MO HEALTHNET OVERSIGHT COMMITTEE MEETING

November 15, 2011
1706 East Elm Street
Jefferson City, MO

MINUTES

Members in Attendance
Corinne Walentik
Timothy McBride
Gerard Grimaldi
Kecia Leary
Mark Sanford
Joseph Pierle
Bridget McCandless
Senator Rob Schaaf
Ingrid Taylor
Rep. Jeanne Kirkton
James McMillen
Carmen Parker Bradshaw

Members in Attendance (cont'd)
Jennifer Tidball for Brian Kinkade
Celesta Hartgraves for Margaret Donnelly
Patsy Carter for Dr. Joe Parks

Members Absent
Rep. Keith Frederick
Sen. Joseph Keaveny

DSS Staff in Attendance
Ian McCaslin, MHD
Marga Hoelscher, MHD
Rhonda Driver, MHD
Karen Purdy, MHD
Samar Muzaffar, MHD
Jennifer Willmeno, MHD
Billie Waite, MHD
Dwight Fine, DSS
Sandra Nelson, FSD
Kim O'Hara, FSD
Jordan Humphreys, DLS
Mark Gutchen, DLS

Others in Attendance
Caroline Brown, Covington & Burling
John Huff, Dept. of Insurance, Finance, and Professional Registration (DIFP)
Michael Murray, Fresenius Medical Care
Leanne Peace, MO Kidney Program
Larry Rohrbach, Flotron & McIntosh
Jim Burns, CMS
Jim Moody, James R. Moody & Associates
Chris Moody, James R. Moody & Associates
Joel Ferber, Legal Services of Eastern Missouri
Mary Beehe , Legal Services of Eastern Missouri
Herb Kuhn, MO Hospital Assn.
Steve Renne, MO Hospital Assn.
Chris Dunn, Missouri Senate
Melba Price, Maximus
Lana Baker, Lobbyist
Megan Burke, Paraquad/DCHR
Grant Cale
Tracy McCreary
Tim Swinfard, MO Assn. of Community Mental Health Centers
Sam Richardson, Molina
Jennifer Bauer, MO Academy of Family Physicians
Jake Luebbering, OA Budget & Planning
Allison Tuma, St. Louis University
Lacey Leitner, St. Louis University
Deeksha Ahija, St. Louis University
Christina Vardell, St. Louis University
Ariana Mooradian, St. Louis University

WELCOME/INTRODUCTIONS/MINUTES – Dr. Corinne Walentik, Chair, called the meeting to order at approximately 12:00 noon. The Committee members introduced themselves, after which the minutes of the August 9, 2011 were approved as submitted.

MO HEALTHNET ENROLLMENT BY ELIGIBILITY CATEGORY– Summarizing the handout, Kimberly O'Hara, Manager for the Family Support Division Program and Policy Unit, reported that preliminary participants as of October 2011 totaled 895,649. The chart reflected that of the 895,649, 60.3% are children, 18.7% are persons with disabilities; 9.1% custodial parents, 8.7% seniors defined as individuals 65 or older; and 3.2% are pregnant women. In addition, 62,465 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.

Despite the enrollment numbers, group discussed that there are still a number of uninsured children. Dr. McCaslin referenced a recent *Health Affairs* article that discussed the success rate of enrolling uninsured children. While it was agreed that there is still work to be done, Missouri compares well nationally with children's participation in Medicaid and the Children's Health Insurance Program. The article will be shared with committee members.

BUDGET UPDATE – Speaking from a powerpoint, Marga Hoelscher, Deputy Director, MO HealthNet Division, reported that SFY 2012 year to date net general revenue through October increased 1.2%. Consensus revenue growth for SFY 2012 is 4%. There have been increases in gross tax collections while a decrease in refunds has been experienced. A chart depicting general revenue growth from SFY 2005 was shared.

