A pathway to a reformed and expanded MO HealthNet system: COMPETITIVE, ACCOUNTABLE, AND SIMPLIFIED
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This document offers a pathway to a competitive, accountable, and simplified MO HealthNet (Missouri’s Medicaid program). We developed the pathway by getting feedback about Medicaid reform and expansion from Missourians who are directly involved in MO HealthNet:

- **Stakeholders** (health providers and advocates for MO HealthNet such as physicians, hospitals, consumer advocates, professional associations, and legislators) gave feedback through surveys, individual interviews, and focus groups
- **Consumers** who get their health care through MO HealthNet gave feedback through focus groups

### STAKEHOLDERS WOULD LIKE TO SEE THESE REFORMS:

**Finding 1: Reform certain systems** (details on page 7)
- Expand Medicaid to improve overall health of Missourians and increase the number of people who are able to work
- Improve managed care oversight to strengthen consumer protections
- Simplify administrative processes to make it easier to apply for and use MO HealthNet
- Improve communication and data sharing among MO HealthNet staff, providers, and managed care organizations
- Increase MO HealthNet staffing levels so the program can be managed effectively

**Finding 2: Reform the provider’s role** (details on page 8)
- Improve the way providers coordinate care so consumers have better health outcomes
- Emphasize care by primary care providers
- Use home and community-based services to give better care to high-cost and complex groups such as the aged, blind, and disabled (ABD)

**Finding 3: Reform the way providers are paid** (details on page 9)
- Pay providers based on quality of care instead of quantity of care
- Raise reimbursement rates for providers
PATHWAY TO A BETTER MO HEALTHNET: OUR RECOMMENDATIONS

RECOMMENDATION 1: Reform delivery systems to create competition (details on pages 10-13)

We recommend creating new systems for care delivery to MO HealthNet consumers. These systems would depend on both the consumer’s eligibility and where they live and would continue the managed care option in communities along Interstate 70. Expanding Medicaid would make enrollment numbers high enough to use multiple delivery models:

<table>
<thead>
<tr>
<th>Primary care case management</th>
<th>Coordinating care entities</th>
<th>Managed fee-for-service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care case management is when a primary care provider receives a small case management fee to coordinate care. The fee is linked to meeting quality goals.</td>
<td>The coordinating care entities would coordinate their enrollees’ care in a specific geographic area and ensure the primary care provider is the main provider of care. Coordinating care entities: • Get a care coordination fee • Get shared savings • Are accountable for the quality and cost of care provided to their enrolled population In this model, medical services are still fee-for-service.</td>
<td>Consumers eligible for both Medicaid and Medicare could choose to enroll in ABD+ networks for coordination of services. This model: • Uses ABD+ network reimbursement and accountability measures • Lets providers access Medicare shared savings with federal approval</td>
</tr>
</tbody>
</table>

RECOMMENDATION 2: Improve accountability (details on page 14)

<table>
<thead>
<tr>
<th>Managed care organizations</th>
<th>Consumers</th>
<th>MO HealthNet</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Use stakeholder advisory boards • Enhance network requirements • Have public reporting of managed care organization performance</td>
<td>Use healthy behavior incentives</td>
<td>• Improve the quality of MO HealthNet consumer data that is shared with providers and delivery systems • Increase staffing to support the goals of reform</td>
</tr>
</tbody>
</table>

RECOMMENDATION 3: Simplify processes (details on page 15)

<table>
<thead>
<tr>
<th>Expand eligibility</th>
<th>Simplify enrollment</th>
<th>Standardize requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implement the Medicaid expansion and 12-months continuous eligibility for children and adults</td>
<td>Develop simplified enrollment forms with adequate explanation of eligibility requirements</td>
<td>Standardize managed care organization administrative requirements to eliminate burden on providers</td>
</tr>
</tbody>
</table>
GOALS OF RECOMMENDED REFORMS

Our recommendations will address stakeholders’ and consumers’ concerns and achieve these goals:

1. **Promote the primary care provider** through a primary care case management structure especially for complex populations such as the aged, blind, and disabled.

2. **Build on the successful health home model** and introduce new provider-driven delivery models, which improves quality and reduces costs by letting providers move toward integrated care delivery, enhanced care coordination, and competition with managed care organizations (see Appendix 3 for cost savings attained through the Missouri health homes).

