MO HEALTHNET OVERSIGHT COMMITTEE MEETING
November 9, 2010
205 Jefferson Street
Jefferson City, MO

MINUTES

Members in Attendance
Ingrid Taylor, MD
Timothy McBride, PhD
James McMillen, MD
Gerard Grimaldi
Kecia Leary, DDS
Corinne Walentik, MD
Carmen Parker Bradshaw
Sen. Joan Bray
Sen. Charlie Shields (via phone)
Rep. Rob Schaaf
Rep. Rebecca McClanahan

Members in Attendance (cont'd)
Brian Kinkade for Ron Levy
Margaret Donnelly
Dr. Joe Parks

Members Absent
Laura Neal

DSS Staff in Attendance
Emily Rowe, FSD
Ian McCaslin, MHD
Marga Hoelscher, MHD
George Oestreich, MHD
Rhonda Driver, MHD
Karen Purdy, MHD
Beth McQuaide, MHD
Diana Jones, MHD
Jayne Zemmer, MHD
Lisa Clements, MHD
Susan Eggen, MHD
Betty Council, MHD
Debbie Goeller, MHD
Mark Cicka, MHD
Theresa Valdes, MHD

Others in Attendance
Jade D. James, MD
Amy Schwartz, BHC
Sam Richardson, Molina
Celesta Hartgraves, DHSS
Jim Burns, CMS
Ginger Steinmetz, Wellcare
Mayme Miller, DMH
Donna Siebeneck, DMH
Joe Bindbeutel, MFCU
Swarna Vallurgall
Iris Tiango
Megan Burke, Paraquad and DCHR
Missy Waldman, Legal Services of Eastern Missouri
Jennifer Bauer, MO Academy of Family Physicians
Susan Wilson, MO Primary Care Assn.
Christian, Jensrud, Amerigroup
Donnel Cox, DentaQuest
Steve Renne, MO Hospital Assn.
Pam Victor, HealthCare USA
Joanne Volovar, Molina
Lovey Barns, Molina
Ryan Randall, Molina
Judy Brennan, BA+
Chad Moore, Children's Mercy-Family Health Partners
Liz Peterson, MD, Children's Mercy-Family Health Partners
Susan Henderson Moore, Polsinelli Shughart

WELCOME/INTRODUCTIONS/MINUTES – Dr. Ian McCaslin, Director-MO HealthNet Division, called the meeting to order at approximately 12:00 noon. Minutes from the May 25, 2010 meeting were reviewed and approved as submitted. Dr. McCaslin introduced new members to the Committee: Ingrid Taylor, MD, Timothy McBride, PhD, James McMillen, MD, Gerard Grimaldi, Kecia Leary, DDS, Corinne Walentik, MD, and Carmen Parker Bradshaw. The proposed meeting schedule for 2011 was reviewed. Members were asked to submit any major conflicts with any meeting dates. Dr. McCaslin pointed to the Puzzled by the Terminology handout which explains eligibility codes, benefit packages, premium payments, and contact/help line numbers. Also included in the handouts was a list of frequently used acronyms.

MO HEALTHNET ENROLLMENT BY ELIGIBILITY CATEGORY– Summarizing the handout, Emily Rowe, Manager for the Family Support Division Income Maintenance Program and Policy Unit, reported that

preliminary participants as of September 2010 totaled 898,585 with an additional 53,833 receiving women's health services. The chart reflects that of the 898,585, 60.3% are children, 18.5% are persons with disabilities; 9.3% custodial parents, 8.7% seniors defined as individuals 65 or older; and 3.2% are pregnant women. The growth since March 2008 has been seen predominantly in children, while the bulk of program expenditures are for persons with disabilities. The MO HealthNet program enrollment typically cycles with the economy; in years with poor economy increased enrollment is experienced. The women's health services program is a limited benefit eligibility category, essentially family planning services. A higher federal match is allowed for these services. The number of participants is not typically included in overall MO HealthNet eligibility number. There are approximately 70,000 children enrolled in CHIP.

Speaking from a PowerPoint Ms. Rowe compared federal mandated coverage levels to Missouri's levels:

- Pregnant women: Federal mandated level 133% FPL; Missouri 185%
- Preschool children: Federal mandated level 133%; Missouri 300%
- School-age children: Federal mandated level 100%; Missouri 300%
- Seniors and persons with disabilities: Federal mandated level 74%; Missouri 85%
- Custodial parents: no federal mandate; Missouri 19%
- Childless adults: no federal mandate; Missouri does not cover

As a result of a question from a committee member, it was discussed that there would be a federal mandate effective in 2014 to cover individuals under the age of 65 who are not pregnant and do not have Medicare coverage with income under 133% FPL. This would include custodial parents. There will be 100% federal match for the first three years, with a gradual phase down.

