MO HEALTHNET OVERSIGHT COMMITTEE
AUGUST 9, 2011

This packet contains the following handouts and presentations:

- MO HealthNet Participation by Eligibility Category Handout
- Budget Update Presentation: Marga Hoelscher, MO HealthNet Division
- Health Home Update Presentation: Mayme Young, Department of Mental Health
- Affordable Care Act Presentation:
  - John Huff, Dept. of Insurance, Financial Institutions and Professional Registration
  - Melinda Dutton, Manatt Health Solutions
  - Patrick Holland, Wakely Consulting
  - Harvey Levin, KPMG
  - Marcia Morgan, Alicia Smith & Associates
- Presenter Biographies
  - Harvey Levin
  - John Huff
  - Marcia Morgan
  - Mayme Young
  - Melinda Dutton
  - Patrick Holland

Participation

	Participants as of March 2008	Participants as of June 2011	Change Since March 2008	Percentage of June 2011 Participants	Current Income Eligibility Maximums (Show as a Percentage of Poverty Level)	Budgeted Participants by June 2012
Children	484,750	542,859	+58,109	60.5%	300%	571,000
Persons with Disabilities	147,208	167,664	+20,456	18.7%	85%	180,000
Custodial Parents	74,561	81,034	+6,473	9.0%	TANF level (approximately 19%)	84,000
Seniors	76,808	77,668	+860	8.7%	85%	85,000
Pregnant Women	28,301	28,081	-220	3.1%	185%	28,000
Total	811,628	897,306	+85,678			948,000
Women's Health Services	19,831	61,663	+41,832		185%	83,000

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

Oversight Committee Budget Update

FY 2011 Net General Revenue

August 9, 2011

- FY 2011 Consensus Revenue Estimate was $7.223 billion

- Last Oversight Report on June 7, 2011
  - Actual 2.7% increase from the YTD May 2010 actual net collections.
  - Refunds increased 6.5% from $1.21 billion to $1.28 billion

- Final FY 2011
  - Actual 5.9% increase from FY 2010 actual net collections.
  - Increase of $410 million from prior year collections
  - Total Net collections from $6.77 billion to $7.18 billion

- FY 2011 gross collections
  - Sales and use tax collections **increase** of **1.0%**
  - Individual income tax collections **increase** of **2.7%**
  - Corporate income tax collections **increase** of **7.0%**
    - Refunds decreased 9% from $1.47 billion to $1.34 billion

MoHealthNet

Oversight Committee Budget Update

Net General Revenue Growth Rates

August 9, 2011

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	-9.1%
FY 2011	5.9%
FY 2012*	4.0%

** Original Estimate*

MoHealthNet

Oversight Committee Budget Update

FY 2013 Budget Preparation

August 9, 2011

- Due to Governor (Office of Administration, Division of Budget & Planning) and General Assembly October 1

- Estimating a Budget Gap
  - Driven by $460 million of one-time federal budget stabilization and state education funds

- Departments to Request Mandatory Items Only
  - MO HealthNet Mandatory Examples:
    - Caseload Growth
    - Federal Participation Rate Changes (FMAP)
    - Pharmacy Inflation and Utilization Adjustments

- Cautiously watching Federal actions
  - Provider tax limits

MoHealthNet

Oversight Committee Budget Update

Proposed Provider Tax Limits

August 9, 2011

- October 1, 2011 tax limit increases to 6% until FFY 2014
  - FY 2011 FRA funded $2.5 billion in Medicaid payments
- Federal Proposals Limit Provider Tax Rates
  - 4.5% in FFY 2015
  - 4% in FFY 2016
  - 3.5% in FFY 2017

Health Homes in Missouri

Mayme Young, J.D.
Dept. of Mental Health

Health Homes
Affordable Care Act

- Section 2703 of the Affordable Care Act allows states to amend their Medicaid state plans to provide **Health Homes** for enrollees with chronic conditions.
- Missouri is seeking approval from the Centers for Medicare & Medicaid Services (CMS) to be able to provide Health Homes to Missourians who are Medicaid eligible participants with chronic illnesses.

What is a Health Home?

A “Health Home” is a place where individuals can come throughout their lifetimes to have their health care needs identified and to receive the medical, behavioral and related social services and supports they need, coordinated in a way that recognizes all of their needs as individuals -- not just patients.

Missouri's Health Homes

- Missouri is the first state to submit a state plan amendment to implement Health Homes.
- Missouri will have 2 types of Health Homes:
  - Primary Health Care Health Home
    - Federally Qualified Health Centers (FQHCs)
    - Rural Health Centers (RHCs)
    - Physician practices
  - Behavioral Health Care Health Home
    - Community Mental Health Centers (CMHCs) & CMHC affiliates

Partners in Planning

The planning process for Missouri's Health Home model has included stakeholders and has been a collaborative effort between the following:

- DSS,
- DMH
- MO Foundation for Health
- MO Primary Care Association (PCA)
- MO Coalition of Community Mental Health Centers (CMHCs)
- Consultants: Michael Bailit & Alicia Smith

Components of a Health Home

- Comprehensive care management
- Care coordination and health promotion
- Comprehensive transitional care including follow-up from inpatient and other settings
- Patient and family support
- Referral to community and support services
- Use of health information technology to link services

Health Homes

This model is intended to be a means to:

1. Implement and evaluate the Health Home model as a way to achieve accessible, high quality primary health care and behavioral health care;
2. Demonstrate cost-effectiveness in order to justify and support the sustainability and spread of the model*; and
3. Support primary care and behavioral care practice sites by increasing available resources and improving care coordination to result in improved quality of clinician work life and patient outcomes.

**The Fiscal Year 2012 state budget assumes $7.8 million in savings from the Health Home initiative*

Missouri's Goals:

- Reduce inpatient hospitalization and E.R. visits,
- Enhance the amount of primary care nurse liaison staffing and primary care physician consultation available at CMHCs,
- Enhance the behavioral consultation available at primary care centers, and
- Enhance the State's ability to provide transitional care between institutions and the community.

Eligibility

Who is eligible to be served in by a Health Home?

1. Persons covered by Mo HealthNet including those covered through Mo HealthNet's Managed Care Plans;
2. Persons with 2 chronic conditions;
3. Persons with 1 chronic condition who are also at risk for a 2nd chronic condition; and/or
4. Persons who have 1 serious and persistent mental health condition

Chronic Conditions:

Chronic health conditions include:

1. Serious Mental Health Condition
2. Substance Abuse Disorders
3. Developmental Disabilities
4. Asthma
5. Diabetes*
6. Cardiovascular disease – including hypertension
7. Overweight (BMI >25)
8. Tobacco use*

* Smoking or diabetes qualifies a person for being at risk of having a 2nd chronic condition

Who will provide the services?

- Applications have been disseminated for primary health care and behavioral health care providers to complete and return to the State for consideration to be a Health Home.

- Review of applications will be performed by Mo HealthNet and Dept. of Mental Health to make the final determination of selected practice sites.

Who will provide the services?

- Sites will be chosen based upon the merits of each individual application and upon the CMS requirement that there be statewide geographic representation.
- At least 25% of a provider's patient base must consist of Medicaid patients and/or uninsured patients.

Who will provide the services?

- Applicants that qualify will work to transform their practices over a 2-year period by participating in ongoing training sessions or "learning collaboratives."
- CMHCs will be required to obtain Health Home certification through nationally recognized Health Home accrediting organizations.
- Primary care practices will be required to obtain NCQA (National Committee for Quality Assurance) Health Home certification.

Primary Care Sites

- DSS is seeking primary care practice sites that are comprised of licensed physicians collaborating with other licensed health care professionals, including nurse practitioners and physician assistants, to serve as Health Homes.

Primary Care Sites

- Because this model emphasizes the integration of primary health care and behavioral health care, the primary care practices will need to establish or enhance the presence of behavioral health consultant staffing at these sites.

- Candidates anticipated to apply for consideration are:
  1. Federally Qualified Health Centers (FQHCs)
  2. Rural health clinics and
  3. Other primary health care providers.

Behavioral Health Care Sites

- DMH is seeking CMHCs with existing Division of Comprehensive Psychiatric Services contracts to serve as Health Homes for Medicaid beneficiaries.
- While some CMHCs have already begun to deliver services based on the Health Home model, the behavioral health providers will be required to:
  1. Better integrate their practices,
  2. Do more outreach and coordination with hospitals and primary care clinics, and
  3. Enhance the amount of primary care nurse liaison staffing available at CMHCs.

3-Part Payment Method

- Subject to CMS approval, providers that meet the Health Home requirements will receive:

  (1) **infrastructure payment** for performing certain start-up activities,

  (2) **per-member-per-month** payments for performing various Health Home activities, and

  (3) may receive **incentive payments** relating to performance.

Payment Method – Part 1

- **<u>Quarterly start-up, training and infrastructure cost reimbursement:</u>** using a methodology developed by DSS and DMH, practice sites will be reimbursed for start-up costs and lost productivity due to collaboration demands not covered by other streams of payment.

Payment Method – Part 2

- **Clinical Care Management per-member-per-month payment**: using a methodology developed by DSS and DMH, practice sites will be reimbursed for the cost of staff primarily responsible for delivery of services not covered by other reimbursement (primary care nurses, behavioral health consultants) whose duties are not otherwise reimbursable by Medicaid.

Payment Method – Part 3

- **Performance Incentive Payment**: practice sites could be paid for up to 50% of the value of the reduction in total health care per-member-per-month costs for the practice site's attributed MHN patients, relative to prior year experience. Savings will be distributed on a sliding scale based on performance relative to a set of site-specific preventive and chronic care measures generated and reported by the practice and subject to DSS audit.

  Payments described in Part 1 and 2 will be based on the number of Medicaid participants assigned to or attributed to the practice site on a date certain each month.

Health Home Update as of August 9, 2011

- The State Plan Amendment for the Behavioral Health model was submitted to CMS on July 19, 2011.
- CMS has 90 days to respond/comment.
- Primary Care State Plan Amendment still in draft form and will be submitted to CMS in near future.
- Dept. of Mental Health is hopeful that CMHCs may start this fall.

Questions?

- Please visit our Health Home website: http://dmh.mo.gov/about/chiefclinicalofficer/healthcarehome.htm

- Or, you may contact me at 573-751-8094, or reach me via email at: Mayme.Young@dmh.mo.gov

The Impact of Health Insurance Exchanges on Medicaid

Presentation to the MO HealthNet Oversight Committee

Jefferson City, MO
August 9, 2011

Agenda

1. **Introduction**– Dwight Fine, Missouri ACA Coordinator
2. **Missouri Vision and Landscape** – John Huff, DIFP Director
3. **Exchange Legislation** – John Huff, DIFP Director
4. **Exchange Funding** – John Huff, DIFP Director
5. **Background on Exchanges** – Melinda Dutton (Manatt Health Solutions)
6. **State vs. Federal Exchange** – Patrick Holland (Wakely Consulting)
7. **Overview of Exchange IT Systems** – Harvey Levin (KPMG)
8. **Medicaid Integration and Coverage Transitions** – Marcia Morgan (Alicia Smith and Associates)

Missouri Vision and Landscape

John Huff, DIFP Director

What is a Health Insurance Exchange?