3. **Expand Medicaid to 138% of the federal poverty level.** The expansion would add about 300,000 lives to MO HealthNet, ensuring a large-enough enrollment to implement the delivery system reforms.

4. **Improve and simplify enrollment and administrative processes**

5. **Offer enhanced reimbursement levels** to practices that meet process and quality measures.

6. **Make the reforms contingent** on continued enhanced federal match for newly eligible adults.
The goal of this project was to collect insights and preferences from stakeholders about what Missouri Medicaid reform and expansion could look like.

In September of 2015, the Health Care Foundation of Greater Kansas City contracted with StratCommRx and ES Advisors, LLC to conduct research and get feedback from MO HealthNet stakeholders and consumers. The foundation requested 2 deliverables:

- A context report
- A pathway document

**CONTEXT REPORT**

The context report is an overview of Missouri’s existing Medicaid program and a look at emerging issues around the program. We created it by doing a literature review and having phone conversations with key government and policy resources. We presented this report to stakeholders in December of 2015.

**PATHWAY DOCUMENT**

This document is the second and final deliverable and is intended to offer a pathway to MO HealthNet reform and expansion that builds on findings of this project.

**Research methods for this pathway document**

After presenting the context report, we collected health care stakeholders’ and legislators’ feedback through a series of phone interviews, focus groups, and in-person meetings. We finished the research in April 2016.

Altogether, we gathered input from 46 health care stakeholders, such as physicians, hospitals, consumer advocates, and professional associations (see Appendix 1 for a breakdown of participants’ affiliations):

- 94 stakeholders were invited to participate
- 46 participated in an interview or focus group
- 28 interviews, including 4 legislator meetings
- 19 completed surveys
- 3 focus groups with a total of 18 participants

At the same time, qualitative researchers from the University of Kansas conducted focus groups with 70 Missourians who have direct experience with MO HealthNet. We also used their findings to develop this report.
The research revealed the following themes, which we used to develop the proposed pathway to Medicaid reform and expansion in Missouri.

**FINDING 1: REFORM SYSTEMS**

**EXPAND MEDICAID**

(See Appendix 2 for basic information on the Medicaid program in Missouri)

Medicaid expansion could streamline administrative processes by raising the number of people who qualify directly and reducing those who must qualify through spend down or disability.

Findings from the research

**95%**

of interviewees strongly agreed that Missouri should expand Medicaid to 138% of the federal poverty level

Medicaid consumers said expanding Medicaid to adults could:

- Improve overall health
- Reduce the number of disabled individuals
- Increase the number of working Missourians

**SIMPLIFY PROCESSES**

Both stakeholders and Medicaid consumers identified a need to simplify and improve the eligibility process and spend down determination.

Stakeholders also identified a need to simplify and improve:

- MO HealthNet and managed care organization communications with consumers
- Appeals processes
- Payments to providers

**SHARE DATA AND IMPROVE DATA INTEGRITY**

Research identified a need for health information exchanges and improved data quality between MO HealthNet providers and managed care organizations.

**INCREASE MO HEALTHNET STAFF**

Interviewees largely agreed that MO HealthNet staffing levels are too low to manage the existing program, including overseeing the managed care organization contracts and administering the enrollment process. Any reform efforts will need to consider the capacity of MO HealthNet.
FINDING 2: REFORM THE PROVIDER’S ROLE

CREATE MORE PROVIDER-LED OPPORTUNITIES

Stakeholders would like providers to better coordinate care for Medicaid consumers and improve health outcomes.

(a system in which a group of providers works together to maintain the health of a specific population and is financially responsible based on the health of that population – it can promote accountability, quality improvement, and improved health outcomes)

EMPHASIZE PRIMARY CARE PROVIDERS

Research identified:

• Primary care case management as the best model of care for all populations except for those in urban areas
  With primary care case management, a patient’s main provider gets a small monthly fee to help organize the patient’s care

• In urban areas, an accountable care organization as the best model, followed by a managed care organization
  An accountable care organization is paid based on the patient’s outcomes instead of the treatments given

TARGET HIGH-COST AND COMPLEX POPULATIONS

The state should target improved care delivery for high-cost and complex populations such as aged, blind, and disabled adults and medically complex children, but should not use traditional managed care organizations to do so.

