

**Insights Audit:  
MO HealthNet Reform Context Report**

**Prepared for the Health Care Foundation  
of  
Greater Kansas City**

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## I. Overview

The Affordable Care Act (ACA) included various provisions focused on expanding coverage, controlling health care costs and improving health care delivery. The overall approach to expanding coverage included several main components:

- The creation of state-based health exchanges, through which individuals and families can purchase coverage, with premiums and cost sharing credits available to individuals and families with incomes between 100 and 400 percent of the federal poverty level<sup>1</sup> (FPL);
- Exchanges through which small businesses can purchase coverage; and
- Expansion of Medicaid up to 138 percent of FPL.

Under the Medicaid expansion component, all non-Medicare eligible individuals under the age of 65, with incomes up to 138 percent<sup>2</sup> FPL, are eligible for Medicaid (*newly eligible adults*). Newly eligible adults include parents, caretaker relatives and childless adults. The Medicaid expansion does not include undocumented individuals who are ineligible for Medicaid under current law.

Originally intended to be a mandatory requirement, the June 2012 Supreme Court ruling effectively made Medicaid expansion optional for states<sup>3</sup>. To finance the expansion, states receive 100 percent federal matching funds through 2016, 95 percent federal match in 2017, 94 percent in 2018, 93 percent in 2019, and 90 percent in 2020 and beyond. As of October 2015, 31 states had adopted the ACA Medicaid expansion.<sup>4</sup>

Other ACA provisions intended to improve health care delivery and outcomes include investments in health information technology, improvements in care coordination between Medicare and Medicaid, and the creation of health homes to improve care for individuals with chronic conditions and serious mental illnesses.

## II. Recent Experience of Medicaid Expansion States

In states that expanded Medicaid (*expansion states*), recent studies identify:

- Significant declines in uninsurance rates from 2013 to the first half of 2015; and
- Net budget savings as a result of expanding Medicaid to newly eligible adults.

### a. Uninsurance Rates

A Gallup and Healthways survey<sup>5</sup> found that uninsurance rates dropped nationwide from 17.1 percent at the end of 2013 to 11.9 percent during the first quarter of 2015, with the greatest gains in health coverage found in expansion states. The poll identified that nine of the ten states with the largest drop in uninsurance rates were expansion states. For example, Arkansas experienced a drop in their uninsurance rate from 22.5 percent to 11.4 percent in one year<sup>6</sup>. In contrast, Missouri had a 3.8 percentage point drop (15.2 percent to 11.4 percent) between 2013 and the first half of 2015.<sup>7</sup>

### b. Economic Impacts

According to the Missouri Department of Social Services data, MO HealthNet enrollment increased by approximately 14 percent and expenditures increased by approximately 8 percent between June 2014 and June 2015<sup>8</sup>. According to the Missouri Department of Social Services, in State Fiscal Year (SFY 2015), the elderly and persons with disabilities accounted for 27 percent of enrollment and 67 percent of expenditures; pregnant women and custodial parents accounted for 11 percent of enrollment and 8 percent of expenditures; children accounted for 62 percent of enrollment and 25 percent of expenditures. Furthermore, according to a Kaiser Family Foundation summary of Medicaid spending by service<sup>9</sup>, in federal fiscal year 2014, Missouri Medicaid

spent 28 percent on long-term care, 64 percent on acute care and 8 percent on disproportionate share hospital payments<sup>10</sup>.

A recent Kaiser Family Foundation report revealed that total national Medicaid spending and enrollment increased in FY 2015 by 13.9 and 13.8 percent respectively, particularly due to enrollment growth in expansion states<sup>11</sup>; however:

- Total enrollment growth and spending is expected to slow in FY 2016 after the initial influx of new enrollment in expansion states; and
- Medicaid directors are reporting net budget savings from expanding Medicaid to newly eligible adults.

The Kaiser report noted, and additional studies corroborate, that expansion states are reporting net budget savings from:

- Replacing general funds, which have historically supported programs and services for the uninsured, with Medicaid enhanced match rates for newly eligible adults, including uncompensated care funding, behavioral health programs or inpatient costs for prisoners;
- Accessing enhanced federal match for some Medicaid beneficiaries previously eligible under certain categories who now become eligible for Medicaid as a newly eligible adult, such as the spend down population or pregnant women; and
- Revenue gains from existing health plan and/or provider taxes as health plan and provider revenues increase from expanded enrollment.

See below for key findings from a State Health Reform Assistance Network examination of the economic impacts of Medicaid expansion in eight states.<sup>12</sup>

