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Weidenbaum Center Forum
Medicaid Financing: Challenges for Missouri and the Nation

Panelist: The Future of Medicaid

June 8, 2007

Thank you Dr. Kimmey. It's a pleasure to be here today. I am surprised, as many of you have stayed as late as you have on a Friday afternoon. This venue is lovely. I haven't had the opportunity to present at a venue like this for many years. It is usually a very much smaller group, but I hope you are much friendlier than some of my provider groups at these smaller presentations.

I have divided my comments into two sections. As Dr. James Kimmey indicated, we will take a look now, from maybe 500 feet or 1,000 feet, at what we are doing today and what we were doing over the last probably 18 months or 2 years. We have been trying to cover the indeterminate hole with a little bit of saneness in the delivery of health care for our most vulnerable Missouri citizens. We will do that for the first half. Then I have chosen to share with you just a little bit on the slides following that, that will give you some ideas of what I think are the most important parts of Senate Bill 577, which as you may know, has totally rewritten the opportunity for us to present Medicaid services to our population.

The first thing that I would like to share with you is a message that you have undoubtedly taken away as a key point today. I have been with you since about noon and certainly the on-going discussion is that we cannot sustain the growth of health care. Nor can we sustain that growth in the state of Missouri. The Social Services heart of our arm of Medicaid represents about 25 percent of all of the expenditures of the state of Missouri. Our budget is about a fourth of the entire budget. The pharmacy budget alone is about 5 percent of the total budget — clearly unsustainable over time. If you look at the graphics there, in the particular areas of the folks that

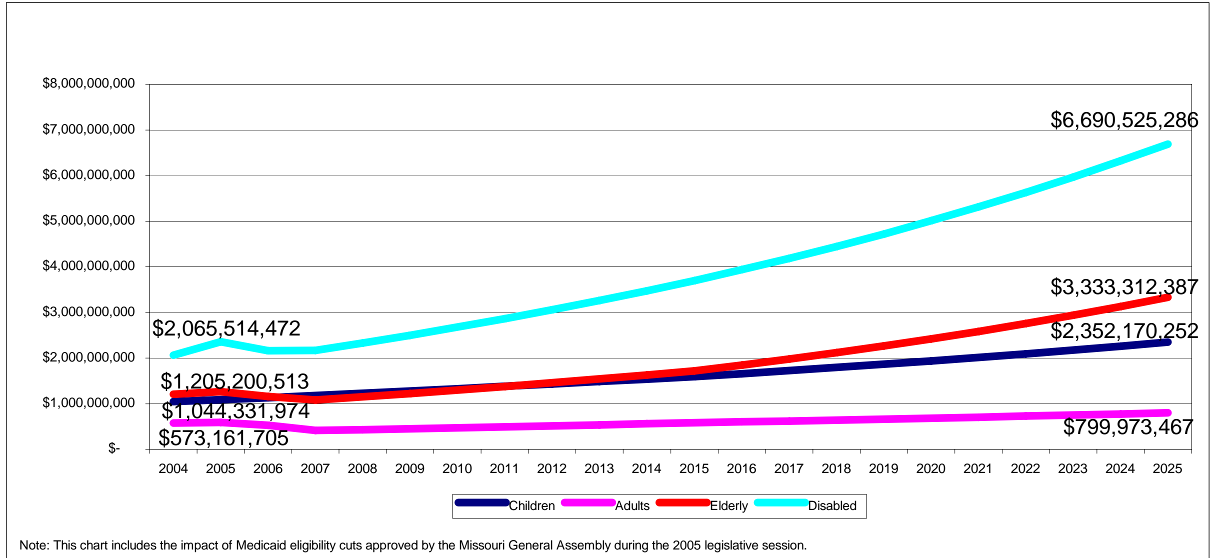
we most likely will be serving, you get an idea of the relative rate of growth (See Figure 1). It is very important to note that we will never see a negative growth on that individual PMPM (per member per month). What we can only hope is that we can bend those trend lines. And, we have been largely successful in the last few years in starting to bend those trend lines. But, we do it very systematically from service to service.