A "Store" or marketplace for private health insurance, an Exchange is designed to:

- **Provide price and quality information to consumers and small businesses thus making the purchasing experience more transparent;**
- **Enhance the shopping experience by requiring greater consistency and uniformity in coverage and benefit design offered by Qualified Health Plans (QHPs);**
- **Promote easy comparison of price and quality information between competing QHPs through uniformity in coverage and benefits;**

What is a Health Insurance Exchange?

An Exchange is designed to (continued):

- **Ease entry into the marketplace for smaller insurers resulting in additional, affordable health insurance options to the market; and**
- **Give small employers the same purchasing power as large employers by combining the insurance needs of a number of small employers in one large purchasing pool.**

The Exchange will focus its attention on small employers.

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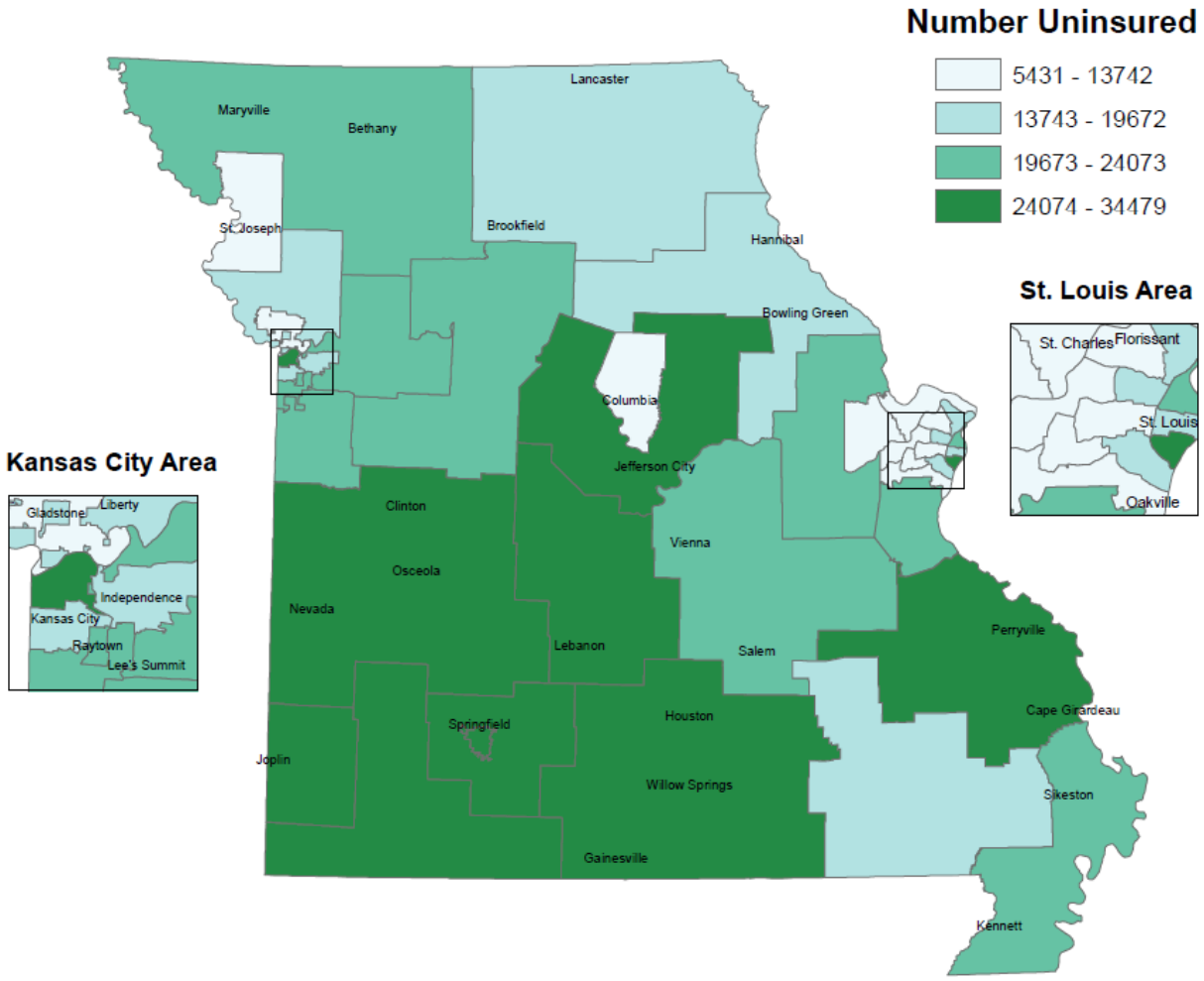
Missouri's Vision

Exchange Vision, Mission and Principles

- A Missouri framework for the Individual, Small Employer and Exchange markets should:
  - Maintain market stability and viability;
  - Enhance competition based on value to consumers;
  - Constrain the rate of growth of Missouri health care costs;
  - Improve health status of enrolled populations; and,
  - Enhance access to quality affordable health insurance coverage of all Missourians.

Landscape: Distribution of Non-elderly Uninsured



Source: American Community Survey (ACS) 2009 data from the Integrated Public Use Microdata Series (IPUMS) of the Minnesota Population Center.
Shaded areas represent Public Use Microdata Areas (PUMAs) which can usually be defined in terms of counties, with a single PUMA covering a single county, a combination of whole counties, or a part of a large county.

Exchange Legislation

John Huff, DIFP Director

NAIC Model Law

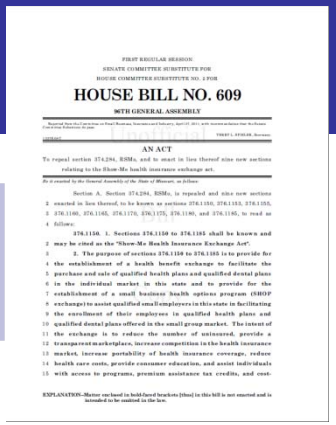
The National Association of Insurance Commissioners (NAIC) drafted a "model act" for States to customize and adopt.

- Basic and broad statutory framework
- Provides minimum language for States to meet ACA Exchange requirements and optional additional language for States to go beyond federal minimum in areas such as:
  - Consumer protections
  - Financial integrity
  - Benefit mandates

Leaves many decisions to states, including:

- ✓ Governance model
- ✓ Separate or merged SHOP and individual markets
- ✓ Definition of "small employer"

House Bill 609



FIRST REGULAR SESSION
SENATE COMMITTEE SUBSTITUTE FOR
HOUSE COMMITTEE SUBSTITUTE NO. 4 FOR

HOUSE BILL NO. 609

96TH GENERAL ASSEMBLY

AN ACT

To repeal section 374.284, RSMo, and to enact in lieu thereof nine new sections relating to the Show-Me health insurance exchange act.

Be it enacted by the General Assembly of the State of Missouri, as follows:

Section A. Section 374.284, RSMo, is repealed and nine new sections enacted in lieu thereof, to be known as sections 376.1150, 376.1153, 376.1155, 376.1160, 376.1165, 376.1170, 376.1175, 376.1180, and 376.1185, to read as follows:

376.1150. 1. Sections 376.1150 to 376.1185 shall be known and may be cited as the "Show-Me Health Insurance Exchange Act".

2. The purpose of sections 376.1150 to 376.1185 is to provide for the establishment of a health benefit exchange to facilitate the purchase and sale of qualified health plans and qualified dental plans in the individual market in this state and to provide for the establishment of a small business health options program (SHOP exchange) to assist qualified small employers in this state in facilitating the enrollment of their employees in qualified health plans and qualified dental plans offered in the small group market. The intent of the exchange is to reduce the number of uninsured, provide a transparent marketplace, increase competition in the health insurance market, increase portability of health insurance coverage, reduce health care costs, provide consumer education, and assist individuals with access to programs, premium assistance tax credits, and cost-

EXPLANATION—Matter enclosed in bold-faced brackets [thus] in this bill is not enacted and is intended to be omitted in the law.

House Bill 609 or the **"Show-Me Health Insurance Exchange Act"**

- Introduced in House of Representatives (February 22)
  - Sponsor: Rep. Chris Molendorp
- Passed unanimously by the House of Representatives (April 14)
- Approved by Senate Committee on Small Business, Insurance and Industry (April 27)
- Did not obtain final approval from the General Assembly before the end of the legislative session
- Senate created Interim Committee on Health Insurance Exchanges

Consensus seems to be emerging in both the legislative and executive branches of state government that as long as the ACA remains law, Missouri should act to establish a state-operated exchange rather than accept the default position of federal operation of an exchange within the State of Missouri as outlined in Section 1311 of the ACA.

Exchange Funding

John Huff, DIFP Director

Federal Funding for Exchanges

"Necessary Exchange costs will be fully funded by HHS until 2015. After January 1, 2015, Exchanges must be self funded."

*U.S. Health and Human Services Department, "Initial Guidance to States on Exchanges," November 18, 2010.

Federal Funding for Exchanges

SEPTEMBER 2010 — Exchange Planning Grant

- HHS awarded Exchange Planning Grants to 48 States and DC*
- Missouri received $1M

FEBRUARY 2011 — Early Innovator Grant

- HHS awarded seven Early Innovator grants to develop Exchange IT systems that will serve as replicable models for other States
- Kansas ($31.5 M), Maryland ($6.2 M), Massachusetts/New England states($35.6 M), New York ($27.4 M), Oklahoma ($54.6 M), Oregon ($48.1 M), Wisconsin ($37.8 M)

*In January 2011, Minnesota subsequently applied for and received a Planning grant. Alaska is the only state not to have applied for or received a grant.

