MO HEALTHNET OVERSIGHT COMMITTEE MEETING
February 2, 2010
205 Jefferson Street
Jefferson City, MO

MINUTES

Members in Attendance
Steven Lipstein, Co-Chair
Steve Bradford
Heidi Miller
Joseph Pierle
Sen. Charlie Shields
Sen. Joan Bray
Rep. Rob Schaaf
Rep. Rebecca McClanahan
Ron Levy, DSS
Dr. Joseph Parks, DMH
Margaret Donnelly, DHSS

Members Absent
Gwen Crimm, Co-Chair
Laura Neal

DSS Staff in Attendance
Brian Kinkade, DSS
Jennifer Tidball, DFAS
Alyson Campbell, FSD

MHD Staff in Attendance
Ian McCaslin
George Oestreich
Judy Muck

MHD Staff (cont'd)
Marga Hoelscher
Billie Waite
Donna Siebeneck
Susan Eggen
Mary Ellen McCleary
Rhonda Driver
Angie Brenner
Diana Jones
Lisa Clements
Karen Purdy
Beth McQuaide
Mark Cicka

Others in Attendance
Terry Savela, The Lewin Group
Kathy Kuhmerker, The Lewin Group
Michelle Jore-Kampfrer, Wash U
Missy Waldman, Legal Services of Eastern Mo.
Joel Ferber, Legal Services of Eastern Mo.
Imre Komaromi, Independent Living Resource Center
Megan Burke, Disability Coalition on Healthcare Reform
Carolyn Klinglesmith, Mo. Homecare Union
Judy Stevens, Mo. Homecare Union
Joe Lawrence, Mo. Homecare Union
Amy Hoyt, Univ. of Mo. Center for Health Policy
Catherine Edwards, Mo. Assn. of Health Plans
Abby Warren, House Intern
Virginia Young, St. Louis Post Dispatch
Michelle Krajewski, The Whole Person
Angie WasDyke, Mercer
Michael Cook, Mercer
Will Richardson, SADI
Jim Swinger, ILC SEMO
Craig Henning, DRA
Mary Schantz, Mo. Alliance for Home Care
Rick Royer, Primaris
Norma Collins, AARP
Carolyn Chambers, RAIL
Grant Cale, BMS
Lana Baker
Chuck Graham
Wayne Lee, Disability Advocate
Gina Luebbering, OA Budget
Amy Schwartze, Behavioral Health Concepts
Steve Renne, Mo. Hospital Assn.
Jeff Hickerson, APS Healthcare
Brian Colby, Health Alliance
Leslie Anderson, Services for Independent Living-Columbia
Illegible – Services for Independent Living - Columbia
Tammie Barrett, DCAI
Carla Sellers, DCAI
Donna Nichols, DCAI
Steve Vaughn, DCAI
Courtney Zimmerman, DCAI
Judy Brennan, BA+
Pamela Johnson, Missouri Care
Ginger Steinmetz, Harmony
Joanne Volovar, Molina
Lovey Barnes, Molina
Chad Moore, CMFHP
Pam Victor, HCUSA
Dan Paquin, HCUSA
Kathy Whaley, HCUSA
Shelly Williamson, DHSS
Randy Rodgers, DHSS
Michael Armstrong, DHSS
Connie Boeckman, DHSS
Chris Larsen, DHSS
Patrick Lynn, DHSS
Nanci McAnaugh, DHSS
Illegible – InfoCrossing
Rachelle (last name illegible), Mo. Coalition

WELCOME/INTRODUCTIONS/MINUTES -- Steven Lipstein, Co-Chair, called the meeting to order at approximately 12:00 noon. Minutes from the October 27, 2009 meeting were reviewed and approved as submitted. The 2010 meeting schedule was reviewed, noting that the May meeting will be held on May 25 instead of May 4 as originally posted. Mr. Lipstein also reviewed the list of deliverables as a result of the comprehensive review of the MO HealthNet program. Some reports had already been shared with Committee members and posted to the MO HealthNet Division (MHD) website.