The history of the coverage of seniors and persons with disabilities and custodial parents was reviewed. At one point Missouri covered seniors and the disabled up to 100% FPL; current level is 85%. The history of coverage for custodial parents was not readily available.

Different programs and poverty levels for eligibility were discussed as well as the federal poverty guidelines. Refugee is defined under the Immigration and Nationalization Act. When determining eligibility, eligibility specialists look first to determine if an individual meets the eligibility criteria in other categories. Under the refugee program individuals are only eligible for eight months from their date of entry into the United States and must be declared a refugee. Individuals have to be in the country five years otherwise before they would be eligible.

Charts depicting national comparisons of coverage of nonelderly residents, Medicaid eligibility for working parents by income, children's eligibility for Medicaid/CHIP by income , and children's participation in Medicaid and CHIP were discussed.

BUDGET OVERVIEW—Marga Hoelscher, Chief Financial Officer, MO HealthNet Division, provided an update on the consensus revenue estimates used during the SFY 2010 budget year. A chart of general revenue sources was also shared. General revenue growth rates over the past several fiscal years were also reviewed. A description of the state appropriations process within the Governor's Office and both the Senate and House of Representatives was provided as well as sources of funding for the SFY 2011 total operating budget. Revenue breakdown in the over $23 billion budget was shared:

- General revenue -- 33.7%
- Federal funds -- 30.2%
- Budget stabilization funds (ARRA) -- 1.2%
- Other funds -- 34.9%

Examples of services funded with general revenue include MO HealthNet ($1.5 billion), Non-Medicaid Department of Social Services ($356.1 million); Elementary and Secondary Education ($2.72 billion); Higher Education ($911.6 million); Corrections ($593.4 million); Mental Health ($575.4 million); employee benefits ($532.8 million); and the judiciary system ($169.1 million).

A chart depicting Medicaid funding outside of the Department of Social Services was also shared. Funding within the Department of Mental Health is primarily used for residential care facilities within the Division of Mental Retardation and Developmental Disabilities. Home and community based services -- i.e., personal care, home health, respite -- are funded through the Department of Health and Senior Services.

SFY 2012 new decision items (NDI) were discussed. An NDI is funding needed on top of the level of spending from the prior fiscal year. Medicaid is an entitlement program which must be funded. Caseload growth estimates included in the NDI were reviewed. The growth estimates are continually reviewed and refined during the budget process.

MO HealthNet Division as submitted a supplemental budget request for SFY 2011 totally $96,231,998. Underfunding of the caseload growth in the SFY2011 budget process as well as hospital growth attributed to the request.

Ms. Hoelscher also reviewed the Expenditures by Large Eligibility Group handout which provides a breakdown of the populations and their corresponding expenditures. As previously noted, the permanently and totally disabled is the most expensive population from the per member per month basis. The average Medicaid per diem for nursing facilities is $132/day. Of note, the chart does not depict add-on payments to hospitals that are not specifically tied to a category but is based on paid claims. Pharmacy is carved out of managed care costs.

Question was raised if there is any correlation between in home services and the reduced nursing home days. Ms. Hoelscher explained that growth in in-home services (personal care) is being experienced while nursing home days are relatively flat. Home health services are administered after a hospital stay. Individuals must meet a certain level of care to qualify for in home and nursing home services. As requested, a breakdown of services included in the rehab and different care categories will be provided.

MO HEALTHNET OVERVIEW – Dr. Ian McCaslin, Director, MO HealthNet Division, discussed the history of Medicaid. The Medicare and Medicaid programs were signed into law on July 30, 1965 by President Johnson at the Truman Library in Independence, Missouri. The first Medicare patient was President Harry Truman. Over time, Medicaid expenditures have actually topped Medicare, which was not predicted at the time of inception. Primary groups covered by Medicaid were reviewed -- -- children, elderly, and the disabled. Challenges from the patient or parent's point of view were discussed, including transportation, access, and quality of service. Overall, however, most are appreciative of the program.

Dr. McCaslin's goal is for MO HealthNet, Missouri's Medicaid program, to be run as a health system which uses evidence based best practices, embraces technology, and is a patient-centered medical home. Medicaid is more than health insurance for low-income families, the elderly, and persons with disabilities. It holds the health care system together for many community health centers. A substantial

portion of Medicaid is spent in long term care, including home and community services and nursing facilities, as well as mental health services.

A map depicting MO HealthNet participation per 1,000 population was shared. Missouri provides services to MO HealthNet participants via two delivery systems: traditional fee-for-service and managed care. A chart depicting average yearly costs per member was viewed as well as a comparison of national managed care trends with Missouri's experience. Dr. McCaslin challenged the committee to determine improvements to the delivery system to maximize expenditures -- value based purchasing.