The Department of Social Services FY 2013 budget request was presented to the Governor via Office of Administration, Division of Budget and Planning, October 1, 2011. An estimated budget gap of $550 million is anticipated in FY 2013, driven by one-time federal budget stabilization and state education funds. The October submission included a request of $84.4 million general revenue in MO HealthNet mandatory items such as caseload growth; federal participation rate changes (FMAP); pharmacy inflation and utilization adjustments; and Medicare premium increases. The October submission did not account for changes to the FMAP rate as that data was not available at the time of submission. It is estimated that the change in the federal participation rate from 63.45% to 61% normal match equates to a $68 million shortfall for Missouri. This represents $100 million in general revenue.

Ms. Hoelscher also discussed the proposal in the President's budget to limit the amount of provider taxes that a state can levy on hospitals and nursing homes. The proposal calls for federal limits to be capped as follows in the coming years:

- October 1, 2011 tax limit increases to 6% until FFY 2014. In Missouri, the hospital provider tax funds $2.5 billion in Medicaid payments.
- FFY 2015 – 4.5% limit
- FFY 2016 – 4% limit
- FFY 2017 – 3.5% limit

In response to a question from a committee member, Ms. Hoelscher indicated that there are other provider groups that could be taxed, i.e., physicians, dentists, home health, but to do so would require federal approval and support from the industry.

The estimated impact of the proposed provider tax restrictions on Missouri is $10.4 billion in foregone services over the period 2015-2021. The annual impact in 2018 is $1.67 billion. Ms. Hoelscher was part of a team that visited with the Congressional delegation regarding the impact to Missouri. Letters have

also been sent by the Governor and House and Senate leadership. The proposed provider tax limits have the effect of shifting the burden to the states and would require significant state budget cuts. If passed, the Medicaid budget could not sustain the entire reduction; the proposed limits would impact the budgets of other state programs. In addition, it is anticipated over 10,000 jobs would be affected over the next decade.

SPENDDOWN DOCUMENTATION – An explanation of the MO HealthNet spenddown program was presented by Sandra Nelson, Deputy Director-Income Maintenance Program and Policy and Field Operations, Family Support Division (FSD). Spenddown is a program by which seniors and people with disabilities, whose incomes exceed the income limit for MO HealthNet, may qualify for MO HealthNet if they have medical bills that equal or are greater than their "excess" income. The process of subtracting those medical bills from the individual's income is called "spend down." FSD is responsible for determining eligibility for the MO HealthNet program and also determines any spenddown amount. The spenddown amount can be met by incurred and reported allowable medical expenses. In order to be eligible for the month, the participant must report their incurred medical expenses to their Family Support Division eligibility specialist for entering into the system. The spenddown amount can also be met by a monthly payment by the participant to the MO HealthNet program. The payment must be equal to the required spenddown amount. There are 23,743 individuals eligible for MO HealthNet through spenddown. Of this amount, approximately 8,633 people incur expenses to meet their spenddown each month. The remaining 15,100 individuals meet spenddown by "paying in" their spenddown each month.

To determine the spenddown amount, the FSD eligibility specialists use a process that compares a participant's income from all sources to 85% of the Federal Poverty Level. After allowing deductions the balance is the participant's spenddown amount. Households closer to the FPL needy amount to begin with will have a lower spenddown amount; those further away will have a higher spenddown. Once the spenddown amount is paid, whether by submission of receipts for incurred expenses or a monthly payment, the individual is eligible. The eligibility is not retroactive to the first of the month and the spenddown amount must be met each month to maintain continuous eligibility. There are a few third parties that can pay an individual's spenddown amount, those being legal financially responsible relatives or Department of Mental Health or Department of Health and Senior Services.

An inconsistency with application of the spenddown policy statewide was recently discovered which prompted many questions. There has been no change in definition of policy. Most of the questions have been around the third party liability. Due to the number of inquiries received from dialysis providers, a statewide conference call was conducted on November 10, 2011 with those stakeholders. Discussions will continue to further clarify the policy and ensure federal law, 42 CFR 435.121, is being upheld. Family Support Division is interested in hearing from organizations that have individuals who believe they have been harmed by the application of a spenddown expense. This information can be forwarded via email to Anna.M.Beckett@dss.mo.gov or by calling 573/751-3221.