MO HEALTHNET ENROLLMENT BY ELIGIBILITY CATEGORY -- Summarizing the handout, Alyson Campbell, Director, Family Support Division, reported that the preliminary number of participants as of December 2009 totaled 881,119, with 37,107 additionally in women's health services. It was noted there have been increases in the enrollment in many categories, with a leveling in others. The June 2010 projection had been adjusted and reconciled with projections in the SFY 2010 supplemental budget request. The SFY 2010 budget was built on an enrollment of 811,000 plus anticipated case load growth in the permanently and totally disabled category of assistance; caseload growth had not been projected for children. The supplemental request is larger than in years past and reflects increased case load not included in the original budget request. Total budgeted participants in the supplemental request is 899,931.

FY 2011 MO HEALTHNET BUDGET OVERVIEW – Marga Hoelscher, Deputy Division Director-MO HealthNet Division, provided an overview of the MO HealthNet budget. Consensus revenue estimates (CRE) used in the SFY 2010 and SFY 2011 budgets was compared as well as general revenue growth rates from SFY 2005 to SFY 2011. SFY 2010 major revenue sources and assumptions made for SFY 2011 CRE were outlined. The Governor's recommendation for the SFY 2011 operating budget totals $23.8 billion total funds, of which $8.3 billion is general revenue (35%). General revenue reductions recommended in the Governor's SFY 2011 budget include $121 million in the MO HealthNet program and a reduction of 544 state employees. No staff reductions were recommended in the MO HealthNet Division. Funding for MO HealthNet is not only included in the Department of Social Services (DSS) budget, but also the Departments of Elementary and Secondary Education, Mental Health, and Health and Senior Services. New decision items requested in the SFY 2011 budget were outlined.

As a result of questions from Committee members it was noted that the enhanced FMAP falls into federal stabilization funds; Missouri is currently drawing approximately $150 million per quarter with the enhanced FMAP.

COMPREHENSIVE REVIEW – DSS Director Ron Levy opened with the background and rationale for undertaking a comprehensive review of the Medicaid program. The review was to encompass a number of areas, but three in particular: (1) comprehensive review of programs and payment rates; (2) program structure, resources, dashboard; and (3) review of the care management programs as well as opportunities for improvement in management of high risk and high cost populations.

This comprehensive review is in addition to an analysis of the historical record of managed care in Missouri in comparison with quality and access measures for the comparative fee-for-service population was provided by Alicia Smith & Associates at the October 2009 committee meeting. The MHD actuary, Mercer, also presented at the October meeting on the managed care cost avoidance model under development and a preliminary review of the cost effectiveness of the CCIP program.

Terry Savela and Kathy Kuhmerker, The Lewin Group, were introduced and gave a presentation. They discussed the assessment focus areas of their review and reports released thus far: Clinical Services, Short-Term Cost Containment, Long-Term Care Review, and Pharmacy. Preliminary overall observations show that MO HealthNet is a leader in implementation of health information technology and the commitment to care management of participants with chronic conditions. Missouri's use of provider taxes minimizes the state's general revenue commitment but also limits program flexibility. Reimbursement systems generally do not account for acuity but are based on units of care (days/hours).

Short-term cost containment opportunities were grouped by Lewin into six general categories: (1) rate changes; (2) benefit management; (3) provider taxes; (4) program integrity; (5) general taxes; and (6) other. A list of the opportunities and the associated budget savings were provided in the presentation. The opportunities were ranked based on savings potential, beneficiary and provider impact, and feasibility. Benefit reductions were not recommended for short-term cost containment, nor were eligibility reductions given the restrictions on same under ARRA provisions.

Long-term care – short-term opportunities were discussed. A comparison of national benchmarks revealed Missouri has, over the long term, significantly increased funding for home and community based services (HCBS), and that the state likely will need to rein in costs and/or utilization in this program for future sustainability. In addition, it was recommended that Missouri further decrease nursing facility utilization. Lewin presented a five-point plan: (1) manage and limit service utilization; (2) nursing facility right-sizing initiative; (3) maximize Medicare SNF benefit; (4) reduce selected HCBS payment rates; and (5) pursue structural changes.