Stakeholders generally felt the health home model is successful and can be built on

• A health home model involves providers working with the patient, their family, and services in their community to help maintain the health of patients with chronic conditions

89% of interviewees agreed or strongly agreed that doctors should be incentivized toward integrated care delivery

90% of interviewees agreed or strongly agreed that the state should improve delivery of care for the aged, blind, and disabled population by encouraging the use of home and community-based services
FINDING 3: REFORM THE WAY PROVIDERS ARE PAID

USE QUALITY-BASED PAYMENT

Most people we interviewed agreed that the state should move away from volume-based payments and reward providers for improved quality of care. Most people cautioned that quality measures must take into account the specific health and socio-economic needs of the Medicaid population. This will help ensure that Medicaid provider performance is fairly measured.

PAY PROVIDERS MORE

Research revealed a common understanding that provider reimbursement rates are too low. This causes:

- Inadequate provider networks
- An inability to invest in quality improvements
Based on the research findings and the current MO HealthNet managed care structure, we recommend these reforms to create a competitive, accountable, and simplified MO HealthNet.

RECOMMENDATION 1: ADD NEW DELIVERY SYSTEMS TO DRIVE COMPETITION

The first reform would add new provider-driven models to delivery of care for MO HealthNet consumers. Provider driven models are delivery systems that make providers responsible for the health outcomes of their patients, basing part of their payment on those outcomes. Expanding Medicaid eligibility is essential for this reform. Expansion can ensure that Missouri enrollment is large enough for multiple delivery models to compete and reduce health care spending overall.

By introducing new provider-driven models of care:

- Consumers can choose the delivery system that best fits their needs
- Providers can compete with managed care organizations on quality and cost

The new delivery systems would include:

1. A primary care case management option
2. 2 types of coordinating care entities – ABD+ (aged, blind, and disabled) network and family network – in which formal provider networks coordinate their enrollees’ care
3. A managed fee-for-service option for dual-eligible consumers (eligible for both Medicare and Medicaid)

Populations served would include:

**AGED, BLIND, AND DISABLED POPULATIONS**

- Mandatory primary case management if not eligible for Medicare
- Voluntary managed fee-for-service if eligible for Medicare
- Optional ABD+ Network regardless of Medicare eligibility

**FAMILY HEALTH POPULATIONS (PARENTS, CARETAKER RELATIVES, CHILDREN, PREGNANT WOMEN, AND NEWLY ELIGIBLE ADULTS)**

- Inside I-70 corridor, mandatory choice between managed care organization or family network with optional ABD+ Network for the medically complex
- Outside I-70 corridor, mandatory primary care case management with optional ABD+ network for the medically complex
The primary care provider (PCP):
• Is at the center of care delivery
• Receives a small case management fee for care coordination

PCPs can include specialists, such as psychiatrists, depending on the needs of the individual. Medical services are still reimbursed via fee-for-service (see appendix 4 for background information on primary care case management programs nationally).

Primary care providers would receive a base monthly per-member fee to coordinate care. The fee could be tiered based on:
• The level of consumer-centered medical home designation
• The complexity of the consumer population (family health versus aged, blind, and disabled)

We recommend matching Medicare rates for primary care services for 3 years if providers meet process and quality measure benchmarks designed to encourage quality care.

To ensure accountability, you may withhold a small percentage of the per-member, per-month fees that primary care physicians can earn back by meeting annual process or quality targets. They could also need to meet process benchmarks toward consumer-centered medical home designation in order to maintain the Medicare-equivalent reimbursement rates.

A coordinating care entity is a network of providers with:
• A governance structure
• Standardized, evidence-based care management practices

A coordinating care entity is similar to an accountable care organization, but is adapted to fit the needs of the Medicaid population and the goals for reform in Missouri. (See Appendix 5 for background on the development of Medicaid accountable care organizations.) They provide a whole-person approach to care management for consumers aimed at improving quality while reducing costs. At a minimum, this would include:
• Primary care providers
• A hospital
• Behavioral health
• Specialist providers

Coordinating care entities would:
• Receive a per-member, per-month care management fee
• Be eligible for shared savings payments after a specified period of time

The coordinating care entity must develop a reimbursement schedule for its provider network designed to:
• Create value and savings
• Encourage practice redesign
• Promote care coordination
• Integrate primary care and behavioral health

Medical services would still be reimbursed through fee-for-service.