With respect to the dialysis individuals affected, it has been reported that individuals were not able to obtain MO HealthNet provided transportation to their dialysis treatment since their spenddown had not been met. Many of these individuals had previously received transportation through the Missouri Kidney Program. The treatment itself was predominantly paid by Medicare. The residual amount – the patient responsibility – is difficult to determine. Assistance from the provider community was requested to aid FSD eligibility specialists in determining the patient share.

A committee member offered that their hospital clinics have found some people don't make follow-up appointments because there is a not a guarantee of transportation to the appointment due to spenddown requirements. The lack of follow-up care impacts an individual's health status. In addition, many chronic disease patients are unable to get low cost medications that would decrease health care costs because of spenddown requirements.

Another committee member expressed concern about timing issues between incurred charges and payment by third party entities. FSD indicated that in determining whether the required spenddown is met, eligibility specialists will only consider payment by third party entities if there is a regular service and history of payment, e.g., dialysis. Generally, an estimate of third party payment has not been made in determining an individual's incurred expense.

Public comment was accepted during discussion of this issue. Leann Peace, Director of the Missouri Kidney Program (MKP) gave an overview of assistance programs through the Missouri Kidney Program, which include assisting MO HealthNet participants with spenddown gap days; paying spenddown amounts; education; transportation to dialysis services; and medication. There are approximately 10,600 dialysis patients in Missouri. MKP recently experienced a 48% budget cut in state appropriations. As a result, their transportation program ended which affected 376 dialysis patients. MKP has had an in-house eligibility specialist for their clients. There is discrepancy in the manner in which spenddown has historically been determined and what is required now. She stated several individuals are missing their dialysis treatment because of lack of transportation. Absent consistent treatment, individuals are at risk and may require nursing home placement. In addition, transplant patients are being put on hold because under the new spenddown definition their MO HealthNet coverage is not considered full insurance by providers.

Mike Murry, Fresinus Medical Care, agreed with the comments of Ms. Peace. He added that the lack of communication has caused a lot of anger among dialysis patients. The suspension of implementation of the procedure is appreciated, but a long-term fix is needed.

Joel Ferber, Legal Services of Eastern Missouri, commented that spenddown is required because Missouri is a 209b state. He encouraged FSD to clarify the discrepancy between the policy manual and practice in writing and to ensure communication with recipients and providers before any change. Mr. Ferber added that the situation affects more services than just dialysis.

Megan Burke, Paraquad, also expressed agreement with previous concerns. Their association has had 26 patients affected and are working with as many as possible to help them avoid a nursing home. These individuals' spenddown range from $4.00-$1819 per month. It is not always realistic to ask family members to pay the spenddown. She also urged better communication.

As a result of discussions, committee members requested an additional report on the issue at the January meeting, to include information on any transplants not occurring.

ACCOUNTABLE CARE ORGANIZATION FINAL RULE OVERVIEW – Herb Kuhn, President and CEO of the Missouri Hospital Association, described an important difference between Accountable Care Organizations (ACOs) and Health Maintenance Organizations (HMOs) is that health care providers themselves, rather than a distant insurance company, control the diagnosis and treatment decisions under new payment incentives. Under an ACO delivery of care, patients retain the freedom to seek additional services from any clinician or facility at any time. The ACO is monitored through performance

on a variety of quality measures, with a focus on prevention and wellness. Under the basic concept in the final rule issued by the Centers for Medicare and Medicaid Services (CMS), the ACO participants assume some degree of financial risk and the opportunity to share in savings from patient outcomes. Speaking from a powerpoint, Mr. Kuhn presented the ACO structure and function. CMS anticipates 50-275 ACOs will be formed, with a possible savings of $940 million.

