

Issues in Missouri Health Care 2013



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Acknowledgement

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Section

1

Executive Summaries

The State of Health in Missouri: Coverage, Access and Health Status

On two well respected state health rankings, Missouri ranks in the bottom third of all states in the United States. According to the 2012 America's Health Rankings, formulated from a variety of national sources, Missouri ranked 42nd overall on a wide range of public and environmental health issues, clinical indicators, and health outcomes. Missouri previously ranked 40th in 2011 and 39th in 2010.¹ The Commonwealth Fund's State Scorecard on Health System Performance, 2009, ranked Missouri 36th in the country on measures of coverage, access, quality, and equity.² Missouri performed better on the Commonwealth Fund's Child Health Scorecard, ranking 21st overall on measures of access and affordability, prevention and treatment, potential to lead healthy lives, and equity for children.³ The Kaiser Family Foundation provides the most up-to-date measures of state health indicators through its interactive website, www.statehealthfacts.org, and indicates Missouri ranks in the bottom quartile of states on a variety of health status measures. Some of the indicators behind these rankings are explored in this collection of briefs.

Since the constitutionality of key components of the Patient Protection and Affordable Care Act (ACA) have been validated by the Supreme Court, Missouri, like other U.S. states, should focus on preparing for the remaining implementation of the law. Missouri has many opportunities to leverage federal resources to improve population health through enhanced access to health care, especially preventive services, and more coverage options for the uninsured. Missouri may have an opportunity to make improvements in this area through state legislative action. Furthermore, the state does not appear to be using health policies with proven effectiveness at addressing some of the indicators of poor health status in Missouri that are preventable conditions (e.g., smoking and obesity).

Uninsured Prescription: Policy Options for Covering the Uninsured

As a result of the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 and the ACA, Missouri has a number of opportunities for policy reforms related to providing health coverage to state residents who are uninsured. These reform options, along with mandated changes, include incremental steps designed to shore up and expand access to the private insurance market, an expansion of the Medicaid program to cover non-Medicare individuals under age 65 with incomes up to 133 percent of the federal poverty level (FPL), the establishment of Health Insurance Exchanges, and requirements for individuals and employers to participate in the health insurance system.

Under the authority of CHIPRA, Missouri may implement new approaches to enrolling children who are eligible for, but not participating in Medicaid and the Children's Health Insurance

1 United Health Foundation. 2011. America's health rankings. Available: <http://www.americashealthrankings.org/>.

2 The Commonwealth Fund. 2009. State scorecard. Available: <http://www.commonwealthfund.org/Maps-and-Data/State-Data-Center/State-Scorecard.aspx>

3 The Commonwealth Fund. 2011. Child health scorecard. Available: <http://www.commonwealthfund.org/Maps-and-Data/State-Data-Center/Child-Health.aspx>

Program (CHIP). Nationally, it is estimated that 65 percent of uninsured children are eligible, but not enrolled in Medicaid or CHIP.⁴ Options include:

- express Lane Eligibility and Automatic Enrollment of eligible Medicaid and CHIP children based on participation in other means-tested government programs such as Food Stamps;
- 12 months of continuous coverage before a member must renew eligibility; and
- elimination of the five-year waiting period for lawfully residing immigrant children and pregnant women.

CHIPRA gives states increased flexibility to provide premium assistance to Medicaid and CHIP-eligible children with access to employment-sponsored coverage. CHIPRA also makes increased federal funding and financial incentives available to support the cost of enrolling more children in Medicaid and CHIP.

The ACA goes beyond CHIPRA in terms of covering Missouri's uninsured. Beginning in 2010, a number of changes were made to the private insurance market, including no annual or lifetime limits on benefits; no rescission of coverage; no pre-existing condition exclusions for enrollees under 19 years of age; and an extension of plan coverage to adult children up to 26 years of age (Missouri already covered adult children in college up to 25 years of age).

In 2014, ACA's most far-reaching provisions to cover the uninsured go into effect. They include mandating that most U.S. citizens have health insurance coverage; expanding Medicaid to cover non-Medicare individuals under age 65 with income up to 133 percent of the FPL; establishing Health Insurance Exchanges (Exchanges); making available tax credit subsidies for people with incomes below 400 percent of FPL to buy coverage through the Exchange; and prohibiting insurers from denying coverage to people with pre-existing conditions or charging very high rates to older or less healthy people. The Exchanges are a key component for covering the uninsured in that they provide a centralized marketplace for individuals and small groups to not only purchase coverage but to access and compare detailed, consumer-friendly information on standardized private health insurance plans. Missouri will participate in the Federally Facilitated Exchange rather than implementing its own state-based Exchange.