Exchange Establishment Grant Application

- **Submitted by MHIP on June 30, 2011.**
- **Level 1 application**
- **Funds 12-month period (10/1/11 – 9/30/12)**
- **Seeking approximately $21M**

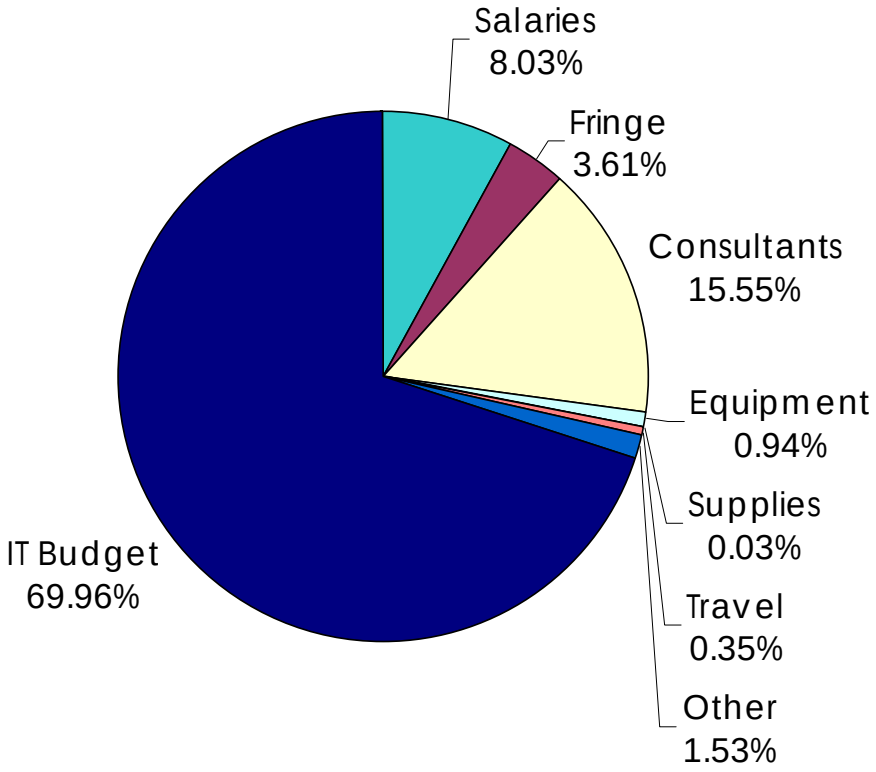
Exchange Establishment Activities

- ***PRIORITY TASK: Building the Exchange IT System***
- Obtaining key staff by leveraging existing state resources;
- Supporting costs required to establish the operational and financial infrastructure of the exchange;
- Supporting ongoing operations and development of a network to connect individuals and small employers to coverage;
- Expanding Stakeholder engagement;
- Establishing the appropriate levels of financial oversight and control to ensure program integrity; and
- Securing ongoing consulting support.

Establishment Grant Application Overview

In year one, the budget is driven primarily by IT costs.

Cost Category	Total Amount
Salaries	$2,145,000
Fringe	$965,250
Consultants	$4,154,653
Equipment	$252,200
Supplies	$8,550
Travel	$92,304
Other	$408,330
Contractual Costs (IT Budget)*	$18,690,397
Total Direct Costs	$26,716,684
Indirect Cost	$0
Total Costs	**$26,716,684**



* $ 5,850,968 of Contractual IT is allocable to Medicaid program

Exchange Establishment Grant Application

- **Currently undergoing budget negotiations with CMS.**
- **Other state applicants:**

Health Insurance Exchange Establishment Grant Applications		
State	*Level*	*Amount Requested (in millions)*
California	1	$40.10
Kentucky	1	$7.67
Maryland	1	*Unknown*
Missouri	1	$20.87
New York	1	$10.60
Oregon	1	$8.96
Health Insurance Exchange Establishment Grant Awards		
State	*Level*	*Amount Requested (in millions)*
Indiana	1	$6.90
Rhode Island	1	$5.24
Washington	1	$22.94

APD Submission Process

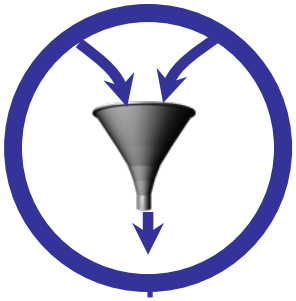
Missouri has submitted an APD to receive 90/10 funds

- Submitted an expedited APD checklist cross-referencing to the Level 1 grant application.
- Described the process to attribute costs for MO HealthNet and Exchange enrollees, respectively.

✓ **This will make federal Medicaid matching funds available for the development of a single integrated process to determine consumer eligibility for all coverage options and subsidies, including MO HealthNet and MO HealthNet for Kids and facilitate enrollment into coverage.**

Critical Tasks Ahead: Build the Exchange

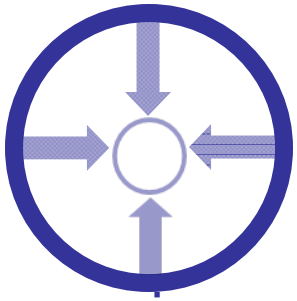
Design and Build ***IT infrastructure*** and interfaces with state and federal systems to support the new eligibility and enrollment process.



Establish an ***eligibility and enrollment process*** for consumer subsidies and ***fully integrate with Medicaid eligibility process*** for adults/children.

Create an ***Internet website*** to provide standardized information on health plans.

Build ***the Exchange to include*** consumer and small business ***outreach, education and assistance*** capacity.



Leverage opportunities for ***administrative integration and consolidation*** with existing state agencies.

Background on Exchanges

Melinda Dutton, Manatt Health Solutions

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Federal Exchange Requirements

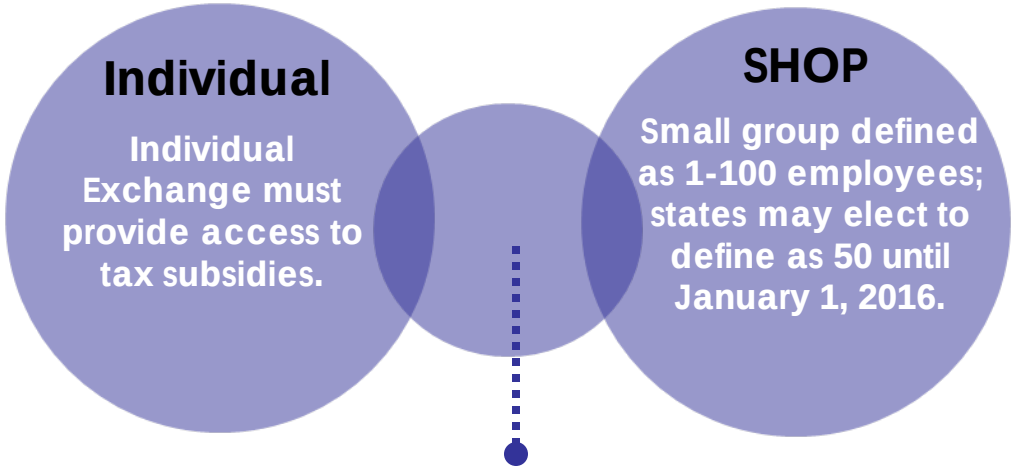
- **ACA requires each state to establish an American Health Benefit Exchange by January 1, 2014.**
  - Subsequent proposed regulations allow states to begin or cease Exchange operations after 2014.

- **ACA stipulates that if a State chooses not to establish an Exchange, the Federal government will operate an Exchange in that State in 2014.**
  - Proposed rules add a third hybrid/partnership approach that combines State-designed and -operated business functions with federally-designed and -operated functions.

- **The Exchange must be operated by a governmental entity (state agency or quasi-governmental entity) or nonprofit entity.**

Federal Exchange Requirements

States must establish an individual Exchange and a small group Exchange (SHOP)



State may elect to develop one Exchange that serves individuals and small groups.

The Exchange must provide for:

- Initial and annual open enrollment periods
- Special enrollment periods

Federal Exchange Requirements: Medicaid Integration

- **ACA requires single, streamlined application for Medicaid, CHIP and subsidies for coverage through the Exchange.**
  - Real-time eligibility determination
- **Coordination with Exchange**
  - Exchange allows for attestation to DOB, age, SSN, income, and citizenship/immigration status (info is verified electronically through Federal records)
  - Medicaid/CHIP eligible individuals identified by the Exchange required to be enrolled without further State determination
- **Coordination for wraparound coverage for Medicaid and CHIP individuals enrolled in premium assistance programs.**

"...the Exchange will need to work closely with Medicaid, CHIP, and other Health and Human Services Programs in order to ensure seamless eligibility verification and enrollment processes."

Cooperative Agreement to Support Establishment of State Operated Health Insurance Exchanges, 1/20/11

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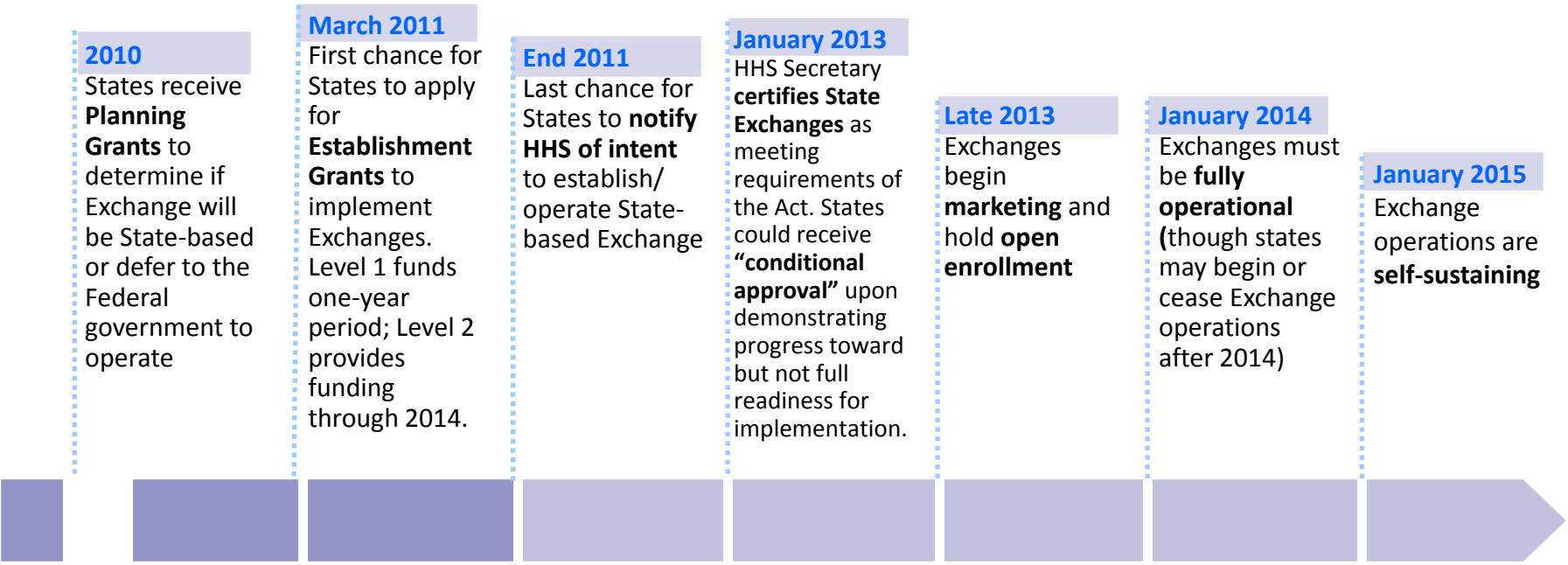
Federal Exchange Requirements: Timeline



States conduct planning and establishment activities in 2011 – 2013.