The MO HealthNet Pharmacy program stands out nationwide as an exceptional program. The reimbursement is structured to support its provider tax. Recommendations were made for enhanced: (1) management of psychotropic medications to balance access with avoidance of excessive and unnecessary services; (2) intervention with high volume/high cost medication users ; (3) strengthening savings that occur under the managed care carveout; and (4) specialty pharmacy management strategies, i.e., consider selective contracting with specialty management organization(s) in targeted areas that can access lower average unit costs and safely deliver drugs to patients; (5) identify magnitude of waste and, if indicated, design a drug distribution strategy to decrease waste for unused drugs; (6) patient education regarding appropriate dosing schedules, managing side effects, and proper use and medication storage.

Based on the broad criteria of savings potential and current issues, five areas were identified for in-depth study as part of the Clinical Services review: (1) inpatient hospital – decrease length of stay and avoidable admissions; monitor and maximize contractor performance; restructure reimbursement methodology; transition to care management; monitor inpatient metrics; and coordinate care coordination program and inpatient review services; (2) outpatient hospital – target emergency room program to minimize inappropriate usage; ensure effective enforcement of outpatient prior authorization for imaging services; restructure outpatient reimbursement methodology; and shift routine physician care from outpatient hospital setting to less costly settings; (3) CCIP – exclude dual eligibles from the program for an immediate annual savings of $14.3 million; focus on high-risk/high-cost members amenable to intervention; enhance effectiveness of physician incentive payments; initiate hospital admission alert system to enable care coordination to extent to transitions in and out of hospitals; strengthen care coordination program contract procurement and payment terms; and tailor care coordination approaches to client situation; (4) DME – explore additional contracting mechanism; remove the 12% add-on payment made for certain rent-to-own items; monitor OIG initiatives

surrounding appropriate payment levels and potential fraud and abuse; and expand prior authorization list; and (5) hospice – reduce length of stay; strengthen certification and recertification requirements; monitor MedPac recommendations for potential program modifications; enhance claims monitoring.

Remaining deliverables as part of the comprehensive review include an assessment of the non-emergency medical transportation program, analysis of high-cost beneficiaries and high-volume providers; and the final assessment report. When available, these reports will be added to the other released reports on the MHD website at http://www.dss.mo.gov/mhd/oversight/reports.htm.

Comments from Committee members include, among others:

- Several members shared concerns about arbitrary caps on services; patients should be assessed on needs and unmet needs.
- Vendors often initiate orders for durable medical equipment and seek a physician's co-signature. Requests initiated by a vendor vs. the participant's physician should be red flagged.
- The objective assessment before using resources for long-term care should be spread to skilled nursing facilities as well and not isolated to home care agencies.
- The recommendations being made will impact the lives of participants in one way or another; be aware of unintended consequences.
- There is a fear that the program will lose specialty physicians by repricing services for dual eligibles.
- The suggested physician rate reduction of 80% of the Medicare rate should be across the board, not to just select provider groups.
- The recommendations on the whole appear sound; there is opportunity to improve care and save funds.
- It would be interesting to know the margins of home health care agencies vs. staff salaries.
- What is the correlation between personal services and personal care to keep a participant out of a nursing facility.
- Eliminate bureaucracies between federal and state programs. Look for adoption of common payment mechanism and policies. Can Medicaid operate under the same rule set as Medicare to make administration easier?

MANAGED CARE COST AVOIDANCE – In follow-up to discussions at the October 2009 Oversight Committee meeting, Angela WasDyke and Michael Cook, Mercer, presented that the managed care program is consistently showing savings relative to projected costs for a companion risk-adjusted population absent managed care. A managed care cost avoidance model was developed to answer the question "If the managed care program did not exist, what would the cost of the existing managed care eligibles be in the fee-for-service delivery system?" Using this model, the review indicated managed care costs were 2.7% lower in SFY 2009 over the fee-for-service benchmark costs. The benchmark is reflective of those populations that would be in managed care if it were offered in that geographic region. It does not include categories of assistance that are not currently eligible for managed care.

In response to questions from Committee members, Mercer advised that the model was based on a particular point in time; results may vary in different time periods. Now that a baseline is available it can be used for comparison purposes.

CCIP RETURN ON INVESTMENT – Mercer also presented the reports of the Chronic Care Improvement Program (CCIP) Financial and Clinical Evaluation. Return on investment (ROI) was presented comparing calendar year 2008 and state fiscal year 2008. The findings for calendar year 2008 yielded a 0.71 : 1 ROI.