While CHIPRA and ACA have great potential for reducing the number of uninsured, there are costs. States that expand Medicaid coverage will bear some additional cost, though more than 90 percent of the expansion cost will be funded by the federal government. This issue brief explores the various options and opportunities for the State of Missouri.

Coverage Issues for Missourians with Chronic Health Care Conditions

In the past, adults with chronic or disabling conditions have faced significant problems trying to obtain health insurance coverage. As a result of the ACA, health insurance coverage for chronically ill Americans is becoming more affordable and more readily available. Starting in

⁴ Kenney, G., et al. "Who and Where Are the Children Yet to Enroll in Medicaid and the Children's Health Insurance Program?" *Health Affairs* 29, No 10 (2010).

2014, the chronically ill and disabled will no longer be excluded from health insurance plans because of pre-existing conditions, nor will they be charged higher premiums to offset the costs of covering their medical conditions. The main issues for chronically ill Missourians are becoming less about health insurance coverage and more about how to ensure the best possible care and outcomes for these vulnerable individuals.

There is a strong relationship between being uninsured and having a chronic condition. There is also a strong correlation between being uninsured and not receiving routine care, which may exacerbate chronic conditions.⁵ The goal of the ACA is to reduce the number of uninsured individuals in the U.S. in general, but the law may be particularly effective in reducing the number of uninsured disabled and chronically ill individuals. The ACA also includes additional consumer protections and establishes demonstration programs and incentives to improve the coordination of care for higher-cost and at-risk individuals, including those with chronic health conditions.

The 2011 Behavioral Risk Factor Surveillance System (BRFSS) data indicated a high prevalence of behavioral risk factors for chronic conditions for adult Missourians:

- 40.4% had high cholesterol,
- 34.3% had high blood pressure,
- 34.6% were overweight, and
- 28.4% engaged in no leisure time physical activity in the past month.⁶

On many indicators of chronic illness, Missourians bear a greater burden of chronic illness than the U.S. on average. In 2011, 10.2 percent of adults in Missouri had ever been told by a doctor that they have diabetes, higher than the U.S. average (9.5%). Missouri's combined obesity and overweight rate was slightly higher than the U.S. average for adults (64.8% vs. 63.3%) in 2011;⁷ the rate for children was similar to the national rate (31.0% vs. 31.6%).⁸ Missouri had the 12th highest death rate in the country for heart disease (202.5 per 100,000),⁹ and also had higher rates of arthritis among adults over the age of 18 (31.0% vs. 25.9%).¹⁰

As in all states, Missouri's Medicaid program has become the primary insurer of people whose medical conditions result in disability and the inability to work. Expanding Medicaid to non-disabled adults below 133 percent of the federal poverty level would reduce the number of uninsured Missourians, including the uninsured with chronic conditions. There is increased recognition, both in Missouri and nationally, that the long-term sustainability of any reform strategies to achieve better health outcomes and reduce the cost of care for individuals with

5 Kenney, G., Zuckerman, S., Going, D., McMorrow, S. May, 2012. Virtually every state experienced deteriorating access to care for adults over the last decade. Urban Institute, available at <http://www.urban.org/UploadedPDF/412560-Virtually-Every-State-Experienced-Deteriorating-Access-to-Care-for-Adults-over-the-Past-Decade.pdf>

6 Missouri Department of Health and Senior Services. December 19, 2012. Pathways to Chronic Disease Resources and Information, available at <http://health.mo.gov/living/healthcondiseases/chronic/chronicdisease/index.html>

7 Ibid.

8 Childhood obesity rates for children 10-17 in 2007. Ibid.

9 Ibid.

10 CDC. December 19, 2012. Chronic Disease Indicators, available at <http://apps.nccd.cdc.gov/cdi/Default.aspx>

chronic or disabling conditions requires more focused and coordinated approaches. This issue brief explores these issues.