#### **2014 and 2015 Budget Impact of Medicaid Expansion on Eight States<sup>13</sup>:**

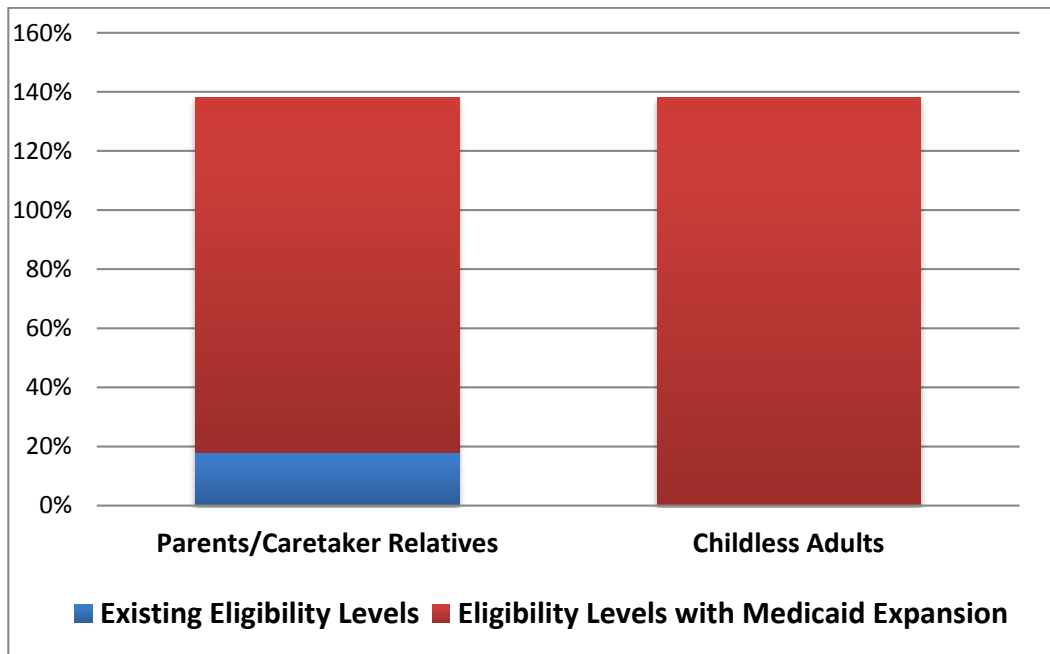
- **\$1.8 billion** in total savings and increased revenues expected by the end of 2015 in these eight states;
- *Accessing enhanced federal match:* Seven states report projected savings from accessing enhanced federal match for some existing Medicaid eligibility groups, totaling between **\$4 million** (West Virginia) and **\$342 million** (Washington) through 2015;
- *Reducing general fund spending:* Five states identified net savings from replacing general funds with Medicaid funds, totaling between **\$20 million** (Colorado) and **\$389 million** (Michigan) through 2015;
- *Revenue gains:* Four states identified revenue gains from existing health plan and/or provider taxes as health plan and provider revenues increase from expanded enrollment, totaling between **\$26 million** (Michigan) and **\$60 million** (New Mexico) through state fiscal year or calendar year 2015; and
- *Offsetting cost of expansion:* Savings and revenue gains in Arkansas and Kentucky are expected to offset costs of Medicaid expansion at least **through FY 2021**.

### **III. Medicaid in Missouri**

#### **a. Eligibility**

A recent Missouri Budget Project report showed that in FY 2015, more than 300,000 Missourians fall into the gap between MO HealthNet<sup>14</sup> coverage levels and 138 percent FPL<sup>15</sup>. The chart below depicts that income limits in

Missouri for parents/caretaker relatives would increase significantly under a Medicaid expansion. It would also provide coverage for childless adults, up to 138 percent FPL, who currently cannot receive MO HealthNet.



### b. Projected Missouri General Fund Savings

According to the Missouri Office of Administration, Division of Budget and Planning,<sup>16</sup> in FY 2023, Missouri would realize approximately \$101 million in net general fund savings even with a 10 percent state match contribution for newly eligible adults. The estimated savings result from: 1) enhanced federal match for individuals who would have been eligible under certain categories and who now become eligible for Medicaid as a newly eligible adult, and 2) reductions in existing state programs. See chart below for a summary of the findings:

Total Projected Missouri General Fund Savings in FY 2023 <sup>17</sup>	
<b>Number of Newly Eligibles</b>	321,298
<b>Savings from Existing Eligibility Category/Programs</b>	
<i>Pregnant Women</i>	\$45,407,096
<i>Breast/Cervical Cancer</i>	\$7,236,157
<i>Ticket to Work</i>	\$887,727
<i>Spend Down</i>	\$15,502,805
<i>Permanently Disabled</i>	\$200,591,104
<i>Women’s Health Services Program</i>	\$216,296
<i>Blind Pension</i>	\$1,122,815
<i>Corrections</i>	\$1,408,863
<i>Mental Health</i>	\$29,816,545
<b>Total State General Fund Savings</b>	<b>\$302,189,408</b>
<b>Cost for Newly Eligible Adults</b>	<b>(\$201,481,855)</b>
<b>Net State General Fund Savings</b>	<b>\$100,707,553</b>

## c. Recent Legislation in Missouri

The Missouri legislature considered a series of Medicaid transformation and expansion pieces of legislation during 2014 and 2015 (summarized in Appendix 1), particularly in 2014. In terms of eligibility, only some of the legislation introduced included Medicaid expansion. Beyond eligibility, the common 2014 legislative themes included:

- Use of premium assistance for employer-sponsored insurance and marketplace coverage between 100 and 133 percent FPL;
- Increases in cost-sharing and changes to asset limits;
- Use of healthy behavior incentives;
- Increased managed care oversight, including the imposition of minimum loss ratio (MLR) standards, increased managed care organization<sup>18</sup> (MCO) reporting, and improved network adequacy, such as any willing provider requirements, use of sanctions, and secret shopper surveys;
- Expansion of Medicaid managed care statewide; and
- Use of provider-based models, such as accountable care organizations, for certain eligibility groups.

## d. Current Missouri Medicaid Delivery System

### i. Mandatory Managed Care

The MO HealthNet managed care system currently operates in 54 designated managed care counties across the state including St. Louis, Kansas City, Columbia, and Jefferson City. In these counties, the following populations are largely required to enroll in an MCO: parents/caretaker relatives, children, pregnant women, refugees, and children who are in the care and custody of the state and receive adoption assistance subsidies<sup>19</sup>.

As of July 1, 2015, 50.5 percent<sup>20</sup> of MO HealthNet beneficiaries were enrolled with one of three managed care plans: Aetna Better Health of Missouri, Home State (Centene), and Missouri Care (WellCare). Managed care plans cover physician, hospital, laboratory and preventive services. Managed care plans do not cover nursing facility, home and community-based (HCBS) waiver services or pharmacy. MCO enrollees must receive MO HealthNet services included in an MCO contract from a Medicaid-enrolled provider that is part of the MCO network<sup>21</sup>.