The key point here, too, is to realize that the relative cost of providing service to the various parts of our community at the very bottom you'll see the children, adults, elderly and disabled. If you consider the children and the adults to be healthy, then the elderly adults are a seven multiplier for the relative cost of providing service. Our ABD (blind and disabled) population, our permanent and totally disabled population, represents slightly over a nine. Those are the people that we really have to focus on if we are going to bend that trend at all, if we are going to provide any long-term solution.

The other thing that I would suggest to you is that we are concerned about our expenditures today. We are concerned about the low hanging fruit and the opportunity to become more efficient in everything we do as a payer today, but we also realize that what we do today will impact the future a great deal. For the state of Missouri we have a flux in the Medicaid program. But, that flux, as you might well imagine, is largely in the healthier population. The populations that we know and love and treat and work with on a very long-term basis are the elderly and the ABD population, or the permanently and totally disabled population. Those are likely going to be with us even as Part D has come into Medicare and taken some of the responsibility for some of the opportunities to pay for services in Medicare, we still inherit one of every two permanently and disabled folks in Missouri, so we are not pushing that out. For the elderly, we still provide one of the most expensive services for the elderly in the long-term care setting. In both cases, we have a very, very vested interest in maintaining long-term and short-term wellness and health in those individuals.

Figure 1

Projected Future Medicaid Spending by Eligibility Group, 2004-2005



Note: This chart includes the impact of Medicaid eligibility cuts approved by the Missouri General Assembly during the 2005 legislative session.

Figure 2

Chronic Disease Benchmarks

Measures	Actual	Benchmark	% Difference
Patients Per 1000 Anxiety Disorder	23.69	9.92	138.80%
Patients Per 1000 Asthma	36.74	29.16	26.00%
Patients Per 1000 Bipolar Disorder	30.32	4.41	588.10%
Patients Per 1000 Coronary Art Dis	39.23	32.69	20.00%
Patients Per 1000 CHF	28.06	10.5	167.30%
Patients Per 1000 COPD	46.32	16.4	182.50%
Patients Per 1000 Depression	73.69	31.86	131.30%
Patients Per 1000 Diabetes	71.78	45.8	56.70%
Patients Per 1000 HIV Infection	3.04	0.48	527.50%
Patients Per 1000 Hypertension	98.53	117.66	-16.30%
Patients Per 1000 Osteoarthritis	59.11	47.47	24.50%
Patients Per 1000 Rheum Arthritis	5.21	4.63	12.40%

The 30 percent of the population is in that ABD population, ABD and elderly, represents about 80 percent of our total expenditures. The take home from Figure 2 is just a little vignette of what the Medicaid population looks like. The benchmark is a third-party benchmark. It's a national benchmark from Thomason health care and the actual is our fee for service Medicaid program. Medicaid, as you may know, is broken into two groups right now, the MCO or managed care population, which is largely women and children, represents about 425,000 of our 825,000 folks. The rest of those individuals are in the fee for service that we are talking about here. Just look at the relative percentage of difference from the general community and the relative percentage that we have in some of the most devastating of the chronic diseases. That's really the impetus for us to have developed and begun a chronic disease management program that we started just almost a year ago as we are together today. We are implementing that and started enrollment in November and have about 20,000 folks on that today of 138,000 overall Missouri that would be eligible for those services. We can talk later if you like about how we selected them and some of the other pieces of that puzzle that will become very interesting to us in our discussion about the future.

I would especially point out to you the diabetes, in that we are 56 percent higher than the general population. Hypertension is interesting in that it is lower, and it is lower because we have few people that have that single disease entity. It is usually a more compounded disease entity and chronic heart failure or more advanced stages of which hypertension is but a symptom. I would also point out to you in the bipolar and schizophrenia, the severe mental illness that is a huge portion of our permanently disabled population and one that is very difficult to manage, as many of you might know.

What we have done, though, is to try to move from a passive claims payment and an enrollment or a safety net provider to a smarter payer, if you will, a payer that will develop care-management programs. We are well into using electronic health records. We are actually cutting

edge among other states in electronic plan-a-care and the implementation of a paid claims tool that allows us to make decisions within our program and that the providers can access to see some of the types of services that the patients most recently had. We are actually rolling 24 months of data there. We use that also in coordination of the chronic care improvement program, using that program to define standards and resolve treatment gaps and to look at medication possession ratios for treatment and therapies. It is a way to get started and with 577 you will see that we have a mandate to go much further with that. We are now emphasizing maintaining and improving the health-care status.

