MO HEALTHNET OVERSIGHT COMMITTEE MEETING

August 9, 2011
1706 East Elm Street
Jefferson City, MO

MINUTES

Members in Attendance
Timothy McBride
Gerard Grimaldi
Kecia Leary
Corinne Walentik
Mark Sanford
Joseph Pierle
Bridget McCandless
Senator Rob Schaaf
Ingrid Taylor
Rep. Jeanne Kirkton
Rep. Keith Frederick
Senator Joseph Keaveny

Members in Attendance (cont'd)
Ian McCaslin
Margaret Donnelly
Mayme Young for Dr. Joe Parks

Members Absent
James McMillen
Carmen Parker Bradshaw

DSS Staff in Attendance
Emily Rowe, FSD
Marga Hoelscher, MHD
Rhonda Driver, MHD
Karen Purdy, MHD
Beth McQuaide, MHD
Geoff Oliver, MHD
Mark Cicka, MMAC
Dwight Fine, DSS

Others in Attendance
John Huff, Dept. of Insurance, Finance, and Professional Registration (DIFP)
Matt Barton, DIFP
Harvey Levin, KPMG
Andrew Gottschack, KPMG
Ian Gilmoor, KPMG
Melinda Dutton, Manatt
Larry Rohrbach, Coventry
Imre Komaromi, Independent Living Resource Center
Andrea Routh, MO Health Alliance
Megan Burke, Paraquad/DCHR
Missy Waldman, Legal Services of Eastern Missouri
Karen Newbury, Legal Services of Eastern Missouri
Steve Renne, MO Hospital Assn.
Chris Dunn, Missouri Senate
Melba Price, Maximus
Chris Moody, James R. Moody & Associates
Susan Henderson Moore, Polsinelli, Shughart
Katie Barr, MO Coalition of CMHCs
Lana Baker, Lobbyist
Pam Victor, HealthCare USA
Lovey Barnes, Molina
Sam Richardson, Molina
Tina Gallagher, Molina
David Garrett, BA+
Judy Brennan, BA+
Chad Moore, Children's Mercy- Family Health Partners
Amy Schwartz, BHC
Donnel Cox, DentaQuest
Danny O'Nell, MO Primary Care Association
Harry Hill, Merck
Berend Koops, Merck

WELCOME/INTRODUCTIONS/MINUTES – Dr. Corinne Walentik, Chair, called the meeting to order at approximately 12:00 noon. Dr. Leary motioned for approval of the June 7, 2011 meeting minutes; Mark Sanford seconded. Minutes were approved as submitted.

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 June 2011 totaled 897,306, with an additional 61,663

receiving women's health services. The chart reflected that of the 897,306, 60.5% are children, 18.7% are persons with disabilities; 9.0% custodial parents, 8.7 seniors defined as individuals 65 or older; and 3.1% are pregnant women. In addition, 61,663 women are receiving services through the Women's Health Services program. This category is reported separately as benefits for this group of eligibles are limited to family planning services, not the full MO HealthNet benefit.

In response to questions from committee members, it was noted that at one time MO HealthNet enrollment was up to almost one million, but has been relative flat over the last few months.

BUDGET UPDATE – Marga Hoelscher reported that there was an increase of $410 million from prior year collections in FY2011. This represents a 5.9% increase from FY2010 actual net collections. Net collections in FY 2011 totaled $7.18 billion. FY 2011 gross collections were also reviewed. Net general revenue growth rates from FY 2005 – FY 2012 (original estimate) were discussed.

Work on FY 2013 budget is underway. Submissions are due to the Office of Administration, Division of Budget and Planning, and the General Assembly October 1, 2011. A budget gap driven by $460 million of one-time federal budget stabilization funds and state education funds is estimated. As a result, very few new decision items will be put forward, only mandatory items, i.e., caseload growth, federal participation rate changes (FMAP), pharmacy inflation and utilization adjustments.

The Department of Social Services is cautiously watching federal proposals to limit provider tax rates. Because Missouri has widely used taxes to fund the Missouri's Medicaid program, the proposed rate restriction disproportionately impacts Missouri. In FY 2011, the Federal Reimbursement Allowance (hospital provider tax) funded $2.5 billion in Medicaid payments.