In May 2015, the Governor approved the FY 2016 appropriations bill (HB 11). This legislation expanded managed care statewide effective June 1, 2016. The managed care expansion applies only to populations currently able to enroll in managed care as described above.

### ii. Fee-for-Service

Individuals who do not live in a designated managed care county, or are eligible for Medicaid through the aged, blind or disabled categories of assistance, are not required to enroll in an MCO. These individuals receive MO HealthNet benefits on a fee-for-service basis and can receive services from any Medicaid enrolled provider.

### iii. Health Homes

In 2011, MO HealthNet received approval from the Centers for Medicare and Medicaid Services (CMS) and implemented two health home initiatives. These initiatives are the Primary Care Health Home Initiative and the Community Mental Health Center Health Home Initiative, through which organizations provide case management and care coordination for participants with chronic medical and/or mental health conditions.

## IV. A Look at National Medicaid Trends

### a. Eligibility

As of October 1, 2015, 31 states adopted the Medicaid expansion. Some expansion states are making changes to existing eligibility categories due to the availability of coverage as a newly eligible adult or through the marketplace. States could not reduce Medicaid eligibility levels until 2014 when coverage options through the marketplace would be available. The chart below depicts optional eligibility categories prior to the ACA, and the states that have eliminated or plan to eliminate these optional eligibility categories.<sup>22</sup>

Eligibility Category	Number of States (including DC) with Category in 2013	States that eliminated or plan to eliminate
Breast and Cervical Cancer Treatment	51	Arkansas, Maryland, Illinois
Spend Down Adults	36	Hawaii, Illinois, Pennsylvania
Pregnant Women above 138% FPL	43	Louisiana
Family Planning Waivers or State Plan	33	Arizona, Arkansas, Delaware, Louisiana, Michigan, Illinois, Ohio, Pennsylvania

### b. Managed Care Delivery System

As of July 1, 2015, 48 states used some form of managed care to serve their Medicaid enrollees. This includes 39 states (including DC) that contracted with risk-based MCOs. As of July 1, 2015, nine states operated primary care case management (PCCM) programs only, and ten states operated both MCO and PCCM programs. Under PCCM programs, states generally pay primary care providers a monthly fee to perform individualized case management and care coordination for beneficiaries. PCCM programs operate within the fee-for-service system.

In 21 states that operated MCO programs only, at least 75 percent of all Medicaid beneficiaries were enrolled in MCOs.<sup>23</sup> The most common groups included in MCO enrollment are children and non-elderly, non-disabled adults. The next table depicts MCO penetration rates for select eligibility groups across the nation.

The Kaiser survey indicates states are continuing to increase use of Medicaid managed care including expanding managed care into new geographic regions or adding eligibility groups and benefits into MCOs including integration of long-term services and supports (LTSS):

- Nine states in FY 2015 and eight states in FY 2016 are expanding voluntary or mandatory MCO enrollment to additional eligibility groups, including six states (New Jersey, New Mexico, New York, Texas, Virginia and Washington) adding persons eligible for LTSS.
- In FY 2015 or FY 2016, while six states indicated they enacted policies to increase PCCM enrollment, five states are discontinuing their PCCM program and transitioning populations into MCOs, and two states have taken action to decrease enrollment in their PCCM program (Illinois and Oklahoma). Most recently, the North Carolina Governor signed into law HB 372 that would discontinue its PCCM program and implement a full risk-capitated payment system<sup>24</sup>.
- In FY 2015, six states implemented MCO arrangements for LTSS and home and community-based services (HCBS) for at least some populations (four states noted this was in relation to the launch of the dual eligible demonstration). In FY 2016, five states indicated they plan to implement new LTSS MCO arrangements.

Number of States: MCO Penetration Rates for Select Eligibility Groups As of July 1, 2015 <sup>25</sup>					
Population	Excluded from MCO	Less than 25% Enrollment	25 – 49% Enrollment	50 – 74% Enrollment	Greater than 75% Enrollment
All States/Groups (39 states)	-	3		15	21
Children	1	2	1	3	32
Adults	1	2	4	11	21
Elderly and Disabled Adults	6	3	9	6	15
Newly Eligible Adults	2			1	23

*Notes:* Total is 39 states. Elderly and disabled excludes dual eligible beneficiaries. Of the 29 states that had implemented Medicaid expansion, 26 had MCOs in operation.  
*Source:* KCMU survey of Medicaid officials in all 50 states and DC, October 1, 2015.

### c. Benefits Under MCO Contracts

In most states, a comprehensive set of acute care services are included in the MCO contracts. However, as of July 1, 2015, for the 39 states with comprehensive MCO contracts there are some notable exclusions or “carve outs”, including: children’s dental<sup>26</sup> (15 states); adult dental<sup>27</sup> (10 states); outpatient mental health (8 states); inpatient mental health (11 states); substance abuse (9 states); institutional LTSS<sup>28</sup> (18 states); and HCBS (19 states).<sup>29</sup>

### d. MCO Quality Initiatives and Consumer Protections

With greater utilization of managed care, an increasing number of states are focusing on improved quality efforts and consumer protections. See the chart below for some common quality strategies, and whether MO HealthNet applies these identified strategies.