Wiring Missouri's Health Care: Electronic Health Records and Health Information Exchange

The American health care system offers some of the most advanced and effective care in the world, but it also is fragmented and inefficient, does not emphasize quality, and makes it difficult for consumers to compare price and quality. As a result, the U.S. spends more per capita on health care than any other developed country, but achieves equal or lower results in terms of health outcomes and access to services.

Modern health information technology (HIT) offers unprecedented opportunities to improve health care for Americans, promising better quality at a lower cost. Policymakers from all spheres have demonstrated a strong interest in using electronic health records (EHR) and an electronic health information exchange (HIE) as tools to achieve a health care system that is efficient, effective, safe, accessible, transparent, and affordable for all Americans.

Missouri has taken significant steps to create an infrastructure that both supports and promotes adoption and use of EHRs. The transition of the Missouri Health Information Technology (MO-HITECH) to Missouri Health Connection (MHC), continued development of several public and private collaboratives, transition from planning for HIE to implementing HIE, and the implementation and operation of the Missouri EHR incentive program will result in a robust HIT program in the state. This issue brief describes the HIT requirements, barriers to implementing EHR's, progress and anticipated activities for both the EHR incentive program and the HIE in implementation in the state.

Addressing Medicaid Fraud and Abuse: Facts and Policy Options

While the true annual cost of health care fraud and abuse is unknown, the National Health Care Anti-Fraud Association estimates conservatively that at least 3 percent of spending for health services—more than \$80 billion each year—is lost to health care fraud in the private and public sectors.¹¹ Other estimates are even higher—as much as \$272 billion lost to fraud and abuse in 2011, including \$98 billion lost from Medicare and Medicaid.¹² If the proportion of state-funded Medicaid spending that is lost to fraud and abuse is the same, the cost to the state of Missouri's Medicaid program could range from \$36 million to \$120 million per year (3% and 10% of \$1.2 billion).¹³ Thus, the state has a large stake in efforts to prevent, detect, and prosecute health care fraud. This issue brief discusses what health care fraud is, summarizes some of the attempts at the federal and state levels to address fraud, and identifies some emerging approaches that hold

11 Daniel R. Levinson, Inspector General, Office of the Inspector General, testimony before Senate Special Committee on Aging, U.S. Senate, May 6, 2009, available at <http://www.hhs.gov/asl/testify/2009/05/t20090506d.html>; National Health Expenditure Estimates available at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet.html>.

12 Donald M. Berwick, MD, MPP and Andrew D. Hackbarth, MPhil, "Eliminating Waste in US Health Care," *JAMA* 307, no. 14 (2012), 1513-1516.

13 The MO HealthNet budget for fiscal year 2012 was appropriated at \$6.8 billion, with about \$1.2 billion coming from state general revenue, \$3.5 billion from federal funds, and the remainder from other funds. See Department of Social Services Financial Summary available at: <http://oa.mo.gov/bp/budg2013/SocialServices.pdf>.

the promise of reducing fraud and abuse in the future. For example, new and emerging data analytics strategies and provider screening applications hold the promise of preventing more fraudulent claims from ever being paid in the future and keeping dishonest players from enrolling as providers. At the same time, state Medicaid officials need to be sensitive to provider complaints regarding the increased administrative burden of Medicaid provider audits. Providers that may already be reluctant to participate in Medicaid due to low reimbursement rates could decide to drop out of Medicaid entirely if they determine that the Medicaid “hassle factor” is too great. Finding an appropriate balance between the goals of applying aggressive anti-fraud and abuse measures and promoting provider access will be a continuing challenge for both federal and state Medicaid officials.

Meeting the Needs of Missourians Who Are Elderly or Have Disabilities: Long-Term Services and Supports

Long-term services and supports (LTSS) refer to a broad range of services and supports for older people and other adults with disabilities who require assistance with activities of daily living. One of the driving forces behind the projected increase in demand for LTSS over the next 15 years is the aging of Baby Boomers.¹⁴ In 2000, persons age 65 and over represented 13 percent of Missouri’s total population. By 2030 this group will represent 21 percent of Missourians.¹⁵ Most individuals prefer to receive LTSS in their own homes or in a community-based residential setting rather than a nursing home. Meeting this growing demand poses significant policy and financial challenges for Missouri in the years ahead.