Milestones include:

- Ensure legal authorization for Exchange
- Establish governance structure
- Develop Budget & sustainability plan
- Complete IT systems design, development and implementation

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State vs. Federal Exchanges

Patrick Holland, Wakely Consulting

WAKELY CONSULTING GROUP
CONSULTING ACTUARIES & HEALTHCARE SPECIALISTS

Implications of State Exchange vs. Federal Exchange

- ***Policy.*** **The Exchange will make a number of policy decisions that will impact state policy and regulatory authority. Examples include:**
  - Health Insurance Regulations
    - Risk adjustment methodologies
    - Reinsurance
    - QHP certification
  - Medicaid Eligibility Determination and Enrollment processes and procedures.

Implications of State Exchange vs. Federal Exchange

- ***Business Operations.*** **The Exchange will make operational decisions and develop operational systems that will need to serve Missouri citizens and interface with state agencies and state-based systems.**

Implications of State Exchange vs. Federal Exchange

- ***Expenses.*** **The ACA commits federal dollars to developing Exchanges and establishes mechanism for self sustainability. Whoever runs the Exchange will be responsible for ensuring adequate resources and will be able to decide the extent to which others (government entities or business partners) contribute to that sustainability.**

State vs. Federal Exchanges - Conclusion

- On balance, it appears that a state-controlled Exchange would better service Missourians
- State control is especially important due to coordination and integration with Medicaid/CHIP
- In a time of heightened state budgetary concerns, operating a state exchange should not entail additional state outlays

Exchange IT Systems

Harvey Levin, KPMG

Missouri's Vision for Exchange Operations

- **Paperless and available 24/7**
- **Transparent and seamless to the applicant**
- **"No wrong door" streamlined application**
- **Accept applications:**
  - Online, in person, by mail, or by telephone
  - Through Exchange or State officials, Navigators, Agents and Brokers and employees working for other State health subsidy programs
- **Real-time eligibility determination**
- **Maximize consumer's ability to complete the application process**

Missouri's Vision: 24/7 Eligibility and Enrollment 365 Days a Year Untouched by Human Hands!

ShowMe Health Insurance Exchange

Eligibility Determination and Plan Selection for Adults and Children Only

Exchange Populations Adults and Children

Select Qualified Health Plans
1. Essential Benefits, if non-Medicaid
2. Medicaid Benefits, if Medicaid eligible

Enroll in Qualified Health Plan

Non-Exchange Populations ABD Populations

Family Support Division
Eligibility Determination for Populations Other Than Adults and Children

Technical Drivers

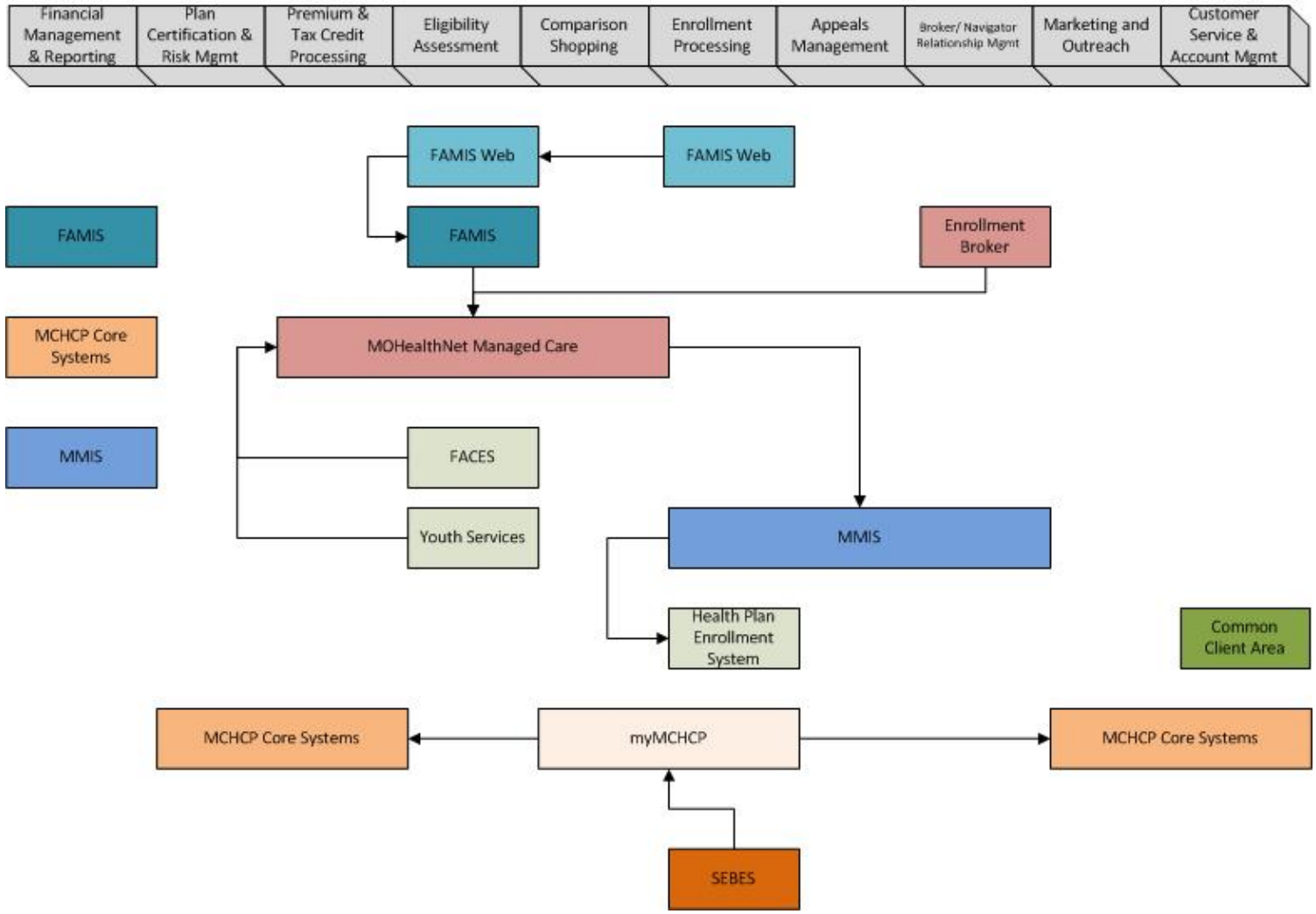
- **PPACA Legislation**
  - Standards
  - Real-time eligibility
  - MAGI, Expanded Coverage, etc.
- **Federal Drivers**
  - Standards compliance
  - Interface with Data Hub
  - Reusability
- **State Drivers**
  - Aging systems
  - Inability to meet ACA and Federal drivers
  - Future viability of Exchange or its components for other purposes
- **Early Innovators**
  - Status
  - Leverage-ability
  - KS Collaboration

Assessing Need

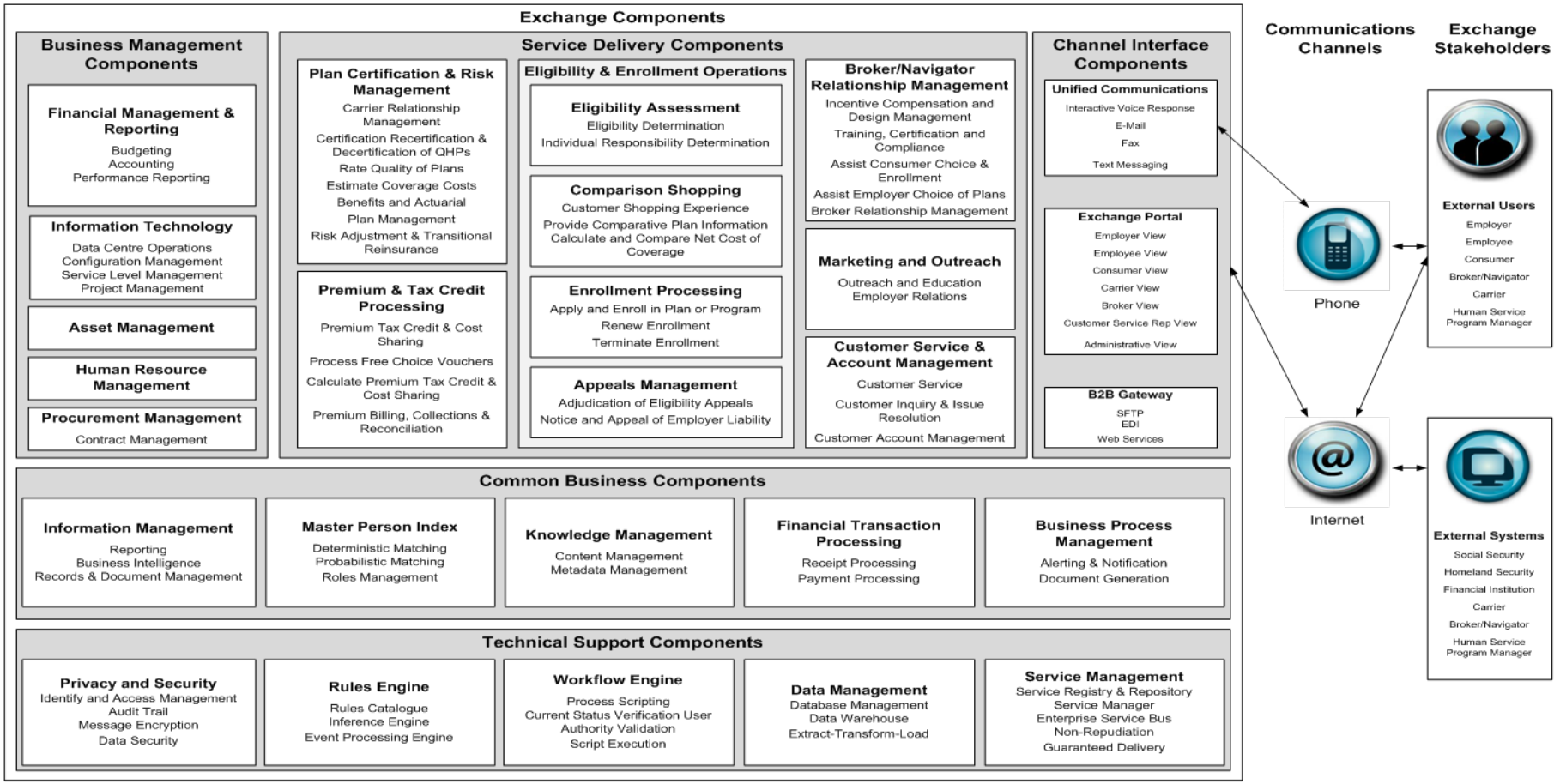
- **Goals**
  - How to construct the Exchange
  - Timely Implementation
  - Determine Cost
- **Inputs**
  - As-Is assessment of MO IT systems
  - To-Be Exchange architecture
  - Gap Analysis
- **Outputs**
  - IT Build Schedule
  - Cost models