We are advancing the resources we have available to the population as we see it. We target the most intensive care to that highest risk population and we are developing a consumer focused and customer directed care to be driven for individual needs to try to keep our elderly out of the long-term care facilities and in their homes longer. The tenants that follow that basic philosophy is making decisions on the medical evidence and the best practices, not just on intuition or expenditures. We used to sort of pay for whatever was billed. Now we are trying to jury that a little bit to the medical evidence while keeping that jurying as transparent as we possibly can so that we do not become a burden to our providers or an inhibiting factor to our recipient base.

Providing management that is transparent to the patients as well, we have launched a website on prescription drug pricing so those folks that were insured with us could help us to jury some of the cost of medications. The uninsured could also determine what the relative cost was of prescription drugs. In review and to insure the quality assurance for the program, they do a total quality assurance look back on all of our provision of services in each of our programs to make sure that we are in fact accomplishing the goals that we set out to do as well as reviewing the outcomes of our effort. Not to punish the many for the sins of a few, that's sort of a statement on prior authorization. You don't want to try to inhibit the right things from happening and make it burdensome for the providers or an access block for the consumers so we don't want to set up

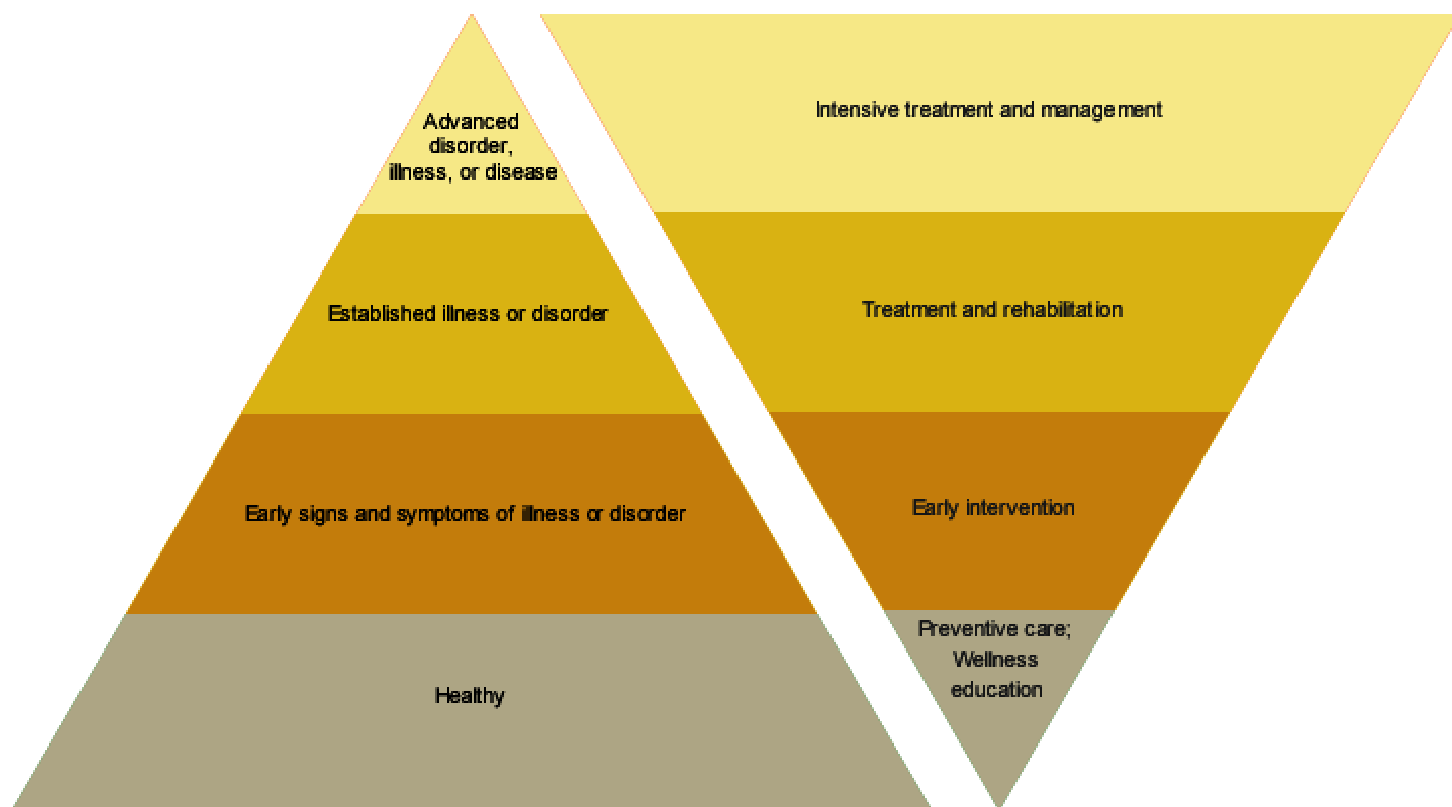
needless roadblocks in the system. Transparency of approval processes and transparency of access issues and transparency of information is a key component of what we've been trying to accomplish.