Quality Initiative	Description	Number of States FY 2014 <sup>30</sup>	Included in MO HealthNet
Minimum medical loss ratios (MLR)	MLR is the calculation of the proportion of monthly capitation payments spent on clinical services to inform the share of dollars spent on patient care, as opposed to administration costs and profit.	19 <sup>31</sup>	No
Auto-enrollment algorithms informed by MCO quality	Beneficiaries who do not choose an MCO within a specified timeframe are auto-enrolled into an MCO. States develop auto-enrollment algorithms using a variety of factors. A growing trend is to incorporate plan quality rankings into its calculation.	8 <sup>32</sup>	No
MCO payment withholds	Under this option, states withhold a portion of the monthly capitation payments that MCOs may earn back for meeting specified quality and/or process measures.	18	Yes
Public reporting of quality metrics	Under this option, states make MCO performance on quality measures publicly available.	23	Yes



<b>Pay-for-performance</b>	Some states employ incentive-based payments to encourage MCOs to exceed minimum quality / performance thresholds.	19	No
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Consumer protections include a wide variety of policies and procedures for issues such as marketing, grievance and appeals, continuity of care, language and accessibility, network adequacy, and care management. Existing federal regulations specify some requirements related to enrollment, disenrollment, network access (including time and distance standards), grievance and appeals, and marketing standards. CMS recently solicited comments on a proposed rule to overhaul existing Medicaid managed care requirements and improve many consumer protections, including network adequacy and consumer choice counseling requirements.

The chart below depicts select consumer protections in the current environment and identifies whether MO HealthNet contracts include similar protections.

<b>Consumer Protection</b>	<b>Description</b>	<b>Included in MO HealthNet<sup>33</sup></b>
<b>Direct tests of network adequacy</b>	All states require MCO network adequacy reports. However, state procedures for assuring compliance with access standards vary from an annual MCO self-attestation of compliance to direct tests of plan compliance. Examples of direct tests include secret shopper calls and provider surveys. <sup>34</sup>	Yes
<b>Panel size requirements</b>	Some states set maximum provider to enrollee ratios to ensure the network is sufficient.	No
<b>Member assessment and care plan requirements</b>	Many states require MCOs to perform health risk assessments (HRA) within a specified time of enrollment, and the timely development of a care plan if indicated by the HRA. States further elaborate on the required components of the care plan, who develops and oversees the care plan and timeframes for reassessment.	Yes
<b>After hours care</b>	States often have contractual requirements for non-emergent, after-hours care, including 24-hour access to primary care providers.	Yes
<b>Continuity of care requirements</b>	Continuity of care protections set standards for when an enrollee transitions from fee-for-service to managed care, or from one MCO to another. Requirements can include upholding an existing plan of care until an HRA is performed and a new care plan is developed.	Yes

To ensure consumer protections are enforced, states must continually monitor and evaluate MCO compliance with contractual requirements. To ensure consumers are protected during an expansion of managed care, consumers and advocates generally encourage states to directly engage consumers and advocates in planning, establish oversight committees with consumer representation, and continue to gather consumer input through focus groups, surveys and stakeholder meetings in various regions throughout the state on an ongoing basis.

## **e. Emerging Delivery System, Care Delivery and Payment Reforms**

In addition to traditional methods to control costs such as use of MCOs, a growing number of states are focusing on other methods to move toward value-based care. States are exploring alternative delivery systems and payment reforms. These reforms include provider-based payment incentives and reimbursement structures with

increasing levels of financial risk designed to encourage care integration and provider accountability for health outcomes. The goal of these efforts is to improve health outcomes while constraining costs. Many of these alternatives are implemented alongside existing state MCO and PCCM efforts. Appendix II provides an overview of the continuum of payment models. Below presents an overview of the number of states pursuing a variety of efforts to increase care integration and improve care delivery.

- *Medicaid accountable care organizations (ACOs)*. An ACO generally refers to a group of health care providers, or a regional entity that contracts with providers, which are held financially responsible for the health of the population they serve. The organizational structure varies, but typically includes primary and specialty care physicians and a hospital(s) who are collectively responsible for coordinating, monitoring and improving the care of the population they serve. ACOs operate under a financial incentive system that rewards the value of care as opposed to volume, typically through one of two financial models:
  - *Shared savings*: Under this model, providers can share in savings if their attributed population uses a less costly set of health care resources than a predetermined baseline. Sometimes, over time, providers transition to share in risk, whereby they would have to pay the state back a percentage of costs if they exceed baseline numbers<sup>35</sup>.
  - *Global budget*: Under this model, ACOs accept full financial risk for the services they provide and receive a capitated payment per member.

In FY 2014, six states had active ACO programs. In FY 2015 or FY 2016, nine states are adopting or expanding ACOs. States use a variety of terms for ACO models; for example, coordinated care organizations (Oregon).<sup>36</sup>

- *Patient-centered medical homes (PCMH)*: Under a PCMH, a multi-disciplinary team holistically manages a client's care and needs including preventive services and access to supportive services, under the direction of a physician. Organizations often seek accreditation through an organization such as the National Committee for Quality Assurance. In FY 2014, PCMH initiatives operated in 26 state Medicaid programs<sup>37</sup>. PCMH initiatives generally include incentive payments for providers to make practice changes.
- *Health homes*: The ACA created an option for states to establish health homes to coordinate care for people who have chronic conditions or serious and persistent mental illnesses. Under this option, states contract with health home providers who are required to operate under a whole-person philosophy, integrating and coordinating all primary, acute, behavioral health and LTSS to treat the whole person<sup>38</sup>. Sixteen states operated Health Home programs in FY 2014<sup>39</sup>. Missouri implemented two initiatives in 2011.
- *Improved Coordination of Care for Dual eligible beneficiaries*: In order to better align coordination of care between Medicare and Medicaid, the ACA created the Medicare-Medicaid Coordination Office (MMCO) and the Financial Alignment Demonstrations. The MMCO worked with states to implement the FAD and a managed fee-for-service model to coordinate care for dual eligible beneficiaries (eligible for both Medicare and Medicaid). In addition, the MMCO has worked with the CMS Innovation Center (CMMI) to develop options for provider-led initiatives to improve care for dual eligible beneficiaries.
  - *Financial Alignment Demonstration*: Under the FAD, states enroll dual eligible beneficiaries into comprehensive MCOs that provide both Medicare and Medicaid services. According to CMS, ten states have approved FADs.<sup>40</sup>
  - *Managed Fee-For-Service*: Under the managed FFS model, CMS and a state enter into an agreement through which the state would be eligible to benefit from savings resulting from initiatives that improve quality and reduce costs for both Medicare and Medicaid. According to CMS, two states have approved managed FFS models.<sup>41</sup>

- *Reduce Avoidable Hospitalizations Among Nursing Home Residents:* Through this effort, CMS provides financial support to organizations that aim to improve the quality of care for people residing in nursing facilities by reducing avoidable hospitalizations. Organizations partner with a group of nursing facilities to implement evidence-based clinical and educational interventions that both improve care and lower costs.