KPMG

Current State Functional Alignment



To-Be Logical Exchange Architecture



To-Be Logical Exchange Architecture

- **Logical view of the Exchange architecture contains both functional and technical components required to meet ACA and other Federal requirements**
  - Functional – Service Delivery and Business Management components
  - Technical – Channel Interface, Common Business, and Technical Support components
- **Aligned with the emerging Federal model and the MO business process model**
- **Assumes a single Exchange for both SHOP and Individual but recognizes certain unique functions of a SHOP**
- **Designed to maximize flexibility and reuse**

KPMG

Gap Analysis and Findings

	FAMIS	FAMIS Web	MMIS	MO HealthNet Systems	SEBES	myMCHCP	MCHCP Core Systems
Privacy and Security	Y	Y	G	Y	Y	Y	Y
Business Rules Engine	R	R	Y	R	R	R	R
Workflow Engine	R	R	R	R	R	R	R
Data Management Enablers	Y	R	Y	R	R	R	Y
Service Management Enablers	Y	R	Y	R	R	R	R
Information Management	Y	R	G	R	R	R	G
Master Person Index	Y	R	R	R	R	R	R
Knowledge Management	R	R	R	R	R	R	R
Financial Transaction Processing	Y	R	R	R	R	R	Y
Business Process Management	Y	R	Y	R	R	R	Y
Unified Communications	R	R	Y	R	R	R	G
Exchange Portal	R	R	Y	R	R	R	R
B2B Gateway	Y	R	G	R	R	R	Y

G
- High component alignment
- High functional / technical capabilities
- Minor capability gaps

Y
- Average component alignment
- Medium functional / technical capabilities
- Some capability gaps

R
- Little component alignment
- Low functional / technical capabilities
- Significant capability gaps

Gap Analysis and Findings

- No Single System has Comprehensive Coverage
- There are differences between the Missouri and the CMS architectures
- No Systems Exhibit Strong Functional and Technical Alignment
- Some Systems May Have Some Reusable Technical Components

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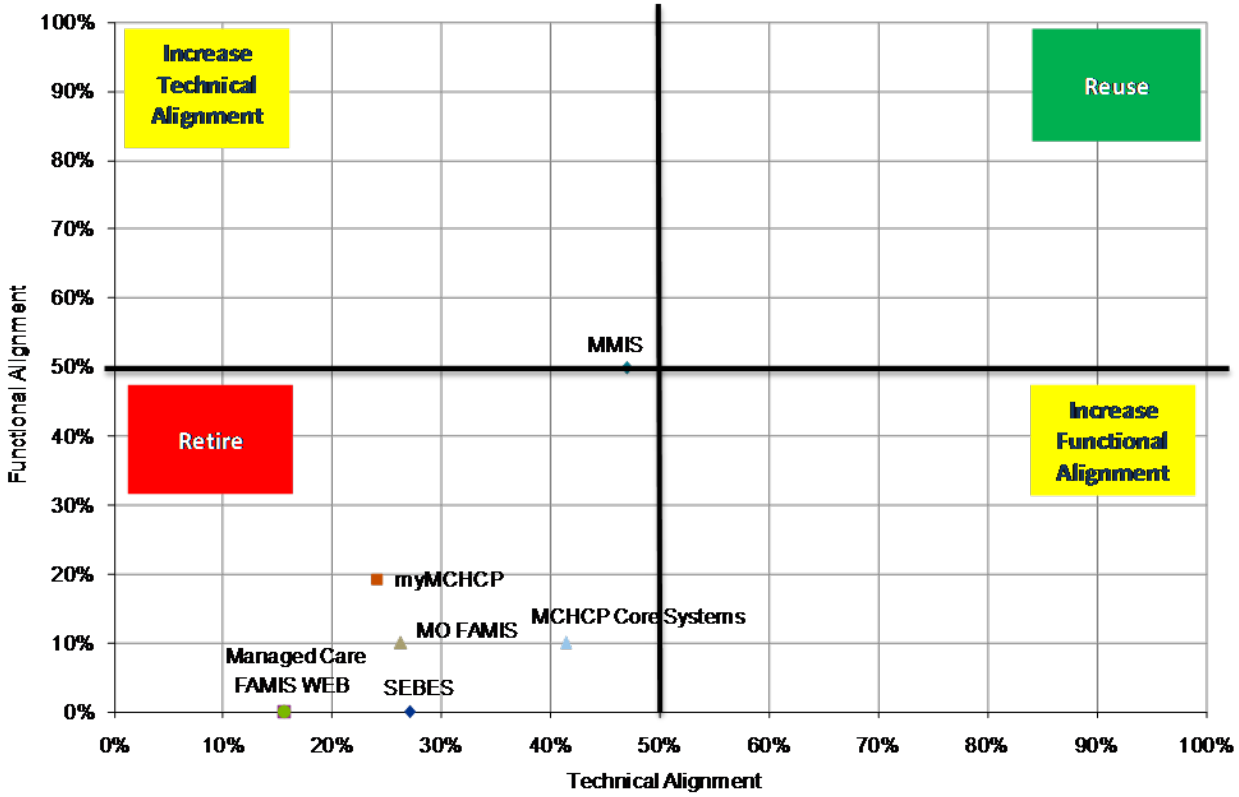
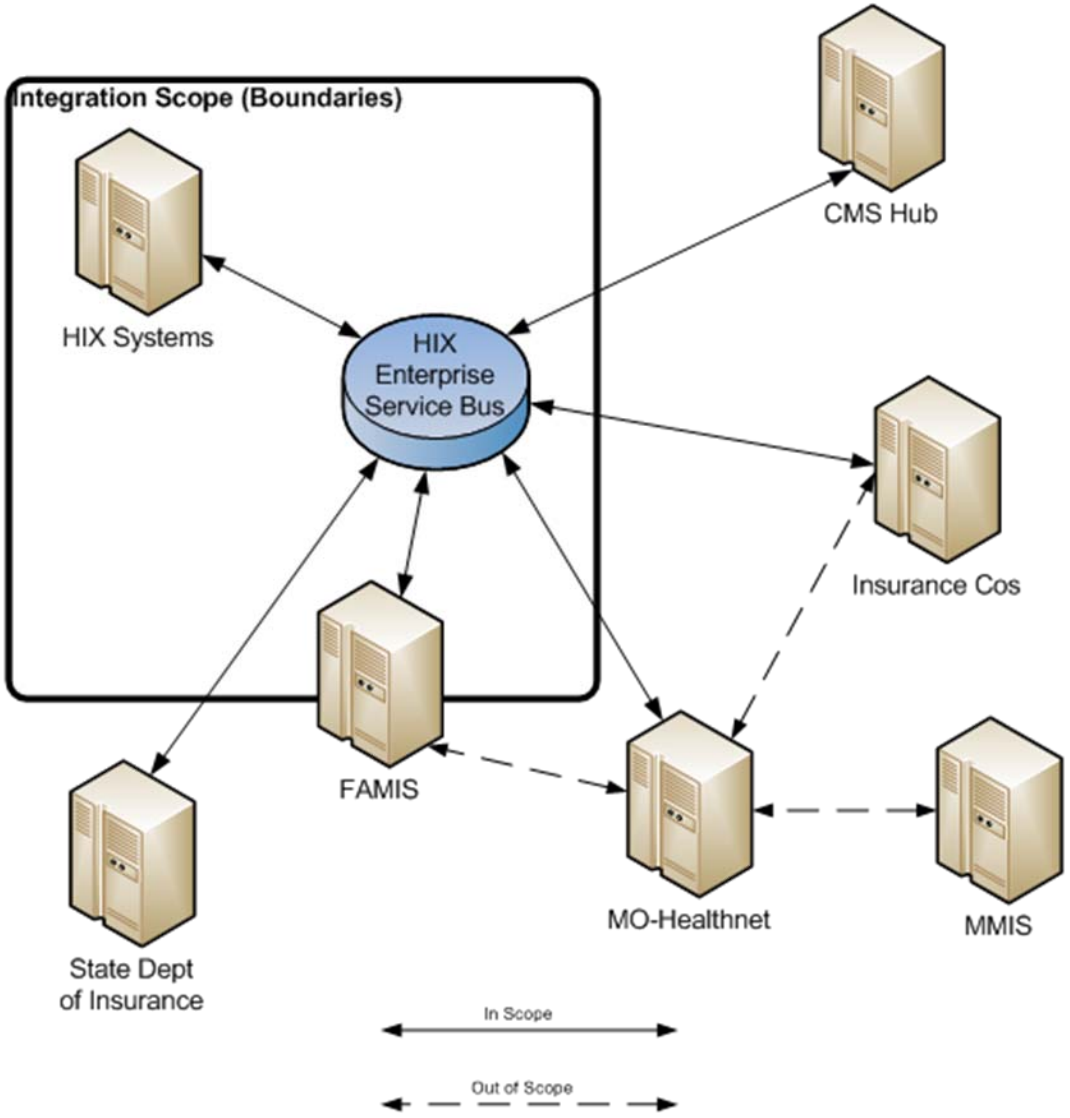
New Systems and Re-usability

- Top Right – good candidates for HIX reuse
- Bottom Left - not candidates for the HIX, likely retirement in a legacy renewal initiative
- Top Left - strong functional alignment but poor technical alignment; to reuse, technical platform improvement required
- Bottom Right - strong technical alignment but poor functional alignment; technical elements possibly reusable as a base to build out more aligned functionality



Integration to Existing Components



Key IT Decisions

Key Decisions

- Finalize Exchange business model
- Select an implementation strategy
- Acquire Exchange building blocks
- Identify and procure state resources, including existing business and technology resources for the project
- Implement a strong IT governance structure