Options for accountability include:
Withholding the monthly per-member, per-month fee that coordinating care entities can earn back by meeting process or quality measure targets
Shared savings payments based on meeting a minimum savings threshold and gatekeeper quality measure thresholds. Gatekeeper quality measures ensure that coordinating care entities focus on improved quality first and not just reduced costs to reach shared savings payments.

Quality measure targets should:
• Match the coordinating care entity’s specific population
• Include risk-adjustment
• Align with the Medicare Access and CHIP Reauthorization Act of 2015
The primary care physicians enrolled in the state’s primary care case management program would be at the center of care delivery and adequately represented in the governance structure.

Coordinating care entities should:

- Coordinate all care including necessary community-based supports
- Promote community-clinical collaborations
- Integrate primary and behavioral health care

There would be two types of coordinating care entities:

- **ABD+ Network**
  An expanded health home model that serves the aged, blind, disabled, high cost, and medically complex populations. ABD+ networks would have the ability to target services to complex populations in its geographic area.

- **Family Network**
  An integrated delivery system that would:
  - Serve the family health population in urban areas
  - Have a larger enrollment minimum than an ABD+ network
  - Establish a full network of providers in order to meet time and distance standards and panel size requirements established for managed care organizations in the respective geographic regions

Coordinating care entities should serve a geographic area defined by either county or zip code. To ensure good care coordination, coordinating care entity providers must share information in a timely manner (such as real-time alerts to primary care physicians of emergency department visits) and use telemedicine when appropriate.

ABD+ Networks would have a smaller enrollment minimum than a family network.

MO HealthNet, with public input, would develop a definition of medically complex before releasing the request for proposals.

Providers that participate in a coordinating care entity could also participate in a managed care organization network. MO HealthNet would be required to ensure that managed care organization contracts include protections for coordinating care entity providers.

Providers that do not participate in a coordinating care entity would continue to:

- Serve Medicaid consumers as usual
- Receive referrals from coordinating care entities or through managed care organization contracts
A managed fee-for-service program would work with ABD+ networks to serve dual-eligible consumers. In this program, ABD+ networks must coordinate all Medicare (Parts A, B and D) and Medicaid covered services including:

- Long-term care
- Institutional care
- Community-based services and supports

Care delivery must include a focus on:

- Improving health in nursing facilities such as recognizing early symptoms and illness
- Assessing and managing health conditions common to nursing home residents
- Serving individuals in the community

The Missouri Quality Initiative is one such existing model.

ABD+ networks would receive a per-member, per-month fee to provide care coordination and care management services. Medical services will still be reimbursed through fee-for-service.

Options for accountability include:

- The same as those for ABD+ Networks
- Access to share in Medicare savings with federal approval
RECOMMENDATION 2: IMPROVE ACCOUNTABILITY ACROSS THE BOARD

The new delivery system payment reforms encourage accountability at the provider and delivery system level. Recommendation 2 ensures accountability for managed care organizations, consumers, and MO HealthNet staff.

IMPROVE ACCOUNTABILITY FOR MANAGED CARE ORGANIZATIONS

The pathway recommends implementing reforms that improve managed care organization accountability. Reforms could include:

- Implement stakeholder advisory boards that include 50% consumer participation
- Enhance network requirements by defining panel size requirements
- Develop easy-to-read materials for consumers and clear guidelines on the grievance and appeals process and how to change providers
- Require MO HealthNet oversight of denials and partial denials of care
- Publicly report managed care organization sanction, grievance and appeals, and quality measure outcomes
- Enforce medical loss ratios and secret shopper surveys

MO HealthNet staffing challenges

Many interviewees noted that:

- Increasing MO HealthNet capacity would improve oversight
- MO HealthNet must enforce sanctions including breach of contract and network inadequacies

To ensure reforms are appropriately implemented and accountability measures are monitored and enforced, the pathway recommends increasing MO HealthNet staff as necessary to meet the goals of reform.