St. Louis University Center for Outcomes Research recently conducted a review of AHRQ prevention quality indicators using both chronic and acute measures. A sample of the major findings of the review includes:

- Between 2002 and 2008, the statewide risk-adjusted rate of preventable hospitalizations fell 15.2% while total hospitalizations increased by 3.3%.
- In 2008, 10.5% of hospitalizations were classified as preventable. Of those, 61% were attributed to three conditions: congestive heart failure, bacterial pneumonia, and chronic obstructive pulmonary disease.
- In 2008-2009, preventable hospitalizations were approximately 1.6 times more likely to occur for African Americans compared to whites. The overall rate of preventable hospitalizations decreased 23.6% for whites and only 12.1% for African Americans, a difference attributable to chronic rather than acute conditions.
- Preventable hospitalizations accounted for an estimated $3.1 billion in hospital charges during 2008.

He stated that the challenge is to move from theory to practice in a way that honors the medical profession and patients with a viable path for real institutions to move to a more integrated health care system.

Discussion after the presentation included a strong interest in the number of duals that could be entered into integrated systems of care and the need to be creative when talking with CMS. If the population is managed effectively, it will also save Medicare funds.

Group also discussed challenges in rural versus urban Missouri and the data about the racial differences. It was noted that Truman Hospital is anchoring a lot of activity in the Kansas City area. In St. Louis, hospitals are working together by giving up disproportionate share funding to help FQHCs support health care needs. The startup cost for an ACO was underestimated by CMS and is a detriment to rural areas. Creativity is needed in rural areas and may include a provider based organization focusing on disease management and frequent health care users.

Another discussion point included the participation in ACOs of providers who are located in zip codes where frequent problems exist and treat higher risk patients – how to ensure diversity and appropriateness of patients who do have social economic challenges to be in competitive ACOs.

AFFORDABLE CARE ACT UPDATE -- John Huff, Director, Department of Insurance, Finance, and Professional Registration; Dwight Fine, Department of Social Services; and Caroline Brown, consultant with Covington and Burling, presented on information technology requirements of the Affordable Care Act (ACA), specifically the impact on Missouri's Medicaid program.

Pursuant to the ACA, state Medicaid programs are required, among other things, to:

- Apply modified adjusted gross income (MAGI) to adjudicate eligibility for Medicaid;

- Electronically verify applicant information;
- Implement a streamlined application;
- Receive and send eligibility information via secure electronic interface;
- Enable individuals to apply through a website.

A team of consultants has concluded that a major eligibility and enrollment system transformation is needed in Missouri to meet these requirements. Their gap analysis revealed that no single component of the current eligibility and enrollment system (FAMIS) is adaptable for reuse under the requirements of the ACA. That assessment raised substantial concern among a number of committee members.

The presenters talked about funding streams available to the state to secure funding to replace the current eligibility and enrollment system (FAMIS). There are grants available through the program designed to encourage states to build health insurance exchanges that would require the use of the same eligibility and enrollment system as Medicaid. Funds are also available on a 90%/10% federal funding participation basis for a limited time from the Centers for Medicare and Medicaid Services. It was stated that if system upgrades are not made, Missouri's Medicaid program will likely be found non-compliant, putting some or all of the program's federal financial participation in jeopardy.

As a result of the discussions, a motion was made that the Oversight Committee encourage state leaders to continue to pursue the implementation of a state based insurance exchange in order to update MO HealthNet's eligibility and enrollment system. The motion passed by voice vote, with one Committee member voting against the motion.

On November 14, 2011, the United States Supreme Court accepted the appeal of the health care overhaul approved by Congress in March. Arguments will be heard later this year on the power of Congress to mandate that Americans buy health insurance or pay a penalty; the constitutionality of the individual mandate; is Congress illegally coercing states to expand Medicaid by threatening to withhold funding from states that refuse.

Missouri is one of 30 jurisdictions that received establishment grant funding. The application was submitted June 30; award was received August 12. Accepting level 1 grant money does not require Missouri to operate a health insurance exchange. Funds from that grant will be used primarily for technical assistance. The grant funds flow through the Missouri Health Insurance Pool (MHIP) as a transitional vehicle. There have been many discussions since receiving the grant. The grantee status may be transferred from MHIP to the Department of Social Services. Nationwide, Kansas continues to move forward in their planning. North Dakota has made the decision not to proceed with a state based exchange. Oregon is an early innovator state, a clear leader. If Missouri applies for Level 2 grant funds it must be certified that the state has authority to operate an exchange. Missouri specifically pursued a Level I grant application in order to give the General Assembly time to provide input on whether Missouri should operate a state-based exchange. The timeline is short; the state is 18 months away from needing to seek certification to operate an exchange.