MANAGED CARE OVERVIEW—Susan Eggen, MO HealthNet Division, reported that Section 208.166, RSMo, provides authority to purchase medical services from health plans. Federal legal authority sections were also outlined. Missouri Medicaid managed care is comprised of three population groupings: parents/caretakers, children, and pregnant women; foster care children; and children in CHIP. Managed care enrollment is mandatory for individuals in these categories of assistance who reside in one of the 54 managed care counties. Total managed care enrollment as of September 24, 2010 was 425,312. A map depicting the three managed care regions was provided as well as the managed care enrollment by region and the health plans in each region.

Health plans under contract to provide services to managed care participants are required to provide certain benefits, such as primary and specialty primary care, maternity services, inpatient and outpatient hospital, mental health, home health, laboratory and diagnostic, and durable medical equipment. In addition, some plans offer additional services, i.e., circumcisions, WIC service, expanded transportation services, incentives for OB care appointments; home monitoring equipment, comprehensive obesity management services. These additional services vary by health plan and must be approved by the state and federal partners prior to initiation.

There are service accessibility standards in place, something that does not exist in the fee-for-service program, and these standards are enforced by contract. Examples include appointment standards, maternity care, prior authorization, and travel distance. These standards were outlined in Ms. Eggen's PowerPoint presentation.

Medicaid reimbursement is currently about 60% of the Medicare rate. Financing will be available from the Federal government in 2013 and 2014 to bring primary care driven codes to 100% of the Medicare rate with the goal of encouraging participation in the program. Permanently and totally disabled individuals are not included in managed care, making their access often questionable. The current rate structure is a barrier in both the fee-for-service and managed care programs.

As a result of a committee member question it was noted that the majority of providers participate in MO HealthNet, but a large percentage limit the number they will accept. While provider participation varies by location and provider type, the biggest challenge is in specialty care and dental services.

Department of Insurance, Financial Institutions, and Professional Registration (DIFP) standards apply to MO HealthNet plans as well as the commercial market, and health plans are required to submit an annual access plan to DIFP by March 1. The average enrollee access rate in each county in the health plan's approved service area must be 90% or better. It would not be known if the provider places limits on the number of MO Health Net participants they accept as patients.

MANAGED CARE QUALITY MEASURES -- Dr. Elizabeth Peterson, Children's Mercy Family Health Partners, spoke to the committee in her role as chair of the MO HealthNet Quality Assurance and Improvement Committee. Speaking from a PowerPoint, Dr. Peterson discussed the value of a case management system, i.e., increased adherence to treatment plans, improved outcomes, increased doctor visits. MHD requires the health plans to administer disease management programs for major depression, asthma, and one of the following: obesity, diabetes, hypertension, or ADHD. Claims and pharmacy data are used to find members who qualify for case and disease management. Early identification of high risk members increases the success rate. All health plans profile their providers on access, quality, and outcomes for members in their care; the plans also monitor for fraud and abuse. The health plans also review high cost items and/or procedures for appropriateness of service and to identify members for case management or other programs.

Per contract, the health plans must conduct one clinical and one non-clinical improvement project annually. Plans must work together on one project selected by MHD, i.e., adolescent well care, dental utilization. Health plans are allowed to incentivize members to achieve outcomes such as increased access to care, member compliance with prenatal and postnatal visits, and increased screening rates.

Health plans have been recognized for best practices in the areas of member outreach and education; member education on screenings and disease management; member education and preventive services; culturally sensitive care by providers; enrollment into Head Start, preventive services, parent health literary; and improved pregnancy outcomes.

The new managed care contract requires the health plans to be NCQA accredited by October 2011. Dr. Peterson described the NCQA standards, accreditation guidelines, as well as the scheduled site visits. Also discussed were Healthcare Effectiveness Data and Information Set (HEDIS) measurements.

The managed care contract sets out service and performance standards. The health plans are subject to significant requirements from various federal and state organizations and are accountable to these entities.

AFFORDABLE CARE ACT; HITECH AND ELECTRONIC TOOLS – Due to time constraints these issues were pended until the February committee meeting.

OPEN PUBLIC COMMENT -- Megan Burke, Paraquad, also spoke on behalf of the Disability Coalition on Health Care Reform. The Coalition is a statewide organization that was founded in 2005, the goal of which is to improve access for individuals with disabilities. Ms. Burke distributed a document that raises concerns regarding implementation of managed care for individuals with disabilities. The report cites many challenges that Missouri would face in such a program. The Coalition encourages the state to increase the quality in the current managed care program before expanding to individuals with more complex needs, and is open to working with state officials to develop solutions.

ADJOURN – Dr. McCaslin expressed appreciation to the elected officials who would be leaving the Committee at the end of the calendar year: Sen. Joan Bray, Sen. Charlie Shields, Representative Rebecca McClanahan, and Representative Rob Schaaf. A full committee is anticipated at the February 8, 2010 meeting at which time a chair will be elected. Dr. McCaslin adjourned the meeting at 3:45 pm.