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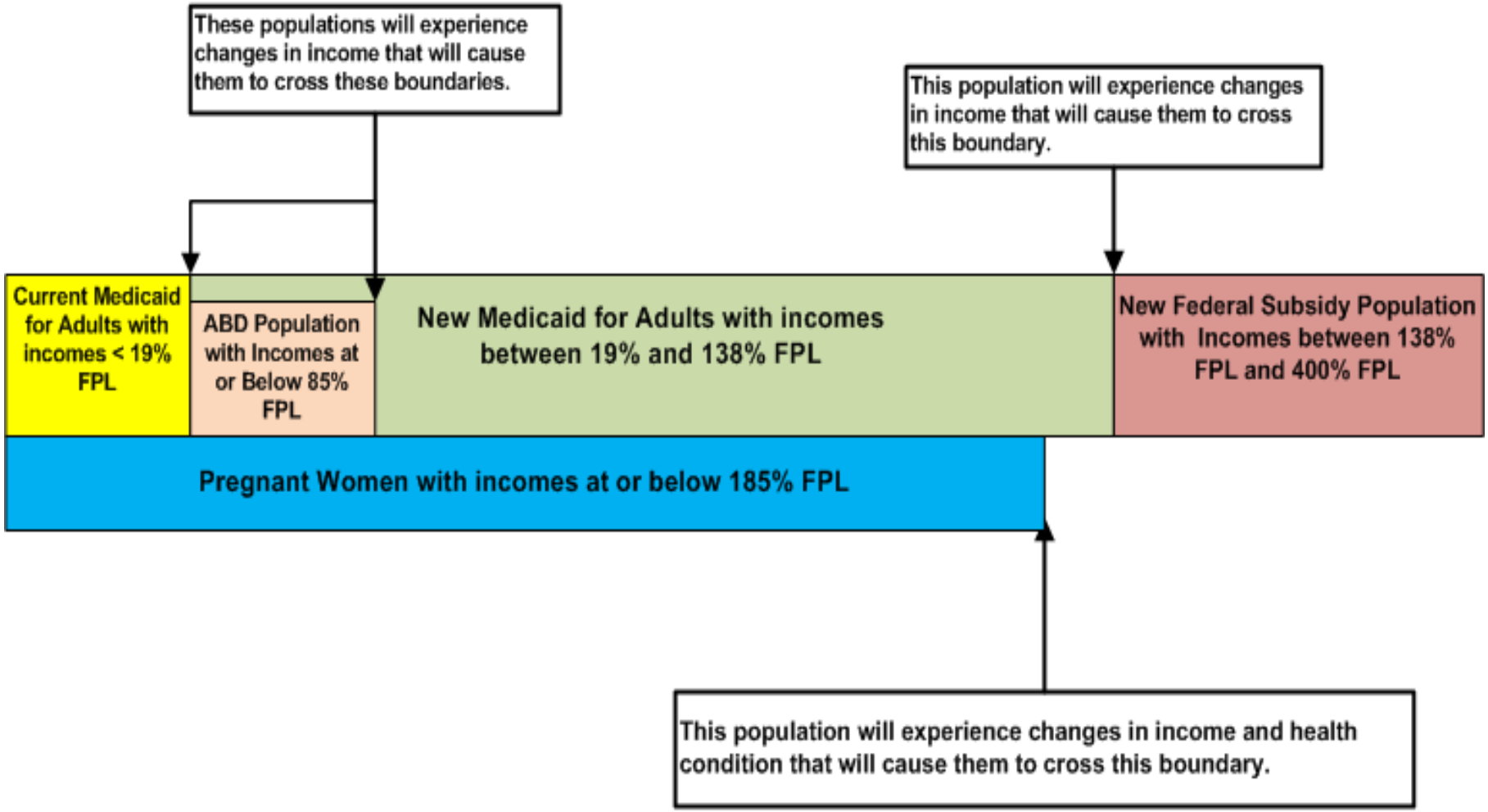
Medicaid Integration and Coverage Transitions

Marcia Morgan, Alicia Smith and Associates

ALICIA SMITH & ASSOCIATES, LLC
HEALTH & HUMAN SERVICES CONSULTING

Continuity of Coverage: The Problem



Continuity of Coverage Barriers

- **In 2014, for families with incomes below 200 percent of the FPL nationally:**
  - More than 35% of adults will experience a change in eligibility within six months;
  - 50% of adults will experience a change within one year;
  - 24% will churn at least twice within a year;
  - 39% will experience such churning within two years.

Source: Health Affairs, **"Issues in Health Reform: How Changes In Eligibility May Move Millions Back And Forth Between Medicaid and Insurance Exchanges ," February 2011.**

Continuity of Coverage Barriers

- **Eligibility for subsidy programs will change as families experience income fluctuations.**
- **As a result of shifting eligibility between Medicaid and subsidized private coverage:**
  - Missourians may face:
    - Gaps in coverage
    - Gaps in care
  - MO HealthNet and the Exchange may face:
    - Administrative complexity and cost
    - Instability of the Exchange risk pools
    - Limitations to cost prediction in the Exchange and Medicaid
    - Limitations to quality measurement and improvement activities

Continuity of Coverage Barriers

- **When consumers experience a shift in subsidy eligibility, they may experience:**
  - **A different group of participating health plans** requiring them to change plans.
  - **Different information about their plan choices for Medicaid v. private products** making it difficult to select a plan.
  - **Different benefit packages** requiring consumers to "re-learn" how to use their coverage and potentially disrupting treatment.
  - **Inconsistent provider networks** requiring consumers to change doctors.
  - **Premium pre-payment requirement for subsidized private coverage** creating a built-in coverage gap for consumers transitioning from Medicaid.

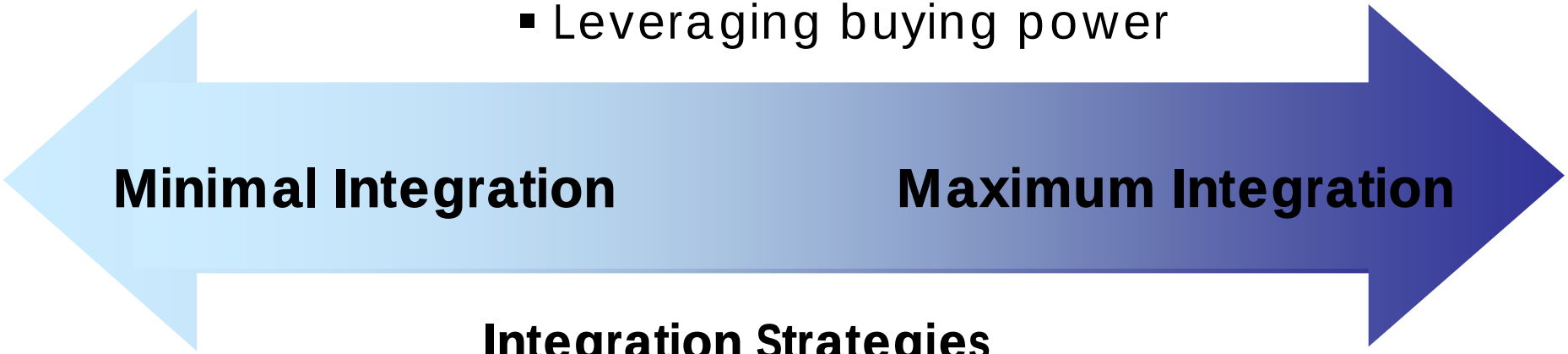
Continuity of Coverage Barriers

- **Families with child(ren) enrolled in CHIP and parents enrolled in essential benefits package with subsidies will be particularly impacted by factors that impede continuity:**
  - May be enrolled in different plans, with different networks, benefit packages, and coverage periods.

Medicaid/Exchange Integration Continuum

Integration Goals

- Facilitating transitions
- Leveraging buying power



Integration Strategies

- Contracted Plans
  - Marketing Rules
  - Quality Strategies
  - Reporting Requirements
- Benefits
- Provider Networks
- Basic Health Plan

