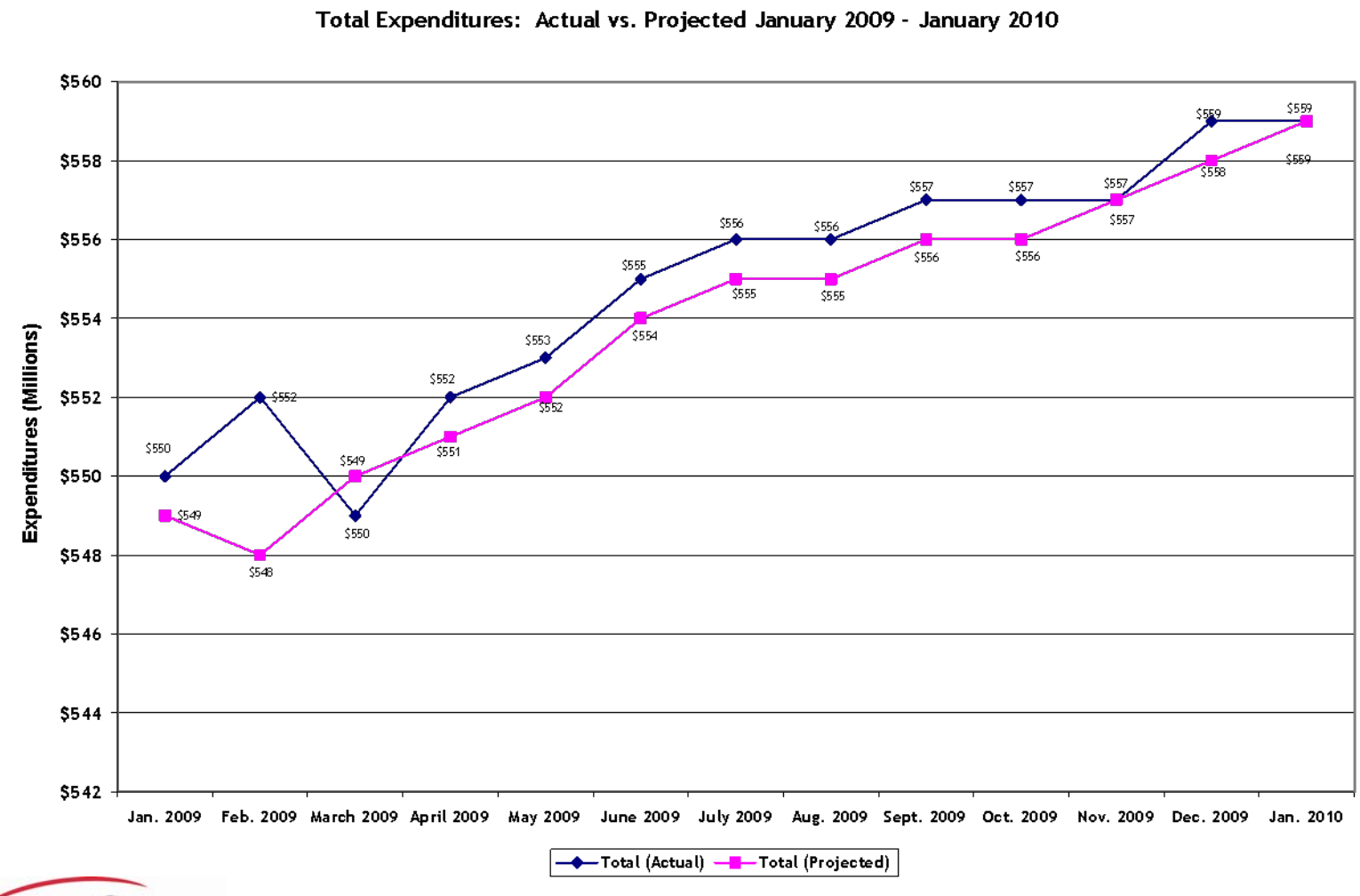

Expenditures – PMPM by Region