Then moving that transformation in Missouri, we were moving from just paying for things to paying for those needed medical necessary services and also trying to jury those services a bit within the context of what is available. The patient's access to individual services is screened by diagnosis and need in many areas. We try to make sure that it makes sense to incorporate that screening in an area so that it is not a needless exercise on either of our parts focusing on incorporating the best practice and again, medical evidence into the payment decisions. We will talk a little bit about the Pay for Performance (P4P) process that we have begun to work on for the chronic care improvement program and what we will be working for in all of Medicaid subsequent to 577. And, then we will talk about designing those programs so that they target service intensity based on the patients need so that we are not approving and encouraging the utilization of higher technology before it is actually necessary.

In the following figure, you will see the same sort of approach there as we are trying to move into transformation (See Figure 3). This was the slide that I referenced that we basically tried to match our resource to our relative level of intensity of services that we provide. You can see how at the chronic care improvement level, the top of those two pyramids, that we are targeting our most resources to those folks that were determined to be most at risk and would likely cost us the most to take care of in the near term future. Now what we have done is we have moved down that pyramid. With 577 we have been asked to take the tools that we have begun to develop and then to deploy those across all of our Medicaid eligibles and to do that in a very short period of time as well.

Figure 3

Philosophical Shift in Healthcare Delivery to Individualized Need-Based System



Again, how do we do that? We do that through information. As we try to develop all of that information, we are developing new management systems. We have a contract for a new management information system that is about ready to be approved. We have a contract for the services that were provided on our unit that is on the street to be bid on and is scheduled to close the end of this month and likely to be awarded shortly thereafter. That is a system that sits on top of our management information system and allows us to do the clinical rules engines. We can use that data in our pharmacy claims and in our medical claims. We will be deploying a tool that will reach out to the patients individually. Surprisingly to me, we found that about 60 percent of the Medicaid recipients had regular and reasonable access to the Internet. So, we are going to try to encourage the utilization of those web portholes — that we use for our providers — for the patients as well. We can use our rules engine to message the patients as well as to coordinate the care through the Chronic Care Improvement Program. We think that the utilization of electronic health records and utilization of our paid claims information and being surrogates to the quality and the detail of the services we provide is imperative. Using those clinical rules, enable that client data to be delivered, juried by our rules engine to either flag claims or to information that's directly targeted to our providers.

We've deployed one of our tools to about 3,500 providers so far and about 1,100 treatment facilities. We are seeing that deployed at emergency rooms so that when individuals present for chronic non-malignant pain, the physician has an opportunity to screen those individuals' previous claims as they appear there, to have the opportunity to do Emergency Department (ED) redirection. If you will, to sort of develop better habits within our population by developing a self-service model so that we in fact do use all of that clinical data and all of our claims data and all of our decision support opportunities and to make that available, again, to the practitioners that touch the patients, to us as a payer and to the consumer to help empower them to take more personal responsibility for their care as well.