Group discussed another proposal to go to a simplified federal match rate, a blended rate. Currently, the federal participation rate in Missouri is 63% although there are enhanced rates for certain services, i.e., 70% rate for CHIP. The division hasn't done a lot of research on the proposal. Total revenue in FY 2005 was requested.

HEALTH HOME UPDATE -- Mayme Young, Department of Mental Health, reported that 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 will have two types of health homes – primary health care health home and behavioral health care health home. The State Plan Amendment (SPA) for the behavioral health component was submitted to the Centers for Medicare and Medicaid Services on July 19, 2011. The primary health care health home SPA is being finalized and will be a separate submission. Upon approval, enhanced federal match is available for eight quarters for both health home programs. A sample case, as well as the SPA submission, is available on the DMH website at http://dmh.mo.gov/about/chiefclinicalofficer/healthcarehome.htm. The planning process for Missouri's health home model involved many stakeholders, including Missouri Foundation for Health, Missouri Primary Care Association, Missouri Coalition of Community Mental Health Centers, Missouri State Medical Association, and others.

Speaking from a powerpoint presentation, Ms. Young noted that a "health home" is not to be confused with "home health." A health home is a place where individuals can come to have their health care needs identified and receive medical, behavioral, and related support services, coordinated in a way that recognizes their needs as individuals, not just patients. Components of a health home were reviewed to include, among others, comprehensive care management; care coordination and health promotion; comprehensive transitional care and follow-up; and use of

health information technology to link services. Health home goals were reviewed and include: reduce inpatient hospitalization and emergency department visits; enhance primary care nurse liaison staffing and primary care physician consultation available at community mental health centers; enhance behavioral consultation available at primary care centers; and enhance the state's ability to provide transitional care between institutions and the community. Ms. Young also reviewed the eligibility components and chronic health conditions set forth in the powerpoint.

Provider applications to be designated as a health home have been submitted for both the primary health care and behavioral health care health home initiatives and are currently under review by state staff. Provider webinars were conducted to provide information in advance of the application deadlines. The state is very pleased with the richness of the applications and geographical representation. Thirty-five primary care applications were received, each representing practices at multiple sites. Site visits will be conducted as part of the review process. Providers do not have to be NCQA qualified at the time of application; eight quarters are allowed to achieve the designation. Data reporting requirements in the health home program are significant. Approved providers will be required to have a functioning and successful electronic health record.

In response to committee questions of why two separate plans are being pursued, it was affirmed that the goals and quality of both health home plans are the same. Community mental health centers (CMHC) were posed and positioned to start sooner than the primary care providers. In order to take advantage of increased funding, the program was separated into two applications. There are currently 29 CMHCs with over 100 sites.

It was also questioned how the health home designation will be determined for participants. Patients will ultimately have a choice, but there will also be an auto enrollment process based on the last provider type to treat the patient. For example, if a patient was seen in the last three months by a community mental health center, the CMHC would be designated as the health home, again with the option of opting out. Additional questions were posed regarding the payment infrastructure and assistance with start-up costs. All incentive payments are based on performance.

The enhanced federal match is available for two years. A committee member questioned the status of the program at the conclusion of the enhanced match. With the evidence of reduced hospital days and emergency department visits, coupled with associated savings, the department will present a proposal to the General Assembly for continued funding. Since many of these participants are dual eligibles, there is a corresponding savings for Medicare. The state is working with CMS to establish a methodology for shared savings.

In response to questions regarding options for dual eligibles, it was shared that there are a number of options under consideration. There has been a targeted focus on the part of CMS to aid states in managing duals since that population drives a substantial portion of health care spending. Dual eligibles will be included in the health home effort, unless a participant chooses to opt out.

AFFORDABLE CARE ACT – Using a powerpoint presentation, John Huff, Director, Department of Insurance, Finance, and Professional Registration, defined Health Insurance Exchange (HIE) as a store or market place for private health insurance designed to provide price and quality information to consumers and small businesses. The HIE is designed to enhance competition among health insurance carriers and reduce administrative load for smaller insurers. A small group market is defined as having 50 employees; 95% of businesses are small businesses. The vision, mission, and principles of the exchange were outlined as well as a map depicting distribution of non-elderly uninsured Missourians.