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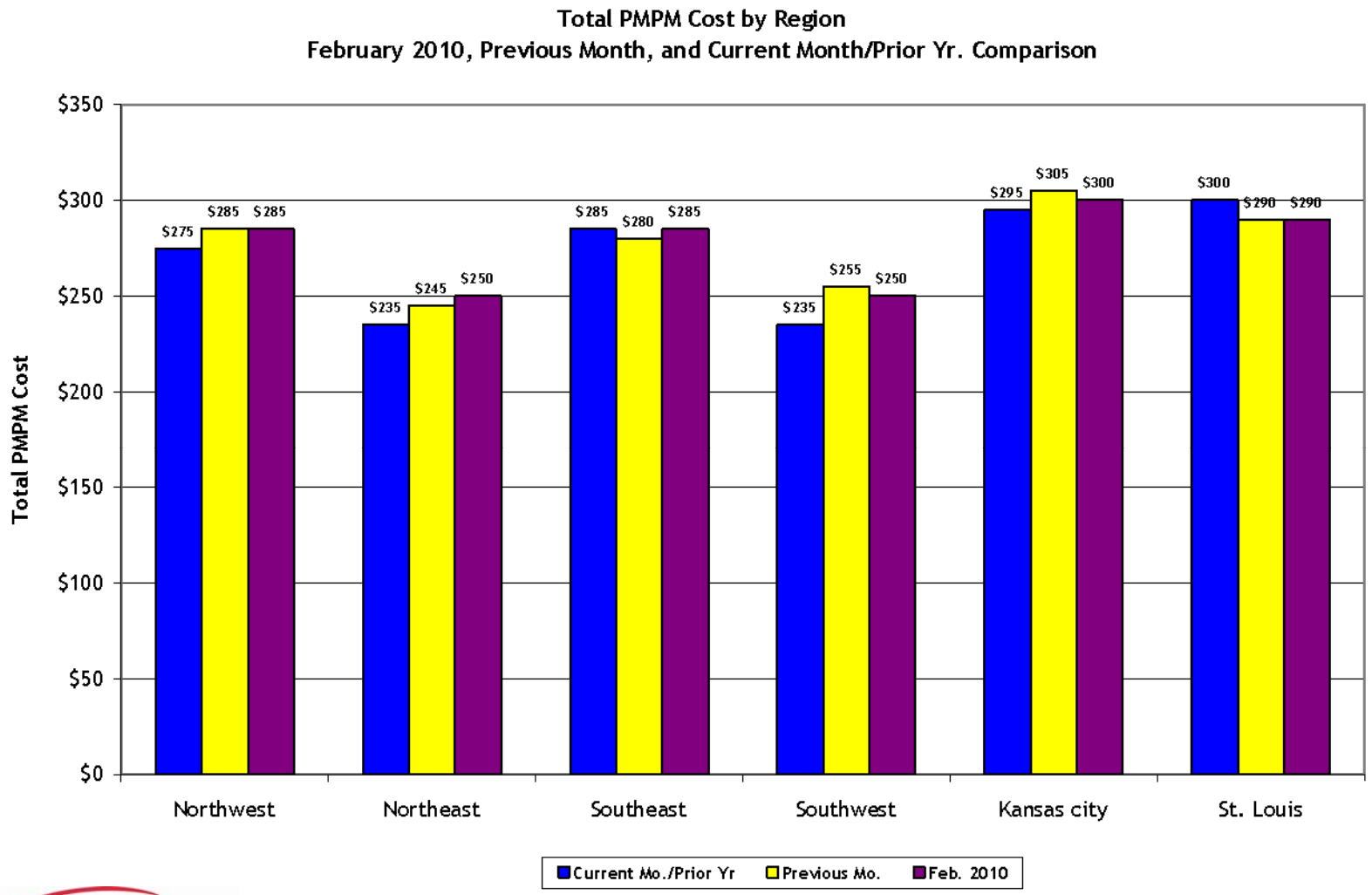