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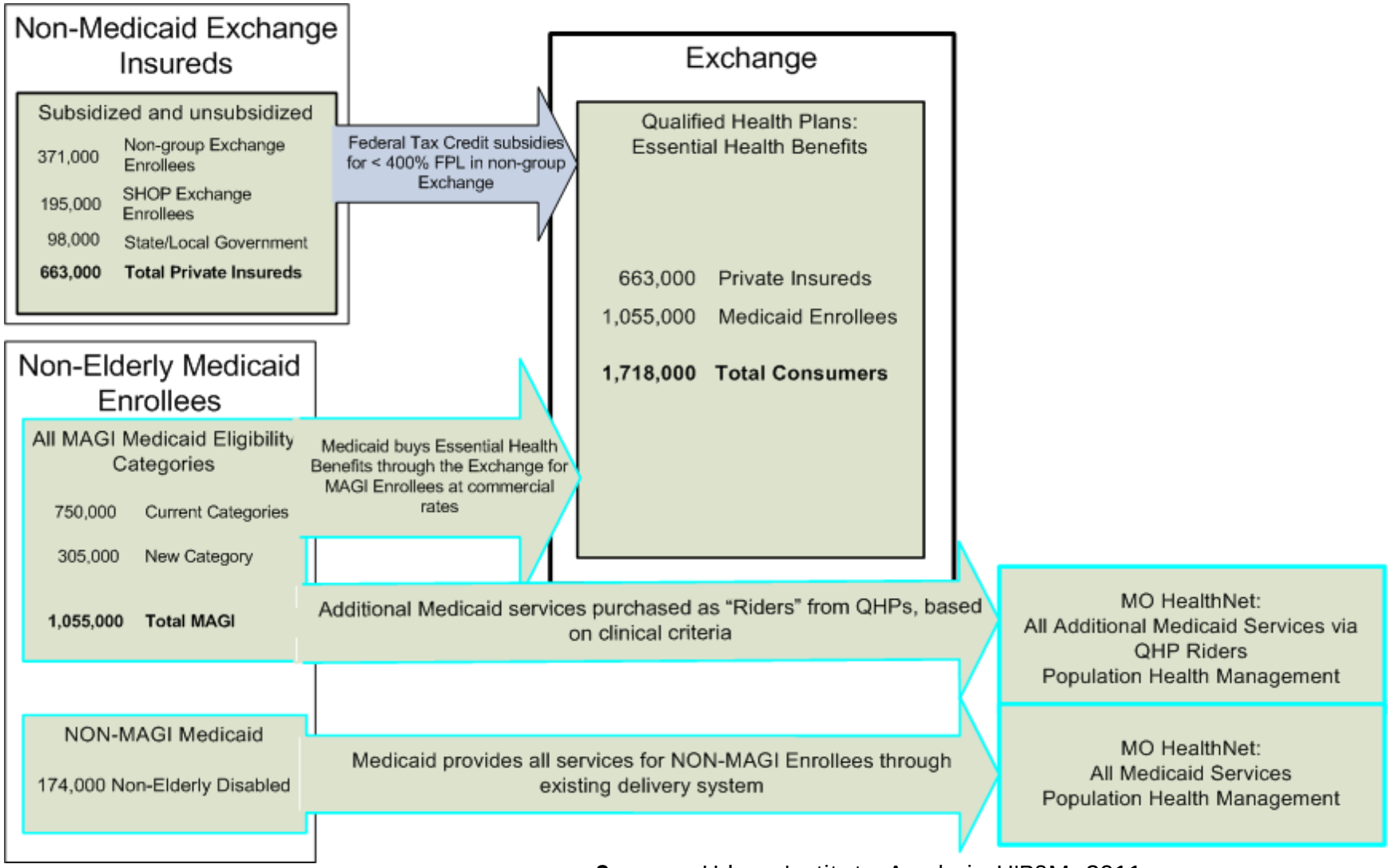
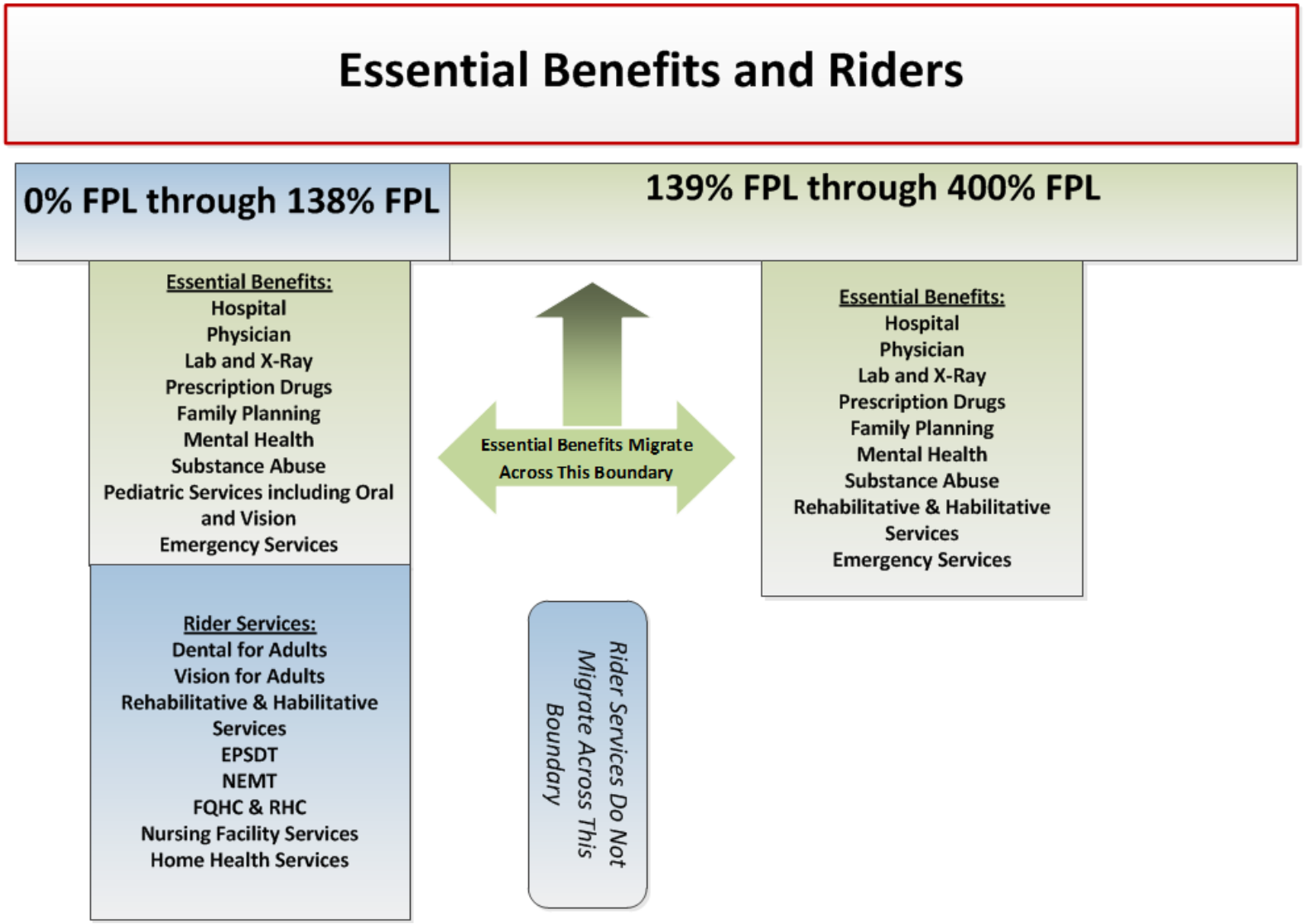
Continuity of Coverage: One Solution



Source: Urban Institute Analysis, HIPSM, 2011

Continuity of Coverage: One Solution



Management of Benefits Between Exchange and MO HealthNet

Benefit	Essential Benefits	Part A Services Available to All	Part B Services Available in Greater Quantity	Part C – Clinically-determined Services
Emergency Services	X			
Physician services	X			
Lab and x-ray	X			
Inpatient hospital services	X			
Prescription Drugs	X			
Outpatient hospital services	X			
Pediatric services including dental and vision	X			
Mental Health & Substance Abuse	X		X	
Rehabilitative and habilitative services	X		X	
EPSDT		X		
Family planning		X		
Non-emergency medical transportation		X		
Federally Qualified Health Care/ Rural Health Center services		X		
Nursing facility services				X
Home Health Care Services				X

Components of Cost - Children	Expenditures PMPY	Components of Cost - Children	Expenditures PMPY
HOSPITALS		NURSING FACILITIES	$0.00
INPATIENT	$959.92	IN-HOME SERVICES	
OUTPATIENT	$536.88	AIDS WAIVER	$0.00
DENTAL SERVICES	$57.02	PHYSICAL DISABLED WAIVER	$0.00
PHARMACY	$430.00	INDEPENDENT LIVING WAIVER	$0.00
PARTD-COPAY	$0.00	BUY-IN PREMIUMS	
PHYSICIAN RELATED		PART-A	$0.00
PHYSICIAN	$12.87	PART-B	$0.00
CLINIC	$206.05	MENTAL HEALTH SERVICES	
FAMILY PLANNING	$30.22	PRIVATE HOME ICF/MR	$0.00
X-RAY AND LAB	$21.18	MR/DD WAIVER	$45.28
NURSE PRACTITIONER	$0.62	PSYCH REHAB-PRIVATE	$0.00
PODIATRY	$1.55	CSTAR - PRIVATE	$29.19
CRNA SERVICES	$0.00	TARGETED CASE MANAGEMENT	$6.56
RURAL HEALTH CLINICS	$202.96	COMMUNITY SUPPORT WAIVER	$0.84
CASE MANAGEMENT	$0.05	STATE INSTITUTIONS	
FED QUALIFIED HEALTH CARE	$205.02	ICF/MENTALLY RETARDED	$0.00
PSYCHOLOGIST SERVICES	$21.85	MENTAL HOSPITAL	$0.00
IN-HOME SERVICES		PSYCH CARE UNDER AGE 22	$6.88
HOME HEALTH SERVICES	$1.16	PSYCH REHAB-PUBLIC	$46.28
ADULT DAY HEALTH CARE	$0.22	CSTAR - PUBLIC	$0.00
HOMEMAKER/RESPITE CARE	$0.00	TARGETED CASE MANAGEMENT	$19.86
PERSONAL CARE	$0.30	FSD CASE MANAGEMENT	$90.99
REHAB AND SPECIALTY SERVICES		EPSDT SERVICES	
AUDIOLOGY SERVICES	$0.50	EPSDT REFERRAL SERVICES	$176.40
OPTOMETRIC SERVICES	$16.54	EPSDT TARGETED CASE MGMT	$2.38
DURABLE MEDICAL EQUIPMENT	$28.10	Total Services Managed by the State	$424.65
AMBULANCE SERVICES	$16.87		
REHABILITATION CENTER	$0.32		
HOSPICE	$0.83		
NON-EMERGENCY TRANS	$10.57		
NON-PARTICIPATING PROV	$0.00		
COMPREHENSIVE DAY REHAB	$0.04		
DISEASE MANAGEMENT	$0.01		
EPSDT SERVICES			
EPSDT SCREENINGS	$41.47		
Total Services Included in QHP	$2,803.12		

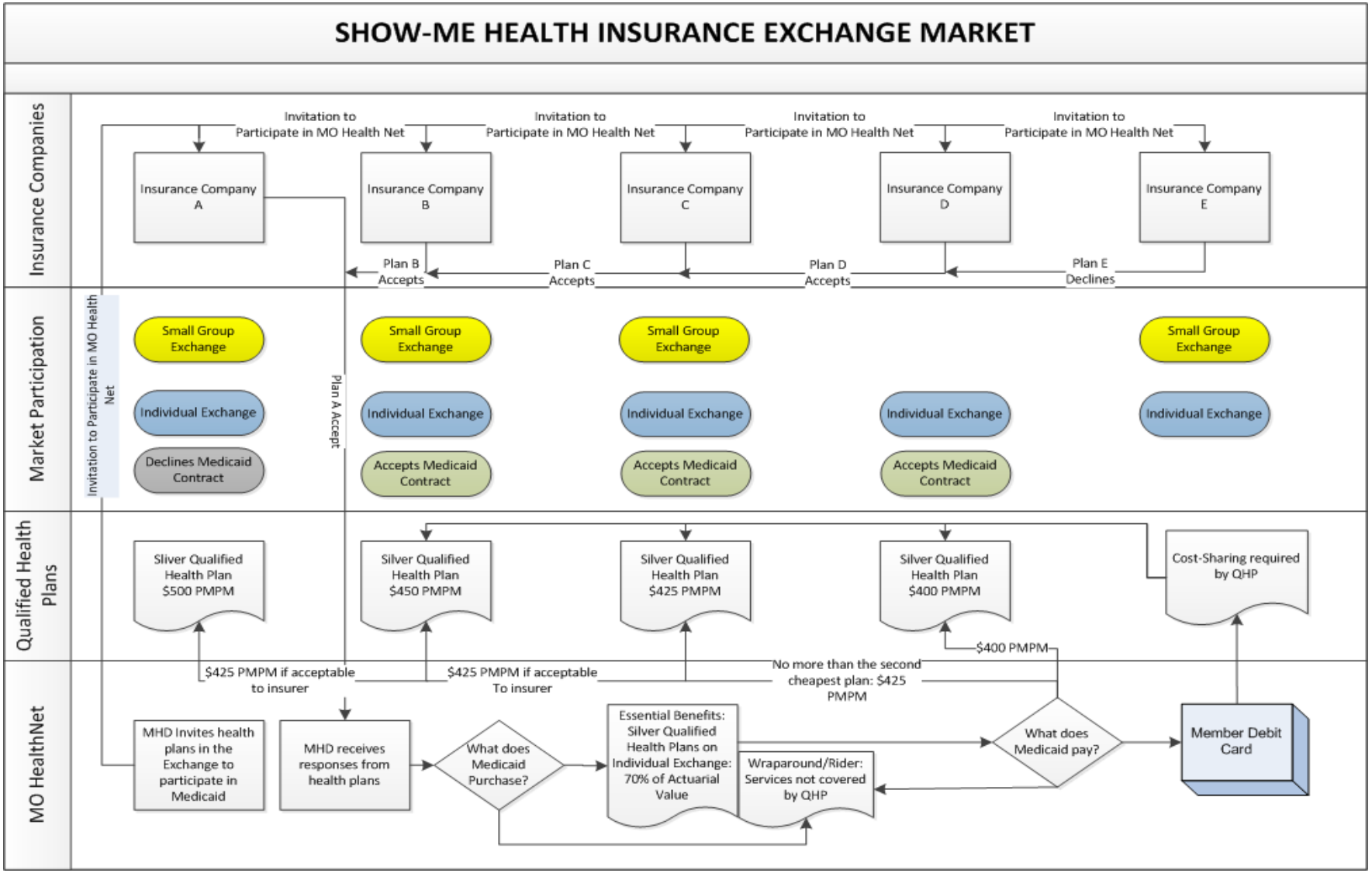
How Could MO HealthNet Purchase Through the Exchange?