The next steps for 2008 and 2013, this was the path we were on before 577 and you will see that it is not inconsistent with 575 but is completing the imagining for pre-certification of some of the tools that we use. Let me assure you of a couple of things. There are always in flux with respect to the medical evidence that we use to support them so if we have missed the mark we use partners to determine the mark, if you will. We use the evidence based practice center of Oregon with 15 other states, the Medicaid Evidence Decision Process with 12 other states. We use our clinical facilities at the University of Missouri at Kansas City. We use our own clinical facilities and then those of our two vendors that work with us so if you think we've actually gone off the deep end, let us know. We are not intransigent to making changes in our rules process and we actually encourage you to look at that. It's all available on our website. You can see how we are thinking and why we are thinking the way we are. We encourage you to make notice of things we have missed the mark on.

The additional services added by 577 will be optometric and dental. It's mandated that those be juried, again, in an electronic process similar to what we are using on a basis of medical need. A statewide patient health record is a separate initiative that was part of the Health Information Technology Fund. The vision there is that the near Medicaid patients will initially be incorporated; their data in with all the Medicaid folks so as patients move in and out of Medicaid that we do not lose contacts of the data that's available to them. Ultimately we hope to give other third parties have access to that data as well so that we can use the various tools that are available to us or that you have available in your institutions to access that on a real-time basis. The cyber access tool that I've been speaking about is real time. As a matter of fact, it is so real time that if you have a prescription filled now it would be available for you to view in 15 seconds on that particular web tool so you can tell whether your patients are taking and filling those prescriptions that are written. You have the opportunity if you use the electronic script option on there to actually follow the prescription to see if it is ever filled.

The other pieces that I would speak to briefly, there is an insurance reform legislation that was passed that I will not speak about today but really has some of the issues that we were talking about in the previous section incorporated into it. We do have a portion of 577 dedicated to insurance reform and especially a section in long-term care insurance integration and then integration home and community-based waiver services for evaluation prior to the application of those. Let's go on to 577. This was a bill that was passed in the very last days of the session that basically removes the Medicaid sunset. We originally sunsetted our Medicaid program for a year from now. This removed the sunset with the idea that we would be given the opportunity to develop a new system. What I'll share with you today — I just want to warn you today that there are just a very few parts of what I thought I'd pull out of 577 — before it's available for implementation the Governor would need to sign that. With the exception of one small section, were he to sign it tomorrow it would not go into effect until the 28th of August. We are not going to wait. We are going to assume that there is a high probability that it will be signed and start working on some implementation pathways now. I don't want you to expect us to be able to flip a switch on July first or the next day after it is signed, if in fact it is, because that certainly will not be an easy thing to do and it will require integration of all of the things that we have just been talking about into the new model.

It does extend coverage for the ticket to work folks. It is a small group of folks, I believe there are about 8,000 total. It increases the foster care children up to age 21, increases and allows sheltered workshop participants to use Medicaid and gives some exemptions of some level of income that is required by those individuals so that they can maintain eligibility, changes the affordability of our S-chip program that has a relative percentage that grows on the relative premium charged on the S-chip program. I think it trends up to 250 percent of poverty but you will want to double-check that. I believe that's the appointed trends out and establishes a pay-for-performance initially a pay-for-play program.

That as we envisioned it now, you will see that this has an advisory group that will be appointed to oversee the implementation of that as we are currently trying to implement that through the Chronic Care Program. The vision we have is that the practitioner will have metrics that are approved by the Quality Assurance Council and those metrics then are used to compare that patient population within the physician's practice, not comparing the physician's practice to another physician's practice. You are competing basically for those opportunities within a very narrow group of folks that you have control over and have the opportunity to work on the metrics. Of course the proof is in the pudding, what the metrics are and how easily they are to be achieved, and then how valuable the P4P is. We have actually found that some of the physician populations have been far more intrigued with the access to information about the patient and the assistance through the Chronic Care Program of trying to assure that the patients make their appointments than they are in getting small sums of money to enhance their reimbursement.