Expenditures – PMPM by Eligibility Category

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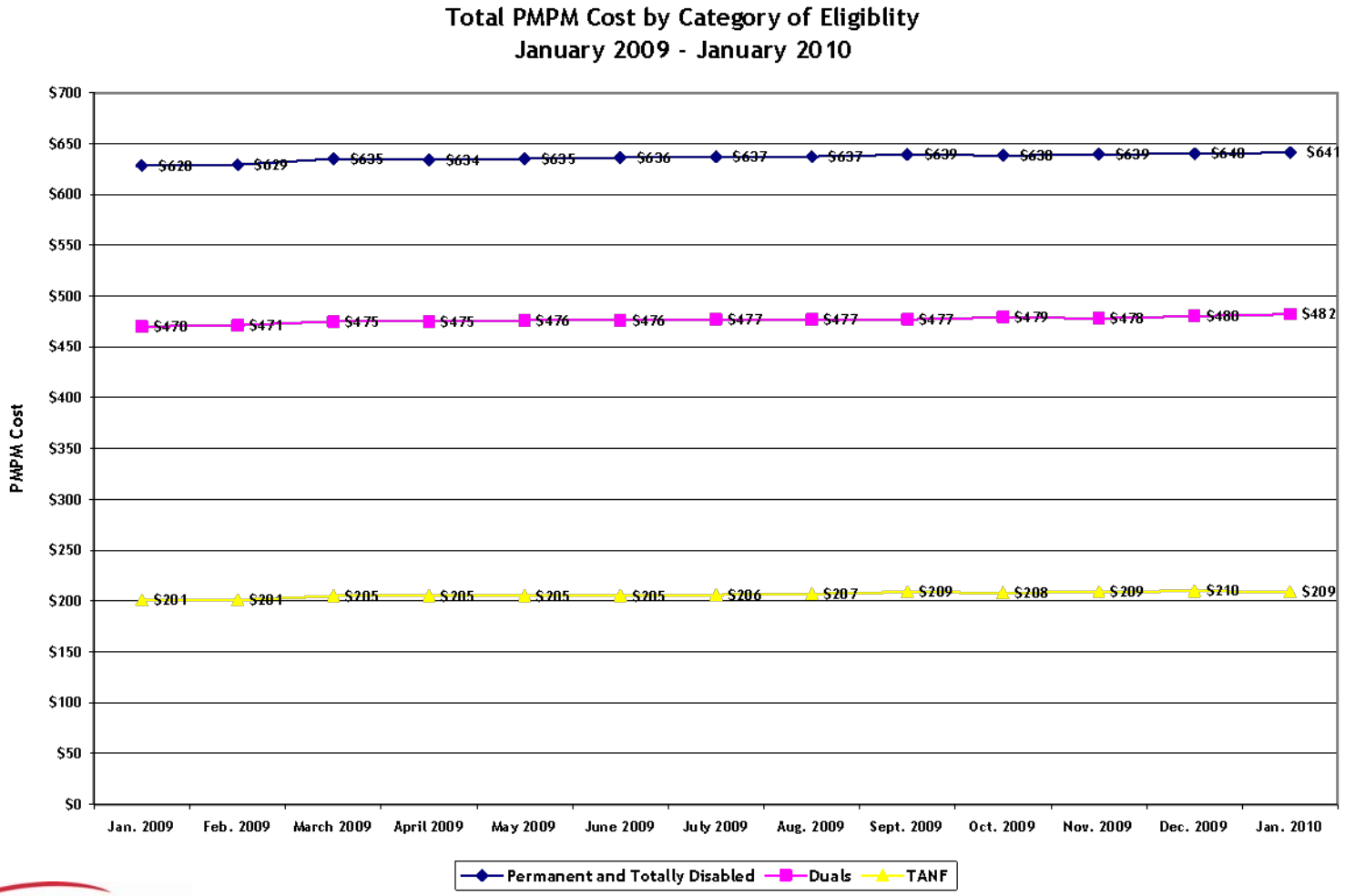