One such initiative is the Missouri Quality Initiative (MOQI), implemented by the University of Missouri. The MOQI actively works in 16 nursing facilities in and around the St. Louis area. The centerpiece of the intervention includes placing advanced practice registered nurses (APRNs) within each facility to provide direct services to residents while mentoring, role-modeling, and educating the nursing staff about early symptom/illness recognition, assessment, and management of health conditions commonly affecting nursing home residents.

In addition to the options provided through the MMCO and CMMI, to improve care for dual eligible beneficiaries, a state may also pursue alignment of Medicare Advantage Special Needs Plans (D-SNPs<sup>42</sup>) with Medicaid MCOs, or Program of All-Inclusive Care for the Elderly (PACE) programs<sup>43</sup>. Missouri currently operates a PACE program.

- *Episode of care payments:* Some states are pursuing episode of care payments, where providers receive a payment for a defined condition or health event, creating a financial incentive for multiple providers to work together to manage care. Two states reported an episode of care payment program in place in FY 2014, while three states noted a small pilot in operation, or planned efforts in FY 2015, FY 2016 or FY 2017<sup>44</sup>.
- *Delivery system reform incentive payment program (DSRIP):* Some states operate Medicaid programs under a Section 1115 waiver and have authority to use Medicaid funds to operate performance-based incentive programs (DSRIPs). Under a DSRIP, states provide funding to hospitals and other providers to implement initiatives that will redesign how care is delivered to focus more on value-based care. Six states currently have DSRIPs in operation, or are implementing DSRIPs.<sup>45</sup>

The MO HealthNet request for proposal (RFP), issued on November 26, 2014, included a local care coordination program requiring MCOs to work with providers to develop care coordination and care management models by July 1, 2016. The RFP noted these models could include ACOs, PCMHs or PCCM programs.

## V. Alternative Medicaid Expansion

As of October 2015, 31 states (including DC) adopted the ACA Medicaid expansion.<sup>46</sup> Twenty-nine states implemented Medicaid expansion as of July 1, 2015, and 26 of those states are providing coverage to the expansion population through MCOs.

Nearly all states are implementing the expansion as set forth under the law. There are, however, a limited number of states that received approval through Section 1115 waivers to implement the expansion in ways beyond Medicaid law. The alternative expansions differed among the states, but general themes included:

- Mandatory premium assistance to purchase a qualified health plan through the marketplace or for employer-sponsored insurance;
- Medicaid premiums or monthly contributions beyond the amounts allowed under current law;
- Use of health savings accounts;
- Healthy behavior incentives to reduce or eliminate out-of-pocket expenses;
- Waivers of required benefits such as non-emergency medical transportation;
- Imposition of higher cost sharing than allowed under current law, particularly as it relates to non-emergent use of the emergency room; and

- Waivers of retroactive eligibility or reasonable promptness to, for example, allow coverage to begin on the first day a premium payment is made as opposed to the date of Medicaid application.

See the chart below of a summary of alternative Medicaid expansion provisions in four states.

State	Premium Assistance	Premiums/Monthly Contribution	Healthy Behavior Incentives	Co-payments	Retroactive Eligibility/Reasonable Promptness
Arkansas	X	X			
Indiana	X	X	X	X	X
Iowa	X	X	X		
Michigan		X	X		

## VI. Looking Forward in Missouri

The Medicaid landscape is changing across the country with the majority of states expanding Medicaid, many embarking on new Medicaid reforms such as managed LTSS or implementing new ACO-type models to deliver care. As we begin the conversation in Missouri and consider national efforts, it is important for stakeholders to consider the following questions.

1. What are the biggest concerns with MO HealthNet now?
2. Is there support for expansion of an MCO model statewide?
3. What types of incentives should providers receive to encourage integrated delivery of care? Should these incentives vary across MO HealthNet eligibility groups?
4. What types of delivery systems would be more readily accepted, such as ACOs, PCCM or Managed FFS, for:
  - a. Individuals who are blind, disabled or elderly?
  - b. Dual eligible beneficiaries?
5. What types of managed care models work better in rural areas? For example, MCO, ACO, PCCM, or Health Homes? What are the biggest challenges to implementing the various models in a certain geographic area?
6. What consumer protections are necessary in an MCO or ACO model?
7. Which type of delivery system(s) provide the highest quality of care to consumers?
8. Would higher cost sharing policies, such as premiums for newly eligible adults with incomes between 100-138 percent FPL face significant opposition from stakeholders?
9. What components of legislation introduced in either 2014 or 2015 as part of a Medicaid reform package faced the most opposition?