- Current Medicaid plans would be encouraged to provide QHPs in the individual market
- MHD purchases silver QHPs for essential health benefits for MAGI Medicaid Population
- Medicaid beneficiaries enrolled in an MHD-contracted QHP receive an EBT/debit card to pay cost-sharing amounts above Medicaid requirements

How Could MO HealthNet Purchase Through the Exchange?

- **Medicaid beneficiaries in QHPs access additional Medicaid services (balance of state plan and 1915(c) services) based on clinical criteria/prior authorization**
- **No change for ABD populations**

How Could MO HealthNet Purchase Through the Exchange?



Questions and Discussion

Presentation to the MO HealthNet Oversight Committee

HARVEY LEVIN
Biographical Sketch

Harvey Levin is a Director in KPMG's Midwest Information Technology (IT) Advisory Services practice. Prior to joining KPMG, Harvey was the Practice Manger for a large consulting firm's Health and Human Services Solutions practice for North America and previously held positions with other nationally recognized Human Services IT consulting firms. Harvey has almost 30 years of proven consultative experience delivering information technology solutions to state, local, and federal government agencies. His experience includes executive management, project management, solution design, relationship management, contract negotiations, subcontractor management, and systems design, development, deployment, and maintenance.

Mr. Levin's career has been spent managing and delivering large-scale information systems, primarily in Health and Human Services, including systems for Welfare, Food Stamps, Medical Assistance, Job Employment and Training, Workforce Investment, Child Support, Child Care, Behavioral and Mental Health, and Child Welfare. These system implementations span the country and include the states of Rhode Island, Indiana, Massachusetts, Maine, Delaware, West Virginia, Nevada, Idaho, Hawaii, Connecticut, Ohio, Florida, Alabama, and the US Virgin Islands.

JOHN HUFF
Biographical Sketch

On February 6, 2009, Governor Jay Nixon appointed John M. Huff, a native of Potosi, Mo., as director of the Missouri Department of Insurance, Financial Institutions and Professional Registration. John was confirmed by the Missouri Senate on February 19, 2009. An attorney, John leads the department that protects consumers through the regulation of professionals and businesses that impact Missourians' lives daily. The department regulates more than half a million insurance companies, banks, doctors, nurses and others. He leads a team of 550 employees.

One of his top priorities is using technology to improve the efficiency and effectiveness of license applications, renewals, complaints, enforcement actions and board and commission nominations.
In September 2010, John was appointed to the U.S. Financial Stability Oversight Council by the National Association of Insurance Commissioners. He is the only insurance regulator on the council, which was created by the 2010 Dodd-Frank Wall Street Reform and Consumer Protection Act. In this role, John had the privilege of testifying before Congress on April 14, 2011, representing the state of Missouri and the NAIC.

In June 2011, John was elected by his peers as vice president of the Midwest Zone of the NAIC, making him a member of the association's Executive Committee. In December 2010 John was elected treasurer of the Interstate Insurance Product Regulation Commission, a partnership among state insurance regulators through the NAIC. The commission reviews several types of insurance policies, ensuring they meet certain standards before they are sold to consumers.

John serves as a director and trustee on several other boards promoting better financial services and education for Missourians:

- Missouri Consolidated Health Care Plan (chair), which provides health insurance coverage for state employees and retirees.
- Missouri Health Insurance Pool, a nonprofit high-risk pool that provides health insurance for Missourians unable to buy affordable coverage because of medical conditions.
- Missouri Council on Economic Education, which promotes economic and financial literacy.
- Missouri State Employees Voluntary Life Insurance Commission, which provides state-sponsored life insurance coverage to state employees.
- Alzheimer's Health State Plan Task Force, which will assess the impact of Alzheimer's and related dementia on Missourians, examine resources and make recommendations.

Before entering public service, John spent 11 years as an executive with leading insurers and reinsurers, including Swiss Re and GE Insurance Solutions. At these companies, John led global teams and was stationed in two different European markets: London and Zurich.

John earned his bachelor's degree in business administration from Southeast Missouri State University. In 1987, he earned an MBA at Saint Louis University, and graduated in 1990 from the Washington University School of Law in St. Louis. He and his wife and daughter live in Columbia.

MARCIA MORGAN
Biographical Sketch

Marcia Morgan has a distinguished, 27-year record in the public sector with a career history of being appointed to organizations experiencing dynamic change due to legislation or policy shifts at the state and federal government levels. Ms. Morgan has demonstrated unwavering commitment, professional competence and great versatility in the administration and management of complex government programs in five executive cabinets and two constitutional offices. Ms. Morgan is uniquely qualified to assist clients in meeting policy objectives while providing operational expertise and sound analysis to support policy and program changes in evolving and challenging state and federal government venues.

Prior to joining Alicia Smith & Associates, Ms. Morgan served in a number of management and policy positions with increasing decision-making authority and visibility. As Secretary and Chief Executive Officer of the Cabinet for Health Services (CHS) for the Commonwealth of Kentucky, Ms. Morgan was responsible for the operations of a multi-faceted, $5+ billion health care agency of 4,200 employees that encompassed Medicaid, Public Health Departments, Mental Health & Mental Retardation Services including state operated hospitals and residential facilities, Certificate of Need, Aging Services and The Commission for Women's Mental and Physical Health.

During and prior to her tenure as Secretary of CHS, Ms. Morgan:

- Served as the Governor's healthcare advisor to the National Governors Association (NGA).
- Led the Cabinet through a reorganization and business process reengineering initiative.
- Established an Olmstead Compliance Plan for the Commonwealth of Kentucky; the Plan incorporated an integrated network approach for the maintenance and establishment of a full array of services providing viable choice for Kentuckians.
- Implemented a consensus forecast approach to the Medicaid budget utilizing linear regression analysis and econometric models to support budget construct in conjunction with traditional utilization, expenditure and eligible population data.
- Was a key player in the Cabinet's Managed Care Development Team. The Team was charged with implementing regional not-for-profit partnerships under an 1115 demonstration waiver. The team's duties included RFP development, evaluation of proposals, contract negotiations and public relations.
- Helped develop and implement Kentucky's Children Insurance (K-CHIP) Program pursuant to Title XXI of the Social Security Act.

Ms. Morgan also served as director of the Office of the Public Accounts, Division of Performance Audit, director of unemployment insurance in the Workforce Development Cabinet, assistant deputy attorney general, as well as in the Natural Resources Cabinet — all with the Commonwealth of Kentucky.

Ms. Morgan received her Bachelor’s in General Studies — major in Political Science, minor in History — from the University of Kentucky.

MAYME YOUNG
Biographical Sketch

Mayme Young is an attorney with the Department of Mental Health working on various projects, including assisting Dr. Joseph Parks with the planning for Health Homes for behavioral and primary health and serving as a liaison with the Medicaid Audit and Compliance Unit (MMAC). Prior to joining the Department of Mental Health, Mayme served as Director of Constituent Services for Governor Nixon and as the Governor's liaison to the Department of Mental Health. Mayme was formerly an Assistant Attorney General in the Consumer and Financial Services Divisions and has practiced law in the private sector in both Austin, Texas and in her family's law practice in her hometown of Charleston, Missouri. Mayme earned her Bachelor of Science in Clinical Psychology in 1996 from Southeast Missouri State University in Cape Girardeau, and her law degree in 2000 from the University of Missouri-Columbia Law School.

MELINDA DUTTON
Biographical Sketch

Melinda Dutton serves as a Partner within the healthcare division of Manatt, Phelps & Phillips, LLP ("Manatt"), and also plays a leadership role within Manatt Health Solutions (MHS), an interdisciplinary policy and business advisory practice within the firm. Ms. Dutton's practice concentrates on advising clients in the healthcare industry with respect to regulatory, public policy and business matters. Ms. Dutton has extensive experience working with public health insurance programs and the healthcare safety net, and represents a broad array of health care clients in navigating the legal, regulatory and political challenges of Medicaid, SCHIP and other public programs. She assists health centers, hospitals, home care agencies and other providers with issues related to business strategy and reimbursement, as well as licensure and regulatory compliance. Ms. Dutton also provides strategic counsel, policy analysis and research support to foundations, think tanks and advocacy organizations for children, the disabled and other vulnerable populations. She has written extensively on the laws and systems that govern public health insurance programs, particularly as they relate to eligibility, benefit delivery and reimbursement, and is currently advising foundations, state governments and provider groups on the implications of health reform.

Ms. Dutton has been engaged in a wide variety of projects involving use of health information technology to improve the quality and efficiency of health care. She has supported statewide, multi-stakeholder health information exchange planning efforts in several states. She served as an adviser to New York State on the Health Information Privacy and Security Collaboration, where she identified laws, policies and business practices that support the private and secure exchange of health information, and has assisted states in developing strategic and operational plans to support both statewide health information exchange and implementation of Medicaid incentives under HITECH.

Ms. Dutton has served as a guest lecturer for numerous health law and policy courses at colleges and universities, including New York University School of Law, Columbia Law School and New York Medical College, and she has served as a practitioner-in-residence at Saint Louis University School of Law, the top-ranked healthcare law program in the country.

Ms. Dutton graduated from Kansas State University, B.A., Political Science, cum laude, in 1988, and Columbia Law School, J.D., James Kent Scholar, 1992.

PATRICK HOLLAND
Biographical Sketch

Currently the Managing Director of Wakely Consulting Group, Patrick Holland was one of the leading figures in the implementation of health care reform in Massachusetts. As the first Chief Financial Officer, Patrick led the financial operations and health plan procurements for the Health Connector, a first in the nation health insurance exchange, since its inception in 2006 through February 2010.

Since leaving the Health Connector, Patrick has been assisting federal and state governments in early planning for state-based benefit exchanges, working with provider-driven organizations to maximize performance under risk-based contracts, developing payment methodologies for a Medicaid demonstration waiver program, and developing a healthcare reform business strategy for a multi-specialty physician organization.

Mr. Holland has over twenty years of experience in the health care industry, including leadership positions at health insurers, integrated provider systems, and a national cost management organization.