Long-Term Care – Nursing Facility Medicaid Census by Region

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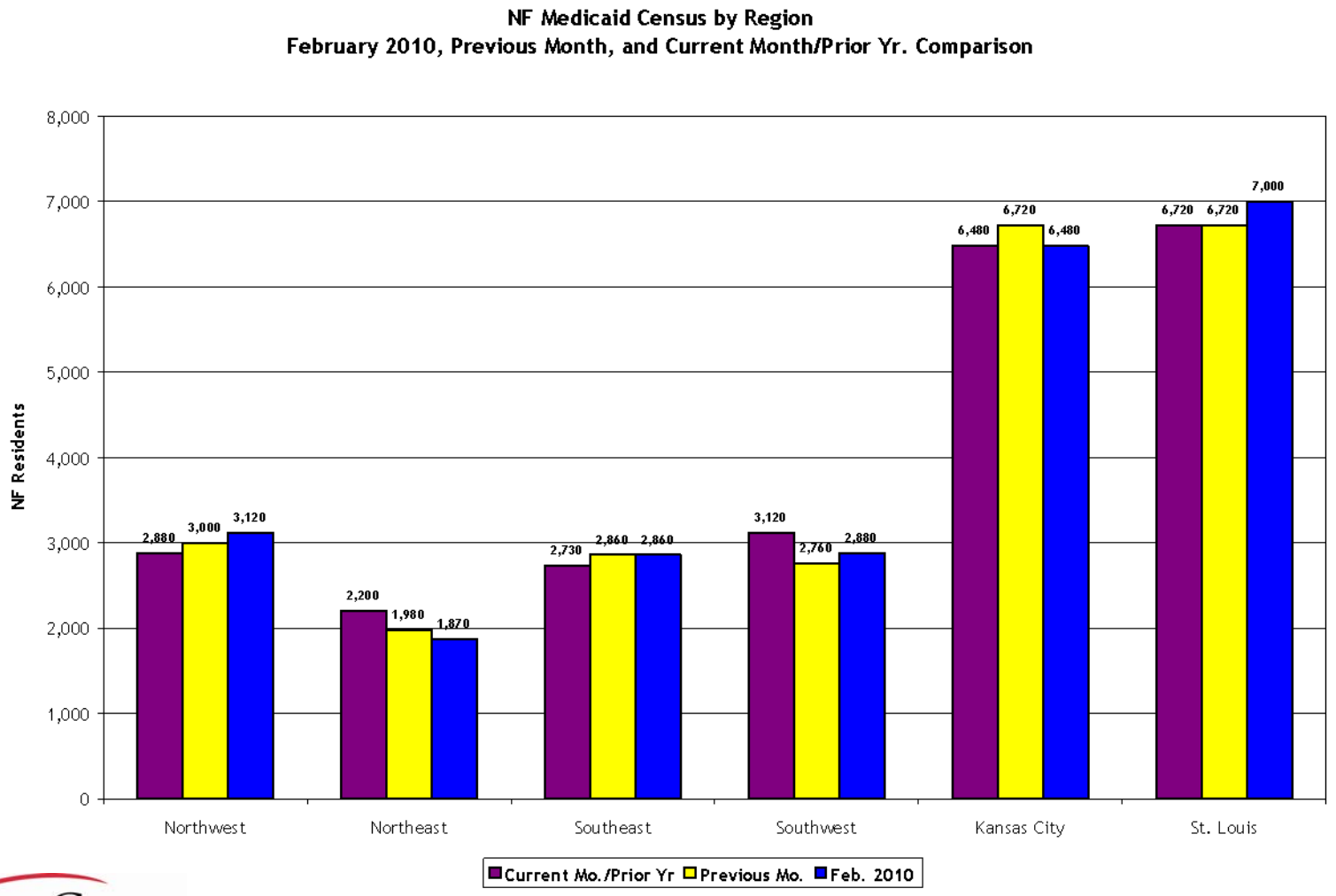

Care Management

Working Definitions (1/2)

- **Managed Care** – Program under which a vendor accepts a capitation payment for each enrollee to provide a defined set of health care services. By accepting the capitation payment the vendor is "at-risk" for the amount of services provided and, therefore, works to manage the participants care.
- **Accountable Care Organization (ACO)**[1] - ACOs can generally be defined as a related set of providers, including at least primary care physicians, specialists, and hospitals, that can be held accountable for the cost and quality of care to a defined population. Accountability is through financial rewards for good performance based on quality and spending. ACOs are not necessarily "at risk." Three ACO characteristics are seen as essential:
  1. Ability to provide, and manage with patients, the continuum of care across different institutional settings
  2. Capability of prospectively planning budgets and resource needs
  3. Sufficient size to support performance measurement

Sources: [12]Devers and Berenson, *Can Accountable Care Organizations Improve the Value of Health Care by Solving the Cost and Quality Quandaries?*, Oct. 2009; accessed at: http://www.urban.org/url.cfm?ID=411975

Working Definitions (2/2)

- **Care Management** – A set of activities designed to assure that each participant has a coordinated plan to address their health care needs. Providers may accept enhanced payment to coordinate care, but are not "at-risk" for the amount of services provided. PCCM and Medical Home programs are examples of care management.
- **Primary Care Case Management (PCCM)** – Basic PCCM program have long been used by Medicaid programs to link patients with providers that perform basic care management functions for a small monthly fee. Increasingly, states are using *enhanced* PCCM programs to provide more intensive case management and care coordination (such as through medical homes)
- **Patient Centered Medical Home**[1] - Each patient has an ongoing relationship with a personal physician who leads a team of individuals that collectively takes responsibility for the ongoing care of patients. Care is coordinated across all elements of the health care system and community. Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it.

Sources: [1]Joint Principles of the Patient-Centered Medical Home, March, 2007; accessed at: http://www.medicalhomeinfo.org/Joint%20Statement.pdf

Focus Should Be on Non-Dual-Eligible, High-Cost Participants

- These participants are primarily under 65 with disabilities and chronic health care needs
  - Nearly 30,000 non-dual eligibles had costs above $25,000 in CY 2008
  - This 3% of beneficiaries generated roughly 40% of expenditures
- This group does not include participants that are also eligible for Medicare benefits (dual eligibles)
  - Acute care costs of dual eligibles are covered by Medicare
  - A "shared-savings" agreement with the federal government would be needed for care management to be cost effective for this population
- This group also does not include non-disabled families, pregnant women, and children, many of whom are already covered by managed care plans