We, as I mentioned earlier, will be adding the optometric and dental. It's currently not funded so I'm not sure of the time frame. That will take administrative action in order for that to be funded and then delivered but it will be back in the covered benefit package. The move to provider reimbursement rates most closely to Medicare, we are now at about 42 percent and with the first phase of the Medicaid reimbursement to Medicare values, I think that will move us up to in the mid 50s. Then we are planning to continue that until we get as much a part of the Medicare rates as we can help the General Assembly reach. We think that by making our efficiency in the delivery of product better then we will free up dollars within the program and we can then move to the provider reimbursement that we realize is very low, comparatively speaking.

We've included coverage for durable medical equipment. It is in the appropriation for this year and has been reinstated. We are using an electronic jurying process for that, providing a pilot premium offset program – back to the insurance discussion that I eluded to – provides for standardized health insurance product, defining what that product is and then it is subject to an

oversight committee. Then we will have the opportunity for those that are working to access that product, that rate that we've been able to essentially bid in the private sector. Establishes guidelines for data exchange with other third parties, again, a very critical part of us being able to integrate health care across our continuum of care.

It expands the women's health program, expands coverage for breast and cervical cancer, and includes services outlined. I gave you that citation on all of the coverage under the women's health program. We are required to promulgate rules for tele-health. We currently cover tele-health but it has not been extremely well used. The dollars have been there but I think the lack of definition has not been well enough disseminated so that it can be used extensively. We will hear about that in the very near future. That will be one of the first things we start working towards. Long-term care partnership, providing mechanisms to fund private long-term care insurance, and also providing coverage through MoHealth Net (SB 577) at an earlier point when that coverage for the long-term care insurance is a part of the package the individual chooses to allow future MoHealth Net coverage without exhausting resources. So we are trying to give an opportunity to the elderly patient to sustain some of their resources by providing for an alternative to long-term care utilization, which as you may well imagine, is one of the most expensive things that we do.

Then it provides for a significant number of specific health-care studies comparing general health outcomes. There's a lot of outcome discussion within the bill and provisions for reporting on the basis of random stratification. It compares access to providers to statewide access so that we can assure that we have the opportunity to provide all of the same types and qualities of services for our Medicaid population as we do for the general population. It establishes access vehicles for MoHealth Net coverage. Basically it tells us that we have to use our managed care delivery system and then develop administrative service organizations. The fallback is then a coordinated fee-for-service plan. At least one of those has to be available in each of six regions around the state. The MCO (Managed Cared Organizations) population, for those groups we've expanded or

will be expanding coverage to 22 additional counties along the I70 corridor. We will be developing skill sets within the divisions and more critically analyze the outcomes from the managed-care organizations and we will be comparing those to the ASO (Administrative Services Organization) outcomes and then to the fee for service outcomes. The General Assembly wants to know which is the better deal. Then we need to be able to take the individuals on the basis of their disease prevalence and their basic risk stratification and compare their outcomes from one delivery system to another. It mandates a health-care home, a MoHealth Home. That's a very critical part of the delivery of the MCO as well as the ASO model and will be one of the things that, as you can well imagine, will be the most difficult for us to implement, but one that we believe using our electronic tools we will be able to accomplish.

All of the opportunities that we have available to use are subject to the approval of our oversight committee. That oversight committee is a little bit daunting and I think it will be a very fun group to work with — all 18 of them. I am looking forward to the opportunity to provide services for them. We also require that they meet four times a year and they are required to advise and approve the plans and review the operations, compare the plans, and they also are required to establish a sub-committee on a single point of entry—which has 21 members. We are going to have a lot of togetherness and I hope *Kumbaya* will be sung by all. It will be very difficult to implement in a year if we cannot reach a consensus and I am sure we will be able to.

The Joint Committee on Health Net is a second General Assembly Committee that is an oversight committee. This is largely a budgetary opportunity, where we will have the opportunity to see a running 4 or 5 year rolling budget and they will be making recommendations on an annual basis to the General Assembly, hopefully on the outcomes that are positive from these programs that we have developed that have been approved by the oversight committee.

The Professional Services Committee is the one I indicated to you, another 18 individuals that will have the opportunity to help us develop P4P. It includes the individuals that will be a part

of that program. That, as I hurry through the very last part of it, will give you an idea of what we are about. I think we are going to have a very busy year. I want to thank you in advance for being part of our providers' network, those of you that are, and invite you to be a full participant in our planning and implementation of MoHealth Net.

Thank you.

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