Information specific to Missouri was included in the powerpoint. Due to time constraints it was not discussed at length. Specific questions can be referred to Dwight Fine at Dwight.fine@dss.mo.gov .

HEALTH HOME UPDATE – Dr. Samar Muzaffar, MO HealthNet Medical Director, presented that there are two Medicaid health home initiatives – primary care and mental health. Missouri's health home initiative for the behavioral health component, submitted in response to Section 2703 of the Affordable

Care Act, was approved by Centers for Medicare and Medicaid Services (CMS) on October 20, 2011. Missouri was the first state to submit an application and the first to receive approval. The primary care health home initiative, submitted on November 4, 2011, is currently under review by CMS. The initiatives are a partnership between the MO HealthNet Division and Department of Mental Health, in collaboration with a number of stakeholder groups, including the Missouri Primary Care Association and Missouri Hospital Association, Missouri Association of Community Mental Health Centers. Information on the initiatives is available on the Department of Mental Health website at http://dmh.mo.gov/about/chiefclinicalofficer/healthcarehome.htm.

To be eligible to participate in the primary care health home program, eligible individuals must have at least two of the following conditions: asthma; cardiovascular disease; diabetes; developmental disabilities; oversight (BMI>25); or one of these conditions and use of tobacco. Eligible health home providers include federally qualified health centers, rural health clinics, and primary care clinics operated by hospitals. Dr. Muzaffar outlined required provider qualifications in the powerpoint presentation. Applications for the primary care initiative were received from 29 providers, representing 110 sites. As part of the application review process, site visits were conducted.

Services through the mental health initiative will begin in January, 2012. Approval of the primary care initiative by CMS is anticipated in time to begin those services in January as well.

As requested by the committee, the list of approved primary care health home applicants will be shared with the committee.

HOME AND COMMUNITY BASED SERVICES OVERVIEW – Speaking from a powerpoint, Celesta Hartgraves, Director, Division of Senior and Disability Services, Department of Health and Senior Services, shared statistics on the growth of the senior and disabled population in Missouri since 2006. The average cost per MO HealthNet participant for nursing facility and home and community based services was also shared. Services within the program are available to seniors over age 60 and adults with disabilities age 18-59 who are eligible for Medicaid benefits; are considering long-term care; need help to stay at home or in the community; and/or need assistance in accessing care or services necessary to maintain independence and dignity. Eligibility is determined by the Department of Health and Senior Services. Program services include, among other things, personal care; attendant care; nurse visits; adult day health care; respite; and certain medical or adaptive equipment. As the number of participants receiving home and community based services grows, so does the number of providers in the program. Charts depicting the number of referrals and providers were shared. The program is authorized in Title XIX and Title XX of the Social Security Act, state statute, and the Older Americans Act. While it is not a mandatory program, federal match is available.

It was noted that with the inception of the Missouri Medicaid Audit and Compliance Unit there are now field staff that verify the administration and integrity of home and community based services.

PUBLIC COMMENT – Joel Ferber, Legal Services of Eastern Missouri, requested an update on Syncare. Ms. Hartgraves reported that the Department of Health and Senior Services terminated the contract with Syncare to provide eligibility determination for home and community based services in September 2011. Temporary staff have now been hired to perform these duties, reduce backlog of applications, and maintain any new referrals received. The Department of Health and Senior Services continues to work with stakeholders to determine the process for future.

When questioned if there was any evidence of a problem before the contract was entered with Syncare, Ms. Hartgrave reported that the contract was implemented as a result of a change in state statute.

ADJOURN – Dr. Walentik adjourned the meeting at 3:50 pm. Next meeting is January 31, 2012.