Our Analysis Identified the Cohort of MO HealthNet Participants for Whom Care Management Offers the Greatest Opportunity

- Through claims analysis we identified more than 10,000 participants with extremely high use of pharmacy services (more than $5,000), emergency room visits (ten or more), and/or inpatient admissions (three or more) in one year

- In a separate analysis, we identified over 6,000 participants that incurred more than $100,000 of Medicaid expenses in 2008

- Many participants don't reach these thresholds, but have chronic conditions, disabilities, and/or serious mental illness and could benefit from a coordinated care management approach

We Recommend A Multi-Phased Approach To Ensuring High-Quality Cost-Effective Care for Non-Dual, High-Cost Participants

1. Continue work toward ultimate goal of managed care or other program that incentivizes delivery system to provide the most effective high-quality care
   - Such programs are ideal for populations with chronic needs
   - Managed care has been most effective to date, although alternatives (e.g., ACOs) are emerging
   - Programs require strong quality and access measurement / oversight

2. Seek enhanced funding for "health homes" under federal health reform – can be used in either managed care or FFS environment

3. Enhance current care management activities by building on existing Chronic Care Improvement Program

Initiating MCO-based Managed Care for the ABD Population Requires Careful Consideration

Missouri may consider expanding the current Medicaid MCOs' role or can initiate a full procurement. For either option, it will be important to consider:

1. How to engage beneficiary stakeholders and secure their support
2. How other stakeholders (e.g. agencies, providers, contractors) will be impacted
3. Whether to enroll the SSI population on a voluntary or mandatory basis
4. What regions to include in a managed care expansion
5. Whether to include both dually-eligible and non-Medicare-eligible participants
6. What services to provide through the MCO
7. What financial arrangement is appropriate for the MCOs (e.g., capitation rate, stop loss)
8. Whether the provider networks are adequate for this new, more complicated population
9. What resources are needed within MO Medicaid
10. How to ensure sufficient managed care quality oversight
11. How MO HealthNet financing arrangements will be impacted

Managed Care Expansion Could Ultimately Be a Viable Option if Key Challenges are Overcome

- Moving high-cost subgroups into capitation may be advisable under the following circumstances:
  - Sufficient time and State resources are provided to ensure a successful implementation
  - Sufficient provider capacity is identified and providers are prepared for the expansion
  - High cost services are included within the managed care scope to maximize ROI
  - The State is able to preserve or replace existing federal UPL revenue, possibly through an 1115 waiver, negotiated with CMS, such as the one that created Florida's Low Income Pool (LIP)
  - To include dual eligibles, Medicare / Medicaid spending would need to be combined to allow the State to share in the savings with CMS

Patient Centered Medical Homes Could Meet the State's Care Management Objectives

- Nationally, there is an increasing use of "Patient Centered Medical Homes," a coordinated approach that relies on primary care teams to address all of a patient's health care needs (NC and VT are leaders in this area)

- National health reform legislation signaled a federal emphasis on the concept and the potential for additional funding opportunities in the future

- Program development ties neatly together with HIT tools such as CyberAccess that MO HealthNet has worked hard to implement

Federal Health Reform Bill Includes State Plan Option for "Health Homes" with 90/10 Funding

- Section 2703 of H.R. 3590 provides for a state plan option to designate "health homes" for individuals with chronic conditions beginning January 1, 2011
- During the first two years that the SPA is in effect, states will receive an FMAP of 90 percent for "payments for the provision of health home services"
- Planning grants are also available beginning January 1, 2011 to develop a SPA under this section
- Eligible individuals include those with two chronic conditions, one chronic condition and at risk for a second, or one serious and persistent mental health condition

Existing Care Management Program (CCIP) Provides a Foundation for Care Management, Including Medical Homes....

- Approximately 2,000 physicians participate in the current care coordination initiative; however, engagement is inconsistent
- Interconnectivity between CyberAccess and CareConnection allows providers and health coaches to share patient information on a real time basis
- The presence of health coaches in FQHCs and the Truman Medical Center offers in-person care management; however, the vast majority of patient contact is telephonic

…But Needs to Be Strengthened by Targeting the Right People and Tailoring the Interventions

- Gateway conditions do not target those individuals who are most likely to benefit from care coordination
  - Our suggested target group include the approximately 10,000 non-dual eligible high utilizers with extremely high use of pharmacy services, emergency room visits, and/or inpatient admissions in one year

- A stepwise approach to care management would target levels of intervention depending on need
  - Lowest levels would involve phone calls and mailings
  - Highest levels could involve extensive face-to-face interaction by multiple persons
  - Impacts on individuals' health status and costs will vary – even when same outreach approach is taken with people with similar-looking circumstances