Excluding dual eligibles for the same time period yielded a 1:6 : 1 ROI. Observations on other conditions where non-CCIP population was not of adequate sample size (excluding dual eligibles) were also presented.
Dual eligibles accounted for 48% of the CCIP population; an analysis of CCIP using only dual eligibles was not conducted. It was noted the clinical outcome measures lag behind financial outcome measures. As the program matures a better clinical matrix is expected that may show differences in outcomes.

Comments/questions from Committee members included, among others:

- Be cautious about speculation of ongoing disease improvement with narrow model. Intervention of the combination of a doctor/nurse/case manager is very effective.
- Participants receive better care if they are included in CCIP. Concern was expressed for other resources and quality of services if dual eligibles are removed.
- There are community support and case management programs through the Department of Mental Health for individuals with mental illness.

PUBLIC COMMENT – Five individuals offered public comment. Mary Schantz, Missouri Alliance for Home Care, urged the elimination of the homebound requirement to qualify for home health services; Missouri is the only state that has not done so. She spoke to several specific recommendations related to the Lewin Group report: MO HealthNet Long Term Care Review – Cost Containment Opportunities. Among others, Ms. Schantz questioned the need for an assessment conducted by a third party vendor; encouraged the continued development and use of a web-based assessment tool for home and community based long term care; cautioned that caps to utilization will add nursing facility care; telephony could be good idea but is limited if tied to phone as many rural clients do not have land lines. Ms. Schantz recommended the State work with the Centers for Medicare and Medicaid Services to find another way to implement the home health provider tax.

Megan Burke, with Paraquad, a Center for Independent Living in St. Louis, spoke on behalf of the Disability Coalition on Healthcare Reform (DCHR). DCHR believes healthcare and long term care systems should create opportunities and remove barriers to allow full participation in all aspects of community life. Cost savings measures must act in congruence with the Olmstead Decision. Key points of the presentation included that personal care hours should be determined by assessed need, and not an arbitrary cap; the assessment process must assure full informed choice and access to services and support; use of telephony for attendant reporting should not be mandatory; utilization review and other oversight mechanisms should assure that people are receiving the services they need; and Missouri's long term care system should promote independent living and community access for people with disabilities.

Wayne Lee, a disability advocate, indicated he is also a dual eligible. Mr. Lee supported the concepts presented in the public comments already voiced. He added that the key to medical care is recognizing and following the individual concept. He suggested asking questions such as what is the individual's diagnosis, how well do they function, what are factors impacting their health, where do they reside; what help do they need.

Norma Collins, Advisory Director of the Missouri Office of the American Association of Retired Persons, spoke on recommendations raised related to long term care in the Lewin Report. Comments included encouraging the pursuit of recommendations noted to right size the institutional capacity in Missouri; more emphasis should be placed on expanding and improving home and community based services; work on suggestions in the Lewin report related to improving the intake/process, more case

management, finish developing the single point of entry; and implementing an assisted living waiver. Ms. Collins urged caution about imposing hard caps on personal care services; expressed concern about reducing rates to home and community based services providers without more study; and offered support of many of the structural reforms, i.e., agency/program consolidation.

Carolyn Klinglesmith, Missouri Homecare Union, indicated support for self determination, lowering of barriers, and improvement of the ability to live independently. Since states are looking at ways to rely more on home care to reduce nursing facility care, it doesn't make sense to target that program for cuts. Instead of a person centered program, the proposed budget limits utilization to 60 hours per month, which equates to two hours per day; this does not keep individuals out of a nursing home. Among other points, Ms. Klinglesmith spoke on the telephony proposal and cautioned that a large number of consumers do not have access to land line telephones; added that cuts to the home care program will not save money in long-run; and that the proposed new assessment system duplicates what is already done.

QUESTIONS/ADJOURN -- Copies of meeting materials and presentations will be made available on the MO HealthNet Oversight Committee Web page at: http://www.dss.mo.gov/mhd/oversight/index.htm.

Co-Chair Steve Lipstein adjourned the meeting at 4:05 pm. Next meeting is May 25, 2010.