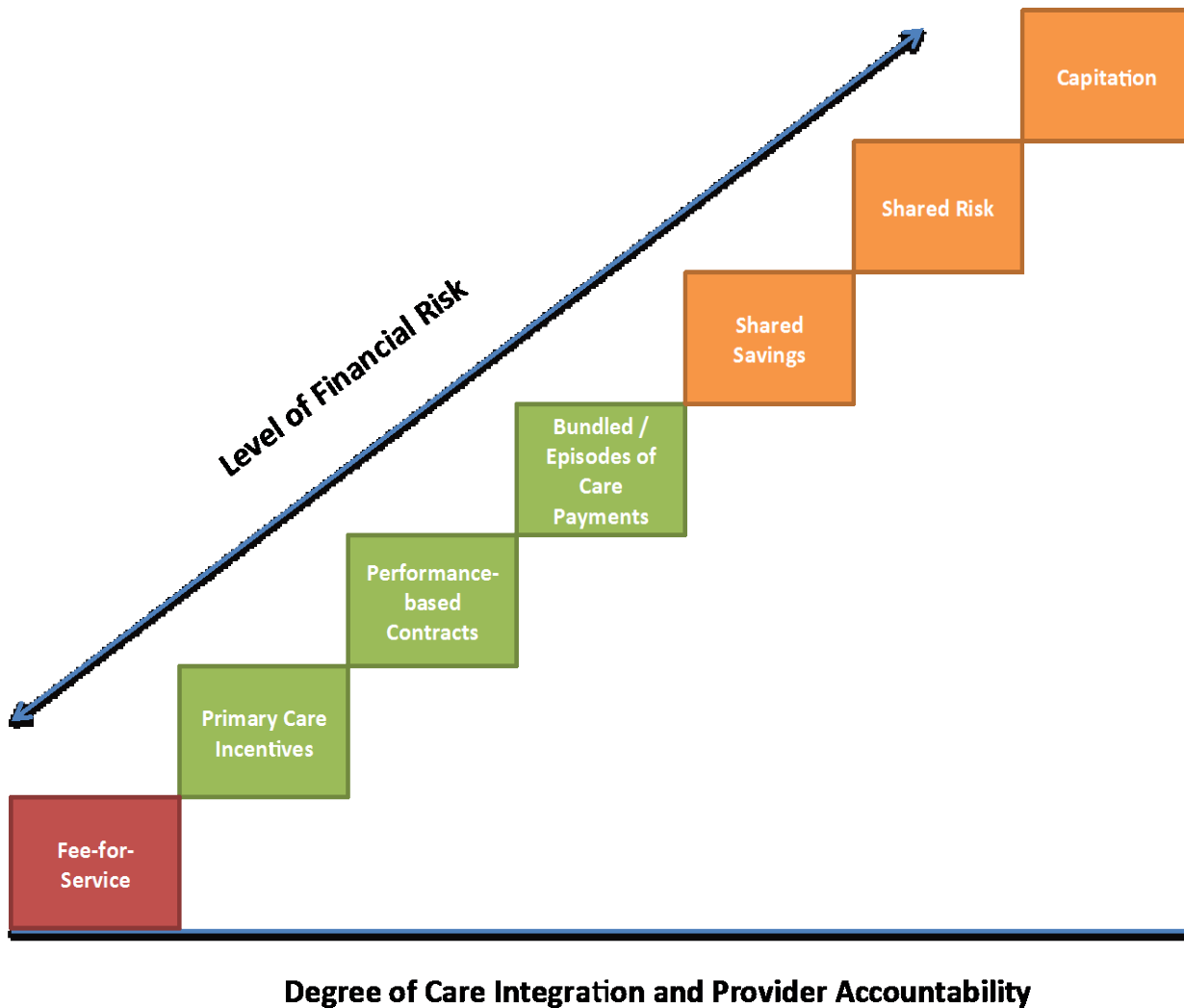
## VII. Appendix 1: Highlights of Recent Legislation

Year / Bill Number	Eligibility	Benefit Changes	Delivery System	Other
<b>2014</b>				
<b>HB 1969 (Barnes)</b>	<ul style="list-style-type: none"> <li>Medicaid and CHIP eligibility reductions for access to employer-sponsored insurance or premium tax credits through the marketplace. Affected eligibility groups included: CHIP, infants less than 1 year of age; women with breast and cervical cancer; pregnant women with incomes between 133-185% FPL; provided only limited Medicaid benefits to Ticket to Work and Blind Pension individuals;</li> <li>Ended the uninsured women's health program; and</li> <li>Shifted Medicaid disability determination process to Social Security Administration.</li> </ul>			
<b>HB 1901 (Torpey)</b>	<ul style="list-style-type: none"> <li>Increased Medicaid eligibility for adults to 133% FPL.</li> <li>Created CHIP coverage for unborn children up to 300% FPL.</li> <li>Included a proof of a work requirement for Medicaid eligibility except for elderly, disabled or medically frail.</li> </ul>	<ul style="list-style-type: none"> <li>Newly eligible adults would receive alternative benefit package, except those who are medically frail.</li> <li>Managed care enrollees are entitled to new essential health benefits package, including preventive care and rehabilitative services.</li> </ul>	<ul style="list-style-type: none"> <li>Expanded managed care statewide for children, parents, pregnant women, and newly eligible adults who are not medically frail.</li> <li>Beneficiaries with incomes between 100-133% FPL would receive subsidies to purchase coverage through the marketplace.</li> <li>Required MCOs to pay Medicaid providers comparable rates to providers in commercial plans.</li> <li>Required managed care plans to use provider</li> </ul>	<ul style="list-style-type: none"> <li>Imposed a premium equal to 1% of income on all Medicaid beneficiaries up to 150% FPL.</li> <li>Required cost sharing up to 5% of family income.</li> </ul>