Actively promote provider engagement

- Create a Physician Advisory Board, with engagement by incoming Medicaid Medical Director, to engage physicians in MO HealthNet
  - Possible topics for discussion would include the promotion/enhancement of CyberAccess, evaluation goals, ongoing measurement strategies, care management tools for providers, future pilot or demonstration projects

- Identify program champions
  - "Providers are critical to any care management program; interested providers will endorse the concepts of the interventions with patients, identify interventions needed for patients, and provide valuable program input."[1]

Source: [1]The Lewin Group, "Designing and Implementing Medicaid Disease and Care Management Programs: A User's Guide," March, 2008. Accessed at: http://www.ahrq.gov/qual/medicaidmgmt/medicaidmgmt.pdf

We recommend that the State expand its care management program using a contractor

- Direct performance by State
  - Entails creating a care management group whose sole function is to interact with targeted beneficiaries and catalogue all outreach activities
  - Would require redeploying some existing personnel and likely some new hiring
  - Would require substantial time to, for example, identify, develop and install a care management system
- Contracting with the existing care management vendor or procuring a new vendor are other options for implementing the enhanced program
  - Contracting out can likely be accomplished more quickly
  - Strong performance incentives would be needed to incent these organizations to maximize net Medicaid savings
- Suggested outreach approach also requires strong analytic component
  - Provide initial and ongoing beneficiary-specific data to outreach team to support their efforts as well as extensive reporting to track outreach efforts and impacts
  - These analytics could be performed directly by the State or contracted out

Evaluation Must Be a Strong Component of Care Management Program, Regardless of Approach

- Establish clear evaluation goals and manage expectations of key stakeholders
- Continue to develop electronic tools to track providers and participants, measure outcomes, and determine ROI
- Leverage incoming Medicaid Medical Director and enhanced Quality Unit to lead evaluation component and spearhead resulting continuous quality improvement strategy
  - An enhanced Quality Unit should be established regardless of the care management approach adopted
- Identify appropriate opportunities to compare performance and outcomes across programs

Reimbursement & Budgeting

MO HealthNet: The Current State

- Outdated reimbursement systems
- Line item budgeting hinders policy making and program assessment

Missouri Should Align Reimbursement with Policy Goals of Efficiency, Effectiveness, and Quality Care

- Institutional reimbursement systems should account for patient acuity
  - Diagnosis Related Groups (DRGs) for inpatient care, Ambulatory Patient Classifications (APCs) for outpatients, and Resource Utilization Groups (RUGs) for nursing facilities, all provide higher rates for more intensive care
- Reimbursing facilities on a reasonable price, rather than provider-specific cost, basis promotes efficiency
  - DRGs and APCs are structured so that payors can reimburse facilities a price for services that does not depend on an individual provider's cost experience
  - Nursing facilities can also be paid a price per day, with acuity adjustment, based on the overall cost experience of the industry
  - Additional analysis of reimbursement policies is warranted for non-institutional services to assure cohesiveness with institutional reimbursement
- Reimbursement systems that promote efficiency should incorporate components to incentivize high quality care
  - Helps mitigate the incentive to simply provide the minimum level of service for the lowest cost

Unify Budgeting to Support Program-Wide Policymaking

- Consider budgeting by population rather than service
- For example, create a global budget for long-term care
  - Current appropriations are service- or program-specific, and this does not allow executive authority to reallocate funds within the LTC system or leverage investments in one place to achieve savings in another
  - Several states have used budget flexibility and administrative consolidation as essential components to improving their LTC systems (e.g., OR, NJ, VT, WA, WI; OH is also beginning the process)

PMPM Budgeting Is Another Alternative

- A budget based on per-member-per-month spending would allow the program to align spending with program needs on an ongoing basis
- Assessing overall cost of care by population group allows focus to be on the cost of care per participant rather than changes in provider category spending
  - For example, budgeting and monitoring on a PMPM basis could inform a discussion on the relationship between increased pharmacy spending and decreased inpatient spending
- Opportunities may exist to use existing Thomson contract to monitor spending on a PMPM basis

Next Steps & First Priorities

Next Steps

- Initiate process to refine objectives, clarify mission, and establish workplan for accomplishing Medicaid program coordination
- Initiate realignment of LTC administration and budgeting
- Identify metrics and implement a performance measurement program
- Determine whether or not to pursue a managed care expansion for high cost participants, weighing financial impact, resource requirements, and provider readiness
  - Enhance care management program in any event
- Begin discussions with stakeholders on efforts to modify reimbursement systems to align with policy principles

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HEALTH CARE AND HUMAN SERVICES POLICY, RESEARCH, AND CONSULTING - **WITH REAL-WORLD PERSPECTIVE**.