Over the past two decades, national and state health care leaders have made efforts to address the growing demands of the LTSS system, but the issue is now receiving especially intense attention. The ACA provides a number of opportunities for states to expand home and community-based services (HCBS) and decrease reliance on institutional care. States are utilizing these funds to explore options to promote choice, examine how LTSS are accessed and received, and effectively leverage Medicaid funding. This issue brief explores the steps Missouri has taken toward building a system of care that continues shifting from an institutional to a home- and community-based care model and toward other improvements in LTSS delivery.

Treating the Whole Missourian: Mental Health and Substance Abuse Disorders

A historic trend to deinstitutionalize individuals with a chronic mentally illness has resulted in decreasing the number of inpatient and residential psychiatric beds in public mental health hospitals from approximately 400,000 nationwide in 1970 to 50,000 in 2006. The loss of public inpatient psychiatric beds was only partially offset by the combined increase during the same time of an additional 50,000 private and general hospital psychiatric beds. Federal policy prohibits Medicaid reimbursement for care provided to beneficiaries in certain inpatient

14 The term “Baby Boomer” describes a person born between 1946 and 1964.

15 Missouri Department of Health and Senior Services. (June 30, 2011). Missouri State Plan on Aging (Fiscal Years 2012 through 2015). Accessed November 19, 2012. Retrieved from <http://health.mo.gov/seniors/seniorservices/pdf/stateplanaging%2020122015.pdf>.

psychiatric institutions who are over age 21 or younger than 65. Given the policy dynamics, states continue to be challenged by the often inappropriate and increasing use of psychiatric emergency services among beneficiaries.¹⁶

In addition, individuals with a serious mental illness are at dramatically higher risk of premature death due to chronic medical illness, in part because of limited access to quality primary care.¹⁷ According to recent state studies, Medicaid beneficiaries with a serious mental illness have higher rates of co-occurring physical health conditions¹⁸ and higher total Medicaid costs (e.g., inpatient hospital, skilled nursing facility, pharmacy) than beneficiaries without serious mental illnesses.¹⁹

Substance use disorders often co-occur with mental illness; however, they have major independent negative effects on individuals' overall health and use of health services. Globally, nearly 4 percent of all deaths (2.5 million deaths per year) are alcohol-related. Alcohol misuse is one of the four greatest risk factors (along with tobacco use, poor diet, and physical inactivity) for the development of some cardiovascular diseases, cancer, chronic lung diseases, and diabetes.²⁰

Missouri made strides to improve the effectiveness of behavioral health services to Medicaid beneficiaries. This issue brief focuses on the state's accomplishment and progress made in implementation of two key behavioral health opportunities available under the ACA:²¹

- **Medicaid Emergency Psychiatric Demonstration.** Missouri was one of 11 states awarded a three-year CMS demonstration grant²² for implementation of Medicaid psychiatric emergency services.
- **Medicaid Health Homes for Individuals with Chronic Conditions.** Missouri became the first state in the nation to receive federal approval of an important new Medicaid service aimed at increasing the integration of physical and behavioral health services.

16 2010 memo from the American Medical Association (AMA) Council on Medical Service regarding Medicaid Coverage of Adults in Psychiatric Hospitals retrieved on January 13, 2012 from <http://www.ama-assn.org/resources/doc/cms/a11-cms-report3.pdf>.

17 For a recent review, see Scott D, Happell B., "The high prevalence of poor physical health and unhealthy lifestyle behaviors in individuals with severe mental illness. *Issues in Mental Health Nursing* 2011;32(9):589-97

18 The Best Practices in Schizophrenia Treatment (BEST) Center of the Northeastern Ohio Medical University and the Health Foundation of Greater Cincinnati commissioned Health Management Associates to conduct a study documenting the business case for integrated physical and behavioral healthcare. The final report is available at <http://www.neomed.edu/academics/bestcenter/integratingprimaryandmentalhealthcare>.

19 Substance Abuse and Mental Health Services Administration. (2010). *Mental Health and Substance Abuse Services in Medicaid, 2003: Charts and State Tables*. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration at <http://store.samhsa.gov/shin/content//SMA10-4608/SMA10-4608.pdf>.

20 World Health Organization. (2011). *Global Status Report on Alcohol and Health*. Available at: www.who.int/substance_abuse/publications/global_alcohol_report/msbgsruprofiles.pdf

21 Section 2703: State Option to Provide Health Homes For Enrollees With Chronic Conditions and Section 2707: Medicaid Emergency Psychiatric Demonstration Project.