			<p>pay-for-performance incentives.</p> <ul style="list-style-type: none"> <li>• Included pay-for-performance incentives for managed care plans.</li> <li>• Created opportunity for ACOs and pediatric care networks.</li> <li>• Created Health Care Home Program.</li> <li>• Included wellness incentives for healthy behavior.</li> </ul>	
<p><b>SB 524 (HCS) (Silvey)</b></p>	<ul style="list-style-type: none"> <li>• Extended Medicaid eligibility up to 133% FPL, as long as the federal government continues to pay at least 90 percent match.</li> <li>• Increased asset limit from \$1,000 to \$2,000 for an individual and from \$2,000 to \$4,000 for a couple.</li> <li>• Eliminates coverage for pregnant women above 133% FPL and provides prenatal care and pregnancy-related services to women to benefit the health of the unborn child.</li> <li>• Eliminated the Uninsured Women’s Health Insurance Program after Medicaid expansion is implemented.</li> </ul>	<ul style="list-style-type: none"> <li>• Provided alternative benefit package that includes essential health benefits to newly eligible who are not medically frail.</li> </ul>	<ul style="list-style-type: none"> <li>• Expanded managed care statewide for individuals who are not medically frail, disabled or aged.</li> <li>• Placed medically frail in health care homes.</li> <li>• Allowed individuals with incomes between 100 and 133% FPL to purchase coverage through the Marketplace.</li> </ul>	<ul style="list-style-type: none"> <li>• Added consumer protections from HB 1901.</li> <li>• Required cost sharing, including premiums up to 1% of income for individuals with incomes between 50% and 100% FPL.</li> <li>• Added workforce participation requirements.</li> <li>• Provided incentives for healthy behavior.</li> <li>• Established a fund for Medicaid-expansion related to savings to cover the cost of the expansion.</li> </ul>
<p><b>SB 739 (Romine) (Floor substitute)</b></p>	<ul style="list-style-type: none"> <li>• Increased asset limit from \$1,000 to \$2,000 for an individual and from \$2,000 to \$4,000 for a couple.</li> <li>• Created CHIP coverage for unborn children up to 300% FPL.</li> <li>• Medicaid and CHIP eligibility reductions for access to employer-sponsored insurance or</li> </ul>	<ul style="list-style-type: none"> <li>• Required Medicaid managed care plans to cover all the essential health benefits except rehabilitative services.</li> </ul>	<ul style="list-style-type: none"> <li>• Expanded Health Homes for all who are medically frail.</li> <li>• Expanded managed care statewide for children, parents,</li> </ul>	<ul style="list-style-type: none"> <li>• Required Medicaid managed care plans to charge maximum cost sharing allowed.</li> </ul>

	<p>premium tax credits through the Marketplace. Affected eligibility groups included: CHIP, infants less than 1 year of age, women with breast and cervical cancer, and</p> <ul style="list-style-type: none"> <li>• Required pregnant women with incomes between 133-185% FPL to enroll in Marketplace plans purchased by Medicaid.</li> </ul>		<p>pregnant women and newly eligible adults.</p> <ul style="list-style-type: none"> <li>• Created Medicaid CCOs for individuals who are aged or disabled.</li> <li>• Required MCOs to pay Medicaid providers comparable rates to providers in commercial plans.</li> <li>• Included new standards for medical loss ratios.</li> </ul>	
<b>2015</b>				
<b>SB 419 (Silvey)</b>	<ul style="list-style-type: none"> <li>• Authorized the Department of Social Services to seek a Medicaid block grant.</li> <li>• Provided for a new, 10-person, joint House and Senate committee authority to design a new Medicaid program.</li> <li>• Created a Healthcare Transformation Trust Fund to fund Missouri’s Medicaid program. No general revenue funds could be appropriated to the fund after the first year; instead, the state’s share must be paid out of provider taxes and savings. A shortfall to the trust fund results in providers receiving a pro-rata reduction in reimbursement rates.</li> </ul>			
<b>SB 301 (Silvey)</b>	<ul style="list-style-type: none"> <li>• Increased aged and disabled asset limit from \$1,000 to \$2,000 for an individual and from \$2,000 to \$4,000 for a couple.</li> <li>• Eliminated coverage for pregnant women with incomes between 133 and 185% FPL.</li> <li>• Eliminated uninsured women’s health program.</li> </ul>	<ul style="list-style-type: none"> <li>• Required Medicaid managed care plans to cover all the essential health benefits.</li> </ul>	<ul style="list-style-type: none"> <li>• Expanded managed care statewide for children, parents, and pregnant women.</li> <li>• Accepted bids from regional and statewide delivery options including pediatric care networks and provider-sponsored options.</li> <li>• Created a Health Care Home program for the medically frail.</li> </ul>	<ul style="list-style-type: none"> <li>• Provided for healthy behavior incentives.</li> <li>• Created new transparency and accountability requirements for MCOs.</li> <li>• Required the department to establish uniform utilization review protocols.</li> </ul>

## VIII. Appendix II: Overview of Value-based Payment Continuum<sup>1</sup>



This chart depicts a continuum of health care provider payment models. It assumes care integration across provider types increases as providers are expected to assume greater levels of financial risk for care delivery and health outcomes.

<sup>1</sup> Based on the Arizona Health Care Cost Containment System graphic. <http://azpaymentreform.weebly.com/value-based-purchasing-basics.html>. Web. 16 Nov. 2015.