INCREASE CONSUMER ACCOUNTABILITY

Options to increase consumer accountability include:

- Strong care management practices that help people engage in self-management of care
- Rewards for consumers such as healthy behavior incentives

Healthy behavior incentives

Healthy behavior incentives could include credits for certain healthy behaviors that could be applied to:

- Co-pays
- Buying health-related products, such as over-the-counter medicines

The healthy behavior incentives should be designed to encourage optimal health outcome goals for the MO HealthNet population and could include:

- Up to $100 for completion of a smoking cessation course
- Between $10 and $25 per healthy behavior activity up to an annual maximum amount for the following activities:
  - Completion of recommended well-child visits
  - Receiving routine immunizations
  - Adherence to routine preventative appointments and routine cancer screenings
  - Maintaining prenatal and postnatal appointments
  - Adhering to tuberculosis testing
  - Completing sexual health education counseling, nutrition counseling, or weight loss management activities
RECOMMENDATION 2: IMPROVE ACCOUNTABILITY ACROSS THE BOARD

INCREASE MO HEALTHNET ACCOUNTABILITY

To support care management, MO HealthNet must more actively maintain accurate and up-to-date consumer information that it would share with providers and delivery systems. One strategy for improving accuracy of MO HealthNet consumer data is improving data sharing across government programs.

Reform MO HealthNet department

Stakeholders largely agreed that MO HealthNet lacks adequate staffing and capacity to properly manage the program. A pathway to reform should include plans to:

• Evaluate and reorganize the department
• Increase staffing levels to support the goals of reform
• Simplify administrative processes to improve customer service and enrollment functions

RECOMMENDATION 3: SIMPLIFICATION

Stakeholders and Medicaid consumers largely agreed that existing processes are cumbersome, time consuming, and confusing for consumers and providers. The reformed MO HealthNet would include:

SIMPLIFIED ELIGIBILITY

We recommend simplifying eligibility processes to

• Allow consumers to enroll easily
• Provide options counseling
• Provide continuity in coverage

Recommendations include:

• Medicaid expansion
• 12-months continuous eligibility for children and adults, consistent with private sector standards
• Simplified Family Support Division enrollment forms with adequate explanation of eligibility requirements
• Increased Family Support Division staffing to process enrollment forms in a timely manner to ensure prompt delivery and continuity of care

LOWAGE LIMIT FOR HOME AND COMMUNITY-BASED SERVICES WAIVER

We also recommend lowering the age limit for the aged and disabled home and community-based services waiver to:

• Support community integration
• Improve care for aged, blind, and disabled consumers

STANDARDIZED ADMINISTRATIVE PROCESSES

Managed care organizations should standardize administrative requirements such as:

• Standard prior authorization forms
• Grievance and appeals processes
• General definition of medical necessity that require managed care organizations to use nationally recognized standards of good medical practice
Legislators can implement many of the reforms through Medicaid state plan amendments. However, some of the proposed reforms require approval by the federal Department of Health and Human Services through 1115 waiver authority, including:

- 12-months continuous eligibility for adults
- Mandated enrollment of children with supplemental security income into a primary care case management model

Pursuing an 1115 waiver gives the State an opportunity to negotiate a delivery system reform incentive payment initiative. A delivery system reform incentive payment initiative would allow the state to reinvest federal savings from proposed reforms at the provider-level in Missouri. These savings can support the development of practice improvements and coordinating care entities.

Furthermore, we recommend that continuation of the reforms outlined in this pathway document are contingent on Missouri maintaining the enhanced federal match for newly eligible adults.
The research revealed the following themes, which we used to develop the proposed pathway to Medicaid reform and expansion in Missouri.

ERIKA SALESKI, ES ADVISORS, LLC

PROFILE

Erika Saleski owns ES Advisors, LLC, which provides consulting services to state and local governments, and community-based, non-profit and for-profit organizations focused on making investments in healthcare and improving health outcomes of low-income communities. Erika offers expertise and a proven track record in project management, Medicaid managed care contracting and care coordination, public policy research and analysis, and federal policy negotiation.

CAREER HIGHLIGHTS

Erika led policy development for the Office of Management and Budget, Executive Office of the President (OMB), under 2 US Presidents, including for over 50 Medicaid 1115 waivers, the Deficit Reduction Act of 2005, the Affordable Care Act, and the American Reinvestment and Recovery Act. While at the OMB, Erika received the Professional Achievement Award 3 years in a row. Recently, Erika provided project management services to lead an overhaul of the Illinois Medicaid delivery system, negotiating state and federal approval of 4 new Medicaid initiatives including a Medicare-Medicaid alignment initiative for dual eligible beneficiaries.