DIFP has been very active in the National Association of Insurance Commissioners (NAIC) which drafted a model act for states to customize and adopt. In Missouri, House Bill 609 – the "Show-Me Health Insurance Exchange Act" was discussed during the 2011 General Assembly, but ultimately did not obtain final approval. The Senate created the Interim Committee on Health Insurance Exchanges. The first meeting of the committee is in Kansas City on August 16; public testimony will be taken at that meeting.

Federal funding for necessary exchange costs will be available until 2015. After January 1, 2015, exchanges must be self funded. DIFP will spend substantial effort to secure funding after the expiration of federal funds. Missouri was awarded $1 million in an exchange planning grant. Missouri has also submitted an application for an exchange establishment grant.

Mr. Huff noted that a massive information technology enhancement effort will be required. He noted that 70% of the establishment grant budget will be for IT spend.

Under the Affordable Care Act (ACA), the Missouri high risk pool will be absorbed by the exchange in 2014. Additional information on the pool, which provides managed health care coverage for Missourians who are unable to secure standard health care coverage because of preexisting high risk conditions, or other lack of availability, may be found at www.mhip.org.

Mr. Huff responded to questions from the membership regarding the need for legislative approval to establish an exchange and anticipated dissention. It is expected that legislative approval will be needed, and as the new entity is planned, changes to other opportunities may occur. Missouri Consolidated Healthcare Plan (MCHCP) is also expected to be involved in the process.

Additional questions from the group focused on the timeline surrounding implementation of a state exchange. The state would need to be able to demonstrate the ability to operate an exchange by January 1, 2013 should they choose to not adopt the federal model. Enrollment would be planned for the third quarter of 2013. Regional and national meetings have been scheduled. Missouri is looking forwarded to sharing early innovations, best practices, and research with other states at these meetings. The time line is aggressive and critical tasks are ahead. Some states have already conceded that they will opt for the federal exchange.

Melinda Dutton, Manatt Health Solutions continued the presentation providing information on federal exchange requirements as established by ACA. She elaborated on the integration of Medicaid into a private market place exchange. ACA requires a single, streamlined application process for Medicaid, CHIP, and subsidies through the exchange. The exchange will need to work closely with these agencies to ensure seamless eligibility verifications and enrollment processes.

She summarized the federal timeline which dictates a fully operational exchange by January 2014. Planning and establishment activity milestones for states were highlighted and include: ensuring legal authorization for the exchange, which is required for level two grant funding; the establishment of a governance structure; development of a budget and sustainability plan; and complete IT systems design, development, and implementation. Federal regulations speaking to the functions of the exchange are in process; these milestones will continually be under revision.

In response to committee questions, Ms. Dutton explained that draft regulations require states to provide notice if they plan to cease or begin state run exchange operations after 2014. Ms. Dutton also addressed a question regarding guidance on the percentage of revenue that would be allowed for administrative costs and the accountability and audit requirements of the grant process.

Implications of a state exchange versus a federal exchange were discussed by Patrick Holland, Wakely Consulting. Examples of exchange policy decisions that will impact the state's policy and regulatory authority included: health insurance regulations (risk adjustment methodologies, reinsurance, and qualified health plan certification) and Medicaid eligibility determinations and enrollment processes. Business operation decisions will need to serve the state's citizens and interface with state agencies. Federal dollars are committed, by ACA, to develop exchanges and establish self sustainability. The exchange will determine how business partners and government entities contribute to that sustainability. Mr. Holland concluded that Missourian's would be better served by a state run exchange, citing the importance of Medicaid/CHIP coordination, the knowledge of its population, and budgetary concerns.

Members requested a document providing an overview of risk adjustment methodologies. All attachments to Missouri's grant applications are available on www.mhip.org and include a preliminary paper regarding risk adjustment methodology.

Continuing the PowerPoint presentation Harvey Levin, KPMG shared information regarding exchange information technology (IT) systems. A summary of Missouri's vision for operations was provided. A paperless and 24/7 available plan which is transparent and seamless to the applicant is desired. Real-time eligibility determinations are a requirement, and applications should be accepted by various means (online, in person, mail, or by telephone) and through diverse agents. Mr. Levin described technical drivers to be considered during development of an exchange. PPACA Legislation, Federal Drivers, State Drivers and Early Innovations were reviewed. In order to assess the state of Missouri's needs the current state functional alignment was evaluated. A slide detailing this information was shared. Logical exchange architecture was described. Collaboration and interface among states and use of information to determine what vendors and early innovators are highly encouraged.