22 The grant is not a lump sum distribution of funds. Rather, state Medicaid agencies may access federal matching funds to offset state expenses incurred in the delivery of inpatient psychiatry services in approved settings for an estimated number of Medicaid eligible individuals age 21 through 64 experiencing a psychiatric emergency medical condition.

Medication Marketplace: Getting the Best Price on Prescription Drugs for Missourians

In the 2011 federal fiscal year, Medicaid pharmacy expenditures in the United States equaled approximately \$30 billion. This spending level was offset by nearly 50 percent (just over \$14 billion) by manufacturer drug rebates, resulting in state and federal expenditures of over \$15 billion.²³ Missouri's pharmacy program accounted for less than 8 percent (\$625 million)²⁴ of the \$8 billion total in Medicaid expenditures in federal fiscal year 2011. Almost all state Medicaid programs employ a number of pharmacy management tools to help contain costs. These tools include preferred drug lists (PDL), supplemental rebate programs, prior authorization programs, state maximum allowable cost ("state MAC") programs, generic incentives, and other utilization management controls.

A national survey of state Medicaid programs (including the District of Columbia) indicates that in FY 2012:²⁵

- 46 states adopted a PDL and obtained supplemental rebates; three of the five states that did not adopt a PDL or supplemental rebates (Arizona, Hawaii, and New Jersey) rely heavily or completely on capitated managed care organizations (MCOs) to administer the Medicaid pharmacy benefit.
- 16 states place limitations on the number of prescriptions that Medicaid will pay for each month.
- 33 states implemented some type of pharmacy cost-containment.

Though containing the cost of Medicaid is a fiscal imperative for state budgets, states remain aware that drug therapies play an essential role in care plans for their beneficiaries and that the use of prescription drugs for chronic illness can reduce Medicaid costs by avoiding expensive emergency room visits, costly complications, and surgeries. How states address the pressure of drug cost increases and the demand for the latest product innovations has a significant impact on the efficacy of medical treatment.

This issue brief is written for individuals who are less familiar with the basics of Medicaid prescription drug pricing, and it provides a basis for reviewing future policy issues facing state Medicaid programs, including MO HealthNet.

Buying Value: Improving the Quality of Missourians' Health Care

Missouri spends \$41.6 billion on health care each year, or \$6,967 per person, slightly more than the U.S. average of \$6,815.²⁶ Yet Missouri ranks in the bottom third of states on quality of care

23 Data from Medicaid Financial Management Report (CMS-64), 2002-2011. Form CMS-64 is a statement of expenditures for which states are entitled to Federal reimbursement under Title XIX. The amounts reported on the CMS-64 are a summary of expenditures and revenues derived from source documents such as invoices, cost reports and eligibility records.

24 Ibid. after rebate amount; combined federal and state funds expenditures of \$974 million minus \$349 million in drug rebates.

25 Kaiser Commission on Medicaid and the Uninsured: Medicaid Today; Preparing for Tomorrow A Look at State Medicaid Program Spending, Enrollment and Policy Trends, Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2012 and 2013.

26 www.statehealthfacts.org

and health outcomes. By leveraging its role as health care purchaser and regulator more fully, Missouri can improve the quality of care and the health outcomes of its citizens, thereby attaining more value from its health care investment.

Missouri had made progress in recent years to promote quality improvement and patient safety through various pieces of legislation, including:

- the Missouri Health Improvement Act of 2007 (Senate Bill 577), which seeks to make MO HealthNet a prudent purchaser of high quality care, and
- the Missouri Health Transformation Act of 2008 (Senate Bill 1230), which requires hospitals to report adverse events and the state to publicly report results annually.

As a result of the Transformation Act, an Oversight Committee was created to develop initiatives to improve care and outcomes. In 2011, the MO HealthNet Division within the Department of Social Services implemented a primary care health home program to provide case management services to participants with chronic behavioral or medical conditions. Simultaneously, the Department of Mental Health implemented a behavioral Health Home program. These Health Home programs are approved with a State Plan Amendment, under the authority of ACA Section 2703. Over 50 organizations in Missouri are participating in the two health home initiatives. MO HealthNet is currently in discussions with CMS to explore the possibility of implementing shared savings initiatives for the home health programs.²⁷

The ACA contains several provisions to promote improvements in quality, including changes in reporting requirements, funding for developing and testing pediatric Accountable Care Organizations (ACOs), and other payment reforms. The new opportunities for the state of Missouri to reward quality care included in the ACA are discussed in this issue brief.