EDUCATION

Bachelor of Psychology, American University in Washington, DC
Master of Public Policy, University of Chicago in Chicago, IL

KELLY FERRARA, STRATCOMMRx

PROFILE

Kelly Ferrara is President and owner of StratCommRx. Kelly wields nearly 20 years of experience in communications consulting for her consumers. She helps companies and organizations understand whom they want to reach and what they want to say, determining how they want to say it and why their audiences should pay attention. In short, she connects messages with audiences.

CAREER HIGHLIGHTS

Kelly’s experience with consumers across a variety of industries has helped her become the strategic thinker, polished writer, insightful collaborator, compelling facilitator, savvy marketer and organizational advocate who is trusted by her consumers and colleagues. A leader in corporate communications and public engagement campaigns for organizations, Kelly has worked with consumers of all shapes, sizes and markets. Kelly describes herself as a puzzle solver – and enjoys sleuthing out clues to unlock communications opportunities for all her consumers. Ask her what makes an ideal consumer, and she’ll reply “someone with an interesting problem to solve.”

EDUCATION

Bachelor of Science, English Education, Southern Illinois University – Carbondale
The research revealed the following themes, which we used to develop the proposed pathway to Medicaid reform and expansion in Missouri.

94 stakeholders were invited to participate in the research effort.

46 stakeholders gave feedback in either individual interviews or focus groups:
- 28 individual interviews, including 4 in-person legislator meetings
- 3 focus groups with 18 total participants

A separate worksheet was available to all participants and 19 were submitted.

### Affiliation of Participants

<table>
<thead>
<tr>
<th>Affiliation</th>
<th># of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Representatives of hospitals and safety net clinics</td>
<td>12</td>
</tr>
<tr>
<td>Consumer Advocates</td>
<td>9</td>
</tr>
<tr>
<td>Members of the Missouri General Assembly</td>
<td>8</td>
</tr>
<tr>
<td>Health policy experts</td>
<td>4</td>
</tr>
<tr>
<td>Physicians</td>
<td>3</td>
</tr>
<tr>
<td>Representatives of insurers</td>
<td>2</td>
</tr>
<tr>
<td>Representatives from behavioral health providers</td>
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</tr>
<tr>
<td>Healthy philanthropy</td>
<td>2</td>
</tr>
<tr>
<td>Aging Advocates</td>
<td>1</td>
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<tr>
<td>Pharmacists</td>
<td>1</td>
</tr>
<tr>
<td>Emergency Medical Technicians</td>
<td>1</td>
</tr>
</tbody>
</table>
ELIGIBILITY

Missouri Medicaid, the MO HealthNet program, provides health coverage to more than 950,000 low-income Missourians.

Individuals can enroll in the program when they meet the requirements for one of the eligibility groups. Each eligibility group provides coverage for individuals up to a certain income level based on the Federal poverty level. Federal poverty level is a measure of income issued annually by the Department of Health and Human Services. For 2016, 100% of FPL is $11,880 for an individual and $16,020 for a family of two.

MANAGED CARE

About 50% of the Missouri Medicaid population uses a managed care organization for most of their Medicaid benefits and services. The aged, blind, and disabled population is not eligible to enroll in a managed care organization and receives services through fee-for-service.

MEDICAID EXPANSION

Missouri does not provide coverage to the Medicaid expansion population (newly eligible adults) as allowed by the passage of the Affordable Care Act of 2010. If Missouri were to expand coverage to newly eligible adults up to 138% of the FPL, it would expand coverage to more than 300,000 individuals. Newly eligible adults include parents, caretaker relatives, and childless adults.

RESOURCES

Missouri Medicaid Basics – Missouri Foundation for Health

Missouri Medicaid Basics – Health Literacy Missouri

Insights Audit: MO HealthNet Reform Context Report

Family Support Division/MO HealthNet Division-Monthly Management Report
http://dss.mo.gov/re/fsd_mhdmr.htm

Investing in Missouri: Creating a Better Future for Our Families

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 Affordable Care Act created an option for states to establish health homes to coordinate care for people who have:

- Chronic conditions
- 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 long-term services and supports to treat the whole person.