MO HealthNet Program Integrity

Oversight Committee Presentation

May 25, 2010

Introduction

- Drew Gattine –
  - Director of Account Management for Ingenix Government Program Integrity
  - Over 17 years experience focused on helping Medicaid agencies deliver quality services and operate efficiently
  - Managed highly successful engagement with the State of Washington for over nine years, delivering over $70 million in recoveries, cost avoidances, and other savings
  - Managed engagement with the Commonwealth of Kentucky driving development of the core algorithms that saved the Commonwealth millions of dollars each year

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Overview

State Medicaid Program Integrity Overview

- Program Integrity (PI) operations seek to ensure that appropriate amounts are paid to legitimate providers for appropriate and reasonable services provided to eligible beneficiaries[1]
- Program Integrity has evolved over the past 15 years to include a complex group of issues not limited to "fraud and abuse"
  - True fraud is generally within the jurisdiction of the Medicaid Fraud Control Unit (MFCU) within the Attorney General's Office
- Most common PI metric are financial measurements of recoveries and costs avoided, but success is difficult to measure
  - The most successful programs avoid making improper payments to begin with
  - Different states count PI results differently, making comparisons misleading
- Efforts to prevent and recover improper payments must be balanced against the need to ensure access to prompt, high-quality care

[1]Kaiser Commission on Medicaid and the Uninsured, "The New Medicaid Integrity Program: Issues and Challenges in Ensuring Program Integrity in Medicaid," June 2007, accessed at: http://www.kff.org/medicaid/upload/7650.pdf

Federal Program Integrity Efforts Also Require State Participation

- Existing efforts include:
  - Medicaid Integrity Group (MIG) – CMS program to implement the Medicaid Integrity Program (MIP), a national strategy to detect and prevent Medicaid fraud and abuse and to support state PI efforts
  - Payment Error Rate Measurement (PERM) – CMS program to measure improper payments in the Medicaid program and CHIP through medical records and data processing reviews
  - Medicare-Medicaid Data Match Program (Medi-Medi) – Program to identify payment anomalies and potential fraud and abuse by combining Medicaid and Medicare data
- Patient Protection and Affordable Care Act includes new PI initiatives:
  - Recovery Audit Contractors (RACs) – Requires states to contract with RACs to identify and recoup overpayments
  - Expanded data reporting – Requires states to submit an expanded set of data elements to CMS from the MMIS

Elements of a High-Functioning Program Integrity Operation

- Maintain a high profile within the Human Services Organization to demonstrate that program integrity is an enterprise-wide responsibility
  - Intertwined with program, policy, claims processing, rate-setting, and provider enrollment
- Maintain a high profile externally
  - Focus on high dollar provider types, but cast a broad net so that all providers know they are being scrutinized
  - Maximize quality and quantity of interactions with critical external partners – law enforcement, MCOs, provider groups, legislature
  - Report on successes
- Establish meaningful goals based on an annual work plan
- Maximize access to data and invest in useful technology
- Develop and leverage subject matter expertise
- Recognize that quality of care is an integral component of program integrity

While Not a High-Performing Program, MO HealthNet's Program Integrity Unit Is Moving in the Right Direction

- Current PI operations in Missouri are about average compared with other programs
- Ongoing operational improvements can improve performance with existing resources
- Additional investment would be required to truly become high-performing

High Level Summary of Recommendations

1. Elevate the profile of Program Integrity in the organization

2. Increase investment in PI staff and tools to become high-performing (e.g., add clinicians, investigators, data tools, travel allowance)

3. Improve collaboration with partners (e.g., MFCU, MHD program areas, DHSS, DMH)

4. Ensure that systems are designed to avoid improper payments rather than paying and recovering

Organization and Staffing

Organization and Staffing

- Current state:
  - Limited clinical resources and staff members that specialize in particular provider types and programs limit the PI unit's ability to prioritize work effectively; however, a newly hired Director is working to change this status quo

- High-Level Recommendations:
  - Elevate the profile of Program Integrity in the organization
    - Establish a Medicaid-wide Steering Committee including DSS, DHSS, DMH
  - Establish a goal-based workplan
    - Evaluate staffing levels to meet workload
  - Increase the number of clinical and investigative staff
  - Maintain PI operations in MO HealthNet