Real Opportunities for Ending the Addiction: Tobacco Use Prevention and Cessation

Tobacco use is the single most preventable cause of death and disease in the United States. Lung cancer ranks as the leading cause of cancer death in the United States for both men and women, and more than 80 percent is caused by smoking.²⁸ An estimated 45 million American adults currently smoke cigarettes.²⁹ Smoking causes cancer, heart disease, stroke, and lung diseases (including emphysema, bronchitis, and chronic airway obstruction). Half of the adults who continue to smoke will die from smoking related causes.³⁰ All tobacco products, including smokeless tobacco and cigars, cause cancer, and all forms of tobacco are addictive.^{31, 32}

27 "Health Home Update, Shared Savings" Presented to MO HealthNet Oversight Committee. April 10, 2012.

<http://dss.mo.gov/mhd/oversight/pdf/120410-health-home-shared-savings-update.pdf>

28 Centers for Disease Control and Prevention. (2008). Smoking-attributable mortality, years of potential life lost, and productivity losses—United States, 2000–2004. MMWR: Morbidity and Mortality Weekly Report, 57(45), 1226–1228.

29 U.S. Department of Health and Human Services. (2012). Preventing tobacco use among youth and young adults: A report of the surgeon general. Atlanta, GA: U.S. Department of Health and Human Services.

30 Centers for Disease Control and Prevention. (2008). Smoking-attributable mortality, years of potential life lost, and productivity losses—United States, 2000–2004. MMWR: Morbidity and Mortality Weekly Report, 57(45), 1226–1228.

31 Institute of Medicine. Clearing the Smoke: Assessing the Science Base for Tobacco Harm Reduction. Washington, DC: National Academies Press; 2001.

32 U.S. Department of Health and Human Services. The Health Consequences of Smoking: Nicotine Addiction. A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, Centers for Disease

Secondhand smoke causes premature death and disease in children and adults who do not smoke. Approximately 88 million nonsmokers, or 40 percent of the nonsmoking U.S. public, continue to be exposed to secondhand smoke.

Tobacco use is also the leading preventable cause of death in Missouri. Smoking kills an estimated 443,000 Americans each year (50,000 from exposure to secondhand smoke).³³ From 2005 to 2007 more than 9,000 Missourians died from tobacco related diseases, including 29 infants due to maternal smoking during pregnancy and 1,180 deaths attributable to secondhand smoke.³⁴ On average, smokers die 13 to 14 years earlier than nonsmokers.³⁵ Smoking causes infertility problems, early births and stillbirths, low-birth-weight babies, and sudden infant death syndrome (SIDS).³⁶

Given this information on the death, disability, and costs that result from tobacco use, policymakers are faced with the challenge of designing effective tobacco-control policies. This issue brief explores Missouri's tobacco-control policies and opportunities to reduce the incidence and impact of tobacco use through cessation programs, smoke-free indoor air legislation, tobacco tax, and regulatory policy.

Transforming Missouri Medicaid: Federal Waiver Options and Processes

Two key programs, Medicaid and CHIP, are important sources of financing for health care services for low-income Missouri adults and children. Both programs are financed jointly by the state and federal governments and are operated by states under federal guidelines that are set forth in law, regulation, and policy letters issued by the Centers for Medicare and Medicaid Services (CMS), the federal agency that oversees these programs.

Under waiver authority created by Congress, CMS can grant a state's request to deviate from statutory and/or regulatory requirements that may stand in the way of service expansion or innovation. The issue brief on Federal Waiver Options and Processes explores the types of waivers and related requirements. Missouri uses nine 1915(c) waivers to provide Home and Community Based Services (HCBS) to a variety of aged, blind, and disabled populations. In addition, the state operates two Section 1115 waivers: 1) a family planning waiver that provides only family planning services to women losing Medicaid eligibility after the birth of a child and 2) the "Gateway to Better Health" waiver designed to preserve St. Louis County and City safety-net health care services available to the uninsured until new ACA-related coverage is being implemented. The MO Healthnet Managed care waiver is authorized under Section 1915(b) and provides for capitated managed care contracts with health plans for certain Missouri counties.