HEALTH HOMES IN MISSOURI

In 2011, Missouri implemented two health homes initiatives, the Primary Care Health Homes and the Community Mental Health Center Healthcare Homes. According to the Missouri Coalition for Community Behavioral Healthcare after the first year of implementation, the Missouri health homes:

- Saved about $36.3 million
- Reduced hospitalizations by more than 9%

BENEFITS AND IMPLEMENTATION

The Center for Healthcare Strategies fact sheet on health homes says, “Health homes can serve as a foundation to build more advanced systems of care, such as accountable care organizations, and to adopt more sophisticated payment methods, like episodes-of-care or bundled payments.”

It goes on to say: “As of July 2016, 19 states and the District of Columbia have Medicaid health home programs. Some states have submitted multiple health home state plan amendments to target different populations or conditions, with 28 health home models in operation.”

RESOURCES

Health Homes Federal Policy
http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Integrating-Care/Health-Homes/Health-Homes.html

Missouri Health Homes Facts and Figures
http://www.mocoalition.org/#!health-homes/c14fu

Medicaid Health Homes: Implementation Update
http://www.chcs.org/media/Health_Homes_FactSheet-07-25-16.pdf
State use of primary care case management in Medicaid dates back to the 1980s. These programs typically center delivery of care around the primary care physician, providing a small case management fee for limited care management activities.

As these programs evolved, States enhanced primary care case management programs to include additional elements, such as “more intensive care management and care coordination for high-need beneficiaries, improved financial and other incentives for primary care physicians, and increased use of performance and quality.”

19 states operate some form of primary care case management:
- 9 states operate primary care case management programs only and
- 10 states operate both managed care organizations and primary care case management dependent upon eligibility

Analysis of some historically prominent primary care case management programs have found overall cost savings:
- An actuarial analysis found the Pennsylvania ACCES Plus program costs for the first year to be about 6% below the program costs for the voluntary managed care organization program
- An actuarial analysis of the Community Care Program of North Carolina found savings for state fiscal years 2003 – 2007 ranged from 6% to 11% depending on the fiscal year

RESOURCES

**Enhanced Primary Care Case Management Programs in Medicaid: Issues and Options for States.**
An overview of program elements and discussion of performance of five enhanced primary care case management programs.

**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.**
This report provides information on which states operate primary care case management programs, and which states plan to adopt or terminate primary care case management programs.

**Insights Audit: MO HealthNet Reform Context Report**
An accountable care organization generally refers to a group of health care providers held financially responsible for the health of the population they serve. They typically include primary and specialty care physicians and hospitals who are collectively responsible for coordinating, monitoring, and improving the care of the population they serve.

The Center for Health Care Strategies says: “Through refined payment incentives, quality measurement and monitoring, analysis of consumer and population health data, and an increased emphasis on care coordination, Accountable Care Organizations have the potential to improve health care quality while reducing costs.”

**FINANCIAL INCENTIVES**

Accountable Care Organizations operate under a financial incentive system that rewards the value of care as opposed to volume. They typically use one of two financial models:

**SHARED SAVINGS**

Under this model, providers can share in savings if their population uses a less costly set of health care resources than a fixed baseline. Sometimes, providers transition to share in risk, so that they would have to pay the state back a percentage of costs if they exceed baseline numbers.

**GLOBAL BUDGET**

Under this model, Accountable Care Organizations accept full financial risk for the services they provide and receive a specific payment per-member over a set time (such as per-month). They get this payment whether or not a person seeks healthcare services.

**CURRENT IMPLEMENTATION**

Currently, 9 states operate Medicaid Accountable Care Organizations and 8 more are pursuing similar programs. Over the past 4 years, states that launched Medicaid ACO or ACO-like programs have reported savings of roughly $167.9 million. See below for savings and utilization results from several state Medicaid Accountable Care Organization programs:

- Colorado achieved $77 million in net savings over 4 years
- Minnesota saved $76.3 million over 2 years
- Oregon decreased emergency department (ED) visits by 23% and held costs under the programs’ required 2% growth rate since 2011
- Vermont saved $14.6 million in the program’s first year

**RESOURCES**

  http://www.chcs.org/media/ACO-Fact-Sheet-032116.pdf
- Medicaid Accountable Care Organizations: State Update. August 2015.
  http://www.chcs.org/media/ACO-Fact-Sheet-8615.pdf
- Medicaid Accountable Care Organizations: State Profiles.
  http://www.chcs.org/media/Medicaid-Accountable-Care-Organization-Programs-State-Profiles-1115.pdf
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