The Inspector General Model

- Some states have moved program integrity activities away from Medicaid operations and into an independent Office of Medicaid Inspector General (OMIG)
- Perception is that an independent office is more effective and less influenced by internal policy decisions
- OMIGs exist in nine states -- Illinois, Texas, New York, New Jersey, Georgia, Kentucky, Utah, Florida and Michigan
- The programs included under the offices vary in each state
  - Some states include the Inspector General for all state programs, while others have a dedicated Medicaid Inspector General
  - Counting of results also varies, making it misleading to compare states with and OMIG to those without (e.g., Texas reports recoveries related to all social services programs, not just Medicaid)

OMIG Has Advantages and Disadvantages

Pros

- Raises PI profile as a separate unique office with the goal of detection, investigation and recovery of money
- May reduce provider influence on decisions made on collections and investigations
- Perceived clout may create a stronger "sentinel effect" with providers (i.e., that OMIG cannot be influenced)
- May be able to take a stronger stance without need to balance policy perspective
- May be better able to obtain staff, systems, and other resources

Cons

- May reduce the PI role as a part of the "management" of the Medicaid enterprise
- OMIG staff may not communicate as closely on problems, policy changes, and system deficiencies, inhibiting front-end prevention
- Aggressive actions may counter Medicaid efforts to increase or protect access by discouraging provider participation
- Can set up an "Us vs. Them" mentality between the Medicaid staff and OMIG, creating opportunity for mistrust
- Provider irritation if the recovery projects are (or are viewed as) auditing for petty billing mistakes vs. fraud or abuse

Missouri's Option to Establish an OMIG Should be Based on Ability to Raise the Profile of Medicaid PI

- Our most important recommendation is to raise the profile of Medicaid program integrity in Missouri
- Program integrity functions should be maintained within the MO HealthNet Division
  - Program integrity is an integral part of program administration and should be woven into the fabric of daily Medicaid operations
- However, if the profile can only realistically be raised though the creation of an OMIG, then this would be the preferred action
  - If an OMIG is created, a steering committee that includes Medicaid staff is strongly recommended
- Decision should not be based purely on a desire for "better numbers"
  - While OMIGs often report improved recoveries, differences in the way that they are counted make comparisons misleading

Operational Recommendations

Cost Recovery

- Current State:
  - Cost recovery activities are driven by contractor-generated "Dashboard" reports that generate cases for program integrity staff to work. Internal analytic capabilities are limited.

- High-Level Recommendations:
  - Dashboards should include all areas of significant expenditures
  - Build increased capacity for ad hoc analytics among PI staff
  - Continue to develop and expand on-site audit capabilities
  - Increase role of PI staff in reviewing clinical areas such as pharmacies and physicians

Cost Avoidance

- Current State:
  - Cost avoidance efforts rely largely on an internally developed system of edits that can be difficult to update, as well as prior authorization controls administered by program staff (outside of Program Integrity).

- High-Level Recommendations:
  - Use dashboard results to identify and correct front-end vulnerabilities through edits
  - Improve edit development/modification and testing process
  - Review and update program policies that are not being enforced by edits and correct, if necessary
  - Continually evaluate potential benefits of a commercial edit system

Provider Enrollment

- Current State:
  - Provider enrollment staff rely on several effective practices for limiting the number of inactive providers on the provider file, but system limitations prevent the capture of some important information. On-site reviews of providers are not routinely performed.

- High-Level Recommendations:
  - Conduct onsite reviews of DME, pharmacy, home health, and other "high-risk" providers prior to enrollment
  - Require periodic re-enrollment to further limit the number of inactive providers
  - Excluded provider lists should be maintained and made available on the State's website

Measuring Results

- Current State:
  - A consistent approach to measuring results has been employed for several years; measured results have shown significant increases since SFY07, highlighted by a substantial increase in reported cost avoidance.

- High-Level Recommendations:
  - Continue current measurement methods, but heighten validation that provider activity accounting for cost avoidance has ceased
  - Consider promoting the most complete snapshot of all payment accuracy activities including Third Party Liability, Coordination of Benefits and Estate Recovery

Coordination With Medicaid Fraud Control Unit (MFCU)

- Current State:
  - The relationship between Program Integrity and MFCU has, at times, been strained and inefficient, but new leadership in both areas have recently made significant steps toward improved collaboration.

- High-Level Recommendations:
  - Continue to reinforce the need for coordination and cooperation with the MFCU
  - Training should be reciprocal, with each agency educating the other
  - Ensure that responses to information requests are not unnecessarily delayed by tracking/approval processes within MO HealthNet

Summary

Summary

- PI Unit operates on par with other average units in other states
- Since appointment of the new PI Director there have been operational enhancements, implementation of new initiatives, and improvement in the critical relationship with MFCU
- The profile of PI should be elevated within the entire organization to create a culture that PI is "everybody's business"
- Additional investment will be needed to make MO HealthNet PI truly high performing

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