Control, Center for Health Promotion and Education, Office on Smoking and Health; 1988.

33 Centers for Disease Control and Prevention. (2008). Smoking-attributable mortality, years of potential life lost, and productivity losses—United States, 2000–2004. *MMWR: Morbidity and Mortality Weekly Report*, 57(45), 1226–1228.

34 Missouri Department of Health and Senior Services (DHSS) Fact Sheet, Tobacco State, July 2010; <http://health.mo.gov/living/wellness/tobacco/smokingandtobacco/pdf/TobaccoState.pdf>

35 Centers for Disease Control and Prevention. Annual Smoking-Attributable Mortality, Years of Potential Life Lost, and Productivity Losses—United States, 1995–1999. *Morbidity and Mortality Weekly Report* 2002;51(14):300–3

36 U.S. Department of Health and Human Services. *The Health Consequences of Smoking: A Report of the Surgeon General*. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2004.

Waivers have become commonplace, particularly those that allow for mandatory enrollment in managed care and those that allow for HCBS services for individuals who would otherwise require institutional care. While states are likely to continue to use waivers to explore new innovations and program improvements, the ACA may reduce the need for waivers to provide expanded coverage. One focus for future waiver activity is likely to be care for dual eligibles, as states plan and implement demonstrations to integrate care for this population.

Assuring an Adequate Health Care Workforce in Missouri's Medically Underserved Areas

Many states with sizable rural populations, like Missouri, struggle to attract and maintain an adequate supply of medical providers, including nurses, primary care physicians, specialists, mental health professionals, and dentists. Demographic shifts in the U.S. raise concerns about the future supply and distribution of adequately trained health care workers that are needed to meet the health care needs of aging and increasingly diverse populations, particularly in rural and medically underserved areas. There is wide-spread concern that the health care workforce shortage will continue to grow, with significant adverse effects as the aging population increases from 13 percent in 2010 to an estimated 19 percent in 2030.³⁷ Not only does an aging population require additional health care resources, but this also means that many health care professionals will be retiring. This double-edged sword has significant implications for health care throughout the U.S. and especially in states with large rural and medically underserved populations, like Missouri.

With an estimated primary care underserved population³⁸ of over 35 million (August 2012), the U.S. currently has a significant shortage of health care practitioners. Missouri has a similar problem, with close to 1.5 million primary care underserved Missourians and an estimated 643 practitioners needed to achieve the target population-to-practitioner ratio of 2,000:1. According to the 2010 U.S. Census, 29.6 percent of Missourians live in a rural area,³⁹ but only 18 percent of the primary care physicians in Missouri are located in rural areas.

Missouri has made numerous efforts to attract and retain health care professionals in rural and other underserved areas, with varying degrees of success. With the passage of the ACA in 2010 and the Supreme Court's validation of the constitutionality of the majority of the legislation in 2012, Missouri has additional opportunities to leverage federal resources to expand the availability of providers to work in medically underserved areas. The purpose of Title V of the ACA is to expand and retain a qualified health care workforce that can respond adequately to the health and medical needs of all Americans, with priority established for vulnerable populations including older adults, children, and the chronically ill and their families. This issue brief

37 Population Reference Bureau. June, 2010. Today's research on aging, available at <http://www.prb.org/pdf10/TodaysResearchAging19.pdf>

38 The Estimated Underserved Population is computed by multiplying the number of primary care physicians in the Health Professional Shortage Area (HPSA) by the target population-to-practitioner ratio (2,000:1), and subtracting this figure from the total HPSA population.

39 Definitions of rural and urban vary. For example, the Missouri Office of Primary Care uses a different definition of rurality which includes 37% of all Missourians. Here we use the U.S. Census definition: any population, housing, or territory that is not urban (urban is defined as at least 2,500 people, at least 1,500 of which reside outside institutional group quarters. U.S. Census Bureau. May 15, 2012. 2010 Census Urban and Rural Classification and Urban Area Criteria, available at <http://www.census.gov/geo/www/ua/2010Urbanruralclass.html>

addresses matters related to Missouri's health care workforce and the challenges Missouri faces in maintaining an adequate health care workforce to meet the needs of rural and other medically underserved areas. It also highlights provisions in the ACA that are designed to expand the supply and distribution of appropriately trained health care professionals to eliminate health care workforce shortages in medically underserved areas.