Findings of a gap analysis review of Missouri's current state systems were summarized. No single system provided comprehensive coverage. Differences between Missouri and Centers for Medicare and Medicaid Services (CMS) architectures were noted. No current systems exhibit strong functional and technical alignment; however some systems may have some reusable technical components. These components were graphed for comparison.

Mr. Levin completed his presentation with a summary of key decisions the state must make as it moves toward a health insurance exchange model. Where the exchange would reside is yet to be determined. Considerations should be given to leverage existing technologies and vendor resources. As the business model is finalized funds should be set aside for IT maintenance. Replacement of the state's infrastructure using federal, non-general revenue, dollars is important to consider. Substantial funding is available to upgrade the state's capacity to improve eligibility and enrollment processes. Special needs populations and those residing in rural areas may need access through other means than a computer portal, and navigators will be required for many. Working in partnership with diverse stakeholders to ensure the availability of this support is of utmost importance. Consideration to long term staff needs and vendor resources should be looked at as well as implementation gets closer. Dialogue with brokers who have expressed an interest in the exchange are planned for this summer.

In response to a question regarding inclusion of the aged, blind, and disabled (ABD) population into managed care, it was shared that no decisions have been made regarding integration of this population into an exchange structure.

Hospitals will be able to sign people up with presumptive eligibility. Planners expect substantial numbers to be signed up by hospitals.

Marcia Morgan, Alicia Smith and Associates presented slides discussing Medicaid integration and issues with coverage transitions. Continuity of coverage barriers exist due to administrative requirements and eligibility changes. Although this "churn" is happening to some extent now it is expected to be more pronounced as other coverage options emerge through ACA. Percentages of adults who will experience a change in eligibility at six months, one year and two years were reviewed. Income fluctuations resulting in shifting eligibility between Medicaid and subsidized private coverage may cause Missourians to face gaps in coverage and care. Inconsistent provider networks among plans and different benefit packages may impede the continuity of care. Administrative complexity and costs, instability of risk pools, and limitations to cost prediction and quality measurement and improvement activities might be a challenge for both MO HealthNet and the Exchange as consumers transition from one benefit to another.

Ms. Morgan discussed goals and strategies if Medicaid were to be integrated into an exchange to facilitate transitions and leverage buying power. A potential solution to continuity of care as individuals in the 0% to 138% FPL range transition to the 139% to 400% FPL was shared. The plan described essential benefits and included rider benefits. Potential options for management of these benefits between the Exchange and MO HealthNet were detailed. A stakeholder group is discussing these issues.

The discussion was opened to the group. Implications on provider tax will be reviewed. Members expressed concern over the differences in provider networks among health insurance plans and expressed the need for aggressive education and outreach to encourage every provider to join both private and Medicaid networks. Taking into consideration rate structures and looking at ways to ease administrative burden in terms of traditional Medicaid will need to be measured. Uniformity in requirements was given as an example to encourage providers to participate. Beneficiary education will also be needed.

Discussion surrounding rider services, specifically dental and vision coverage for children, ensued. Members queried how often eligibility would be reviewed. Additional guidance is expected on this issue with release of the essential benefits package from HHS later in the year.

Dr. Walentik commented that a positive of ACA is the requirement for coverage of habilitative services for children that are often not a covered service through private insurance at present. She expressed the need for this benefit during the formative years of a child. Dr. Walentik requested ACA updates at future Committee meetings.

Public Comment- Megan Burke, ParaQuad, addressed the committee in the open comment period and stated her appreciation for the presentation. She is serving on a consumer workgroup weighing the effects of ACA. She expressed concerns about the benefit packages and where individuals with disabilities will fall. Her constituents don't always fall into ABD population and will fall into the expanded benefit category. She asked the group to make sure benefits will meet the needs of this population as well. She also asked for clarification on where the ticket to work program might fall within an exchange.

Other Business-A handout with potential meeting dates for 2012 was included in the meeting packet. Members were asked to check calendars and report back any concerns with these dates. 2012 meeting dates will be finalized at the next scheduled meeting of the Committee.