## Endnotes

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- <sup>1</sup> Federal poverty level is a measure of income level issued annually by the Department of Health and Human Services (HHS). For 2015, 100% of FPL is \$11,770 for an individual and \$15,930 for a family of two.
- <sup>2</sup> The ACA expanded Medicaid to 133 percent FPL. Under federal regulations, states may disregard up to 5% of income, effectively increasing Medicaid eligibility to 138% FPL.
- <sup>3</sup> <http://files.kff.org/attachment/fact-sheet-summary-of-the-affordable-care-act>. Web. 21 Oct. 2015.
- <sup>4</sup> Smith, Vernon, and Robin Rudowitz. "Medicaid Reforms to Expand Coverage, Control Costs and Improve Care: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2015 and 2016." *The Henry J. Kaiser Family Foundation*. Web. 26 Oct. 2015.
- <sup>5</sup> Cross-Call, Jesse. "Medicaid Expansion Is Producing Large Gains in Health Coverage and Saving States Money." *Center on Budget and Policy Priorities*. Web. Oct. 2015.
- <sup>6</sup> Ibid.
- <sup>7</sup> Witters, Dan. "In U.S., Uninsured Rates Continue to Drop in Most States." *Gallup*. Web. 20 Oct. 2015.
- <sup>8</sup> Excludes Women's Health Services.
- <sup>9</sup> <http://kff.org/medicaid/state-indicator/distribution-of-medicaid-spending-by-service/#>
- <sup>10</sup> Disproportionate share hospital payments are payments made to hospitals by state Medicaid programs that serve a large number of Medicaid patients and the uninsured.
- <sup>11</sup> Rudowitz, Robin and Laura Snyder. "Medicaid Enrollment & Spending Growth: FY 2015 & FY 2016." *The Kaiser Commission on Medicaid and the Uninsured*. Web. Oct. 2015.
- <sup>12</sup> Arkansas, Colorado, Kentucky, Michigan, New Mexico, Oregon, Washington and West Virginia
- <sup>13</sup> Bachrach, Deborah. "States Expanding Medicaid See Significant Budget Savings And Revenue Gains." *State Health Reform Assistance Network*. Web. 19 Oct. 2015.
- <sup>14</sup> MO HealthNet is the term for Medicaid in Missouri.
- <sup>15</sup> <http://www.mobudget.org/wp-content/uploads/2015/10/Recommendations-Invest-in-MO.pdf>. Web. 26 Oct. 2015.
- <sup>16</sup> Ibid.
- <sup>17</sup> Assumes no changes to current income limits above \$138% FPL in the existing eligibility categories.
- <sup>18</sup> MCO refers to a health plan organization that receives a monthly per capita payment for each member to manage and provide all Medicaid benefits and services per its contract with the State.
- <sup>19</sup> Mental health services are provided on a fee-for-service basis for children in this eligibility category.
- <sup>20</sup> Smith, Vernon, and Robin Rudowitz. "Medicaid Reforms to Expand Coverage, Control Costs and Improve Care: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2015 and 2016." *The Henry J. Kaiser Family Foundation*. Web. 26 Oct. 2015.
- <sup>21</sup> MCOs may have to pay for services out of network if necessary to comply with its contract.
- <sup>22</sup> Smith, Vernon and Robin Rudowitz. "Medicaid Reforms to Expand Coverage, Control Costs and Improve Care: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2015 and 2016." *The Henry J. Kaiser Family Foundation* (2015). Web. 26 Oct. 2015.
- <sup>23</sup> Smith, Vernon and Robin Rudowitz. "Medicaid Reforms to Expand Coverage, Control Costs and Improve Care: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2015 and 2016." *The Henry J. Kaiser Family Foundation* (2015). Web. 26 Oct. 2015.
- <sup>24</sup> <http://www.ncleg.net/gascrpts/BillLookup/BillLookup.pl?Session=2015&BillID=h372>. Web. 12 Nov. 2015.
- <sup>25</sup> Ibid.
- <sup>26</sup> Out of 38 states as North Dakota does not cover children in their managed care contracts.
- <sup>27</sup> Out of 29 states as 10 states do not cover adult dental.
- <sup>28</sup> Study did not distinguish between eligibility and service carve-outs.
- <sup>29</sup> Smith, Vernon and Robin Rudowitz. "Medicaid Reforms to Expand Coverage, Control Costs and Improve Care: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2015 and 2016." *The Henry J. Kaiser Family Foundation* (2015). Web. 26 Oct. 2015.
- <sup>30</sup> Ibid.
- <sup>31</sup> As of July 1, 2015
- <sup>32</sup> As of July 1, 2015
- <sup>33</sup> MO HealthNet consumer protections identified through a review of MO HealthNet RFP issued on November 26, 2014.
- <sup>34</sup> Murrin, Suzanne. "State Standards for Access to Care in Medicaid Managed Care." *Department of Health and Human Services, Office of Inspector General*. Sept. 2014.
- <sup>35</sup> <http://www.chcs.org/media/ACO-Fact-Sheet-8615.pdf>. Web. 24 Oct. 2015.
- <sup>36</sup> Smith, Vernon and Robin Rudowitz. "Medicaid Reforms to Expand Coverage, Control Costs and Improve Care: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2015 and 2016." *The Henry J. Kaiser Family Foundation* (2015). Web. 26 Oct. 2015.
- <sup>37</sup> Ibid.
- <sup>38</sup> <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Integrating-Care/Health-Homes/Health-Homes.html>. Web. 22 Oct. 2015.
- <sup>39</sup> Smith, Vernon and Robin Rudowitz. "Medicaid Reforms to Expand Coverage, Control Costs and Improve Care: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2015 and 2016." *The Henry J. Kaiser Family Foundation* (2015). Web. 26 Oct. 2015.
- <sup>40</sup> <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/ApprovedDemonstrationsSignedMOUs.html>. Web. 25 Oct. 2015.

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<sup>41</sup>Ibid.

<sup>42</sup> Dual Eligible Special Needs Plans (D-SNPs) are offered to dual eligible beneficiaries and offer the opportunity of enhanced benefits by combining those available through Medicare and Medicaid.

<sup>43</sup> The PACE program provides comprehensive medical and social services to certain frail, community-dwelling elderly individuals, most of whom are dually eligibles to help people meet their health care needs in the community instead of going to a nursing home or other care facility.

<sup>44</sup> Smith, Vernon and Robin Rudowitz. "Medicaid Reforms to Expand Coverage, Control Costs and Improve Care: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2015 and 2016." *The Henry J. Kaiser Family Foundation*. Web. 26 Oct. 2015.

<sup>45</sup>Ibid.

<sup>46</sup> Ibid.