Section

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A large, light blue graphic in the background. It features a heart shape formed by a thick, wavy line. A pulse line, resembling an ECG, starts from the left edge, enters the heart, and continues downwards and to the right, ending in a large, stylized 'V' shape.

The State of Health in Missouri: Coverage, Access and Health Status

Issue Statement

How does Missouri rank nationally on key indicators of health? How does federal health reform affect health care coverage, access, and health status for Missourians? What opportunities does Missouri have to improve health care coverage, access, and the health status of its residents?

Background

On two well respected state health rankings, Missouri ranks in the bottom third of all states in the United States. According to the 2012 America's Health Rankings, formulated from a variety of national sources, Missouri ranked 42nd overall on a wide range of public and environmental health issues, clinical indicators, and health outcomes. In 2011, Missouri previously ranked 40th overall and 39th overall in 2010.¹ The Commonwealth Fund's State Scorecard on Health System Performance, 2009, ranked Missouri 36th in the country on measures of coverage, access, quality, and equity.² Missouri performed better on the Commonwealth Fund's Child Health Scorecard, ranking 21st overall on measures of access and affordability, prevention and treatment, potential to lead healthy lives, and equity for children.³ The Kaiser Family Foundation also provides the most up-to-date measures of state health indicators through its interactive website, www.statehealthfacts.org, and it indicates Missouri ranks in the bottom quartile of states on a variety of health status measures. Some of the indicators behind these rankings are explored in this brief.

Since the constitutionality of key components of the Patient Protection and Affordable Act (ACA) have been validated by the Supreme Court, Missouri, like other U.S. states, should focus on preparing for the remaining implementation of the law. Missouri has many opportunities to leverage federal resources to improve population health through enhanced access to health care, especially preventive services, and more coverage options for the uninsured.

Key Indicators

The following section highlights key indicators of health insurance coverage, access to care and health status in Missouri relative to the United States and shows how Missouri ranks among states.

Insurance Coverage

Insurance coverage increases, but does not guarantee, access to needed health care. During the economic downturn, employer-based coverage decreased and Medicaid enrollment increased due to loss of income and unemployment.⁴ The uninsured population grew during the recession, but as the economy has begun to recover and unemployment has decreased, the uninsured

¹ United Health Foundation. 2011. America's health rankings. Available: <http://www.americashealthrankings.org/>.

² The Commonwealth Fund. 2009. State scorecard. Available: <http://www.commonwealthfund.org/Maps-and-Data/State-Data-Center/State-Scorecard.aspx>

³ The Commonwealth Fund. 2011. Child health scorecard. Available: <http://www.commonwealthfund.org/Maps-and-Data/State-Data-Center/Child-Health.aspx>

⁴ Carrier, E., Yee, T., Garfield, R. October, 2011. The uninsured and their health care needs: how have they changed since the recession? Kaiser Family Foundation (KFF). Available: <http://www.kff.org/uninsured/upload/8246.pdf>

population is now beginning to decrease.⁵ At the same time, Medicare enrollment is increasing as Baby Boomers age in to the program.

Rates of insurance coverage in Missouri are similar to those in the U.S. overall. The rate of employer-based coverage is slightly higher in Missouri than the U.S. rate (50.2% vs. 49%), and this likely contributes to Missouri's lower uninsured rate compared to the U.S. (14.4% vs. 15.8%).⁶ Data from the 2010-2011 Current Population Survey rank Missouri 21st in the percentage of the population that was uninsured, one of the few measures examined where Missouri ranked in the top half of states. Promisingly, Missouri's uninsured population has decreased from a 2007-2008 average of 914,000 (15.3%) to a 2010-2011 average of 852,700 (14.4%);⁷ however, this may be due to an increase in Medicaid enrollment during the recession.

Overall, uninsured rates for the older adult population are low because Medicare provides virtually universal coverage to individuals age 65 and older. Uninsured rates are also lower for children because of access to Medicaid and the Children's Health Insurance Program (CHIP). While Missouri has slightly lower uninsured rates for adults and low-income adults than the United States overall, a higher percentage of uninsured low-income children are uninsured compared to the United States. Missouri ranked 42nd on this indicator.⁸

Table 1. Uninsured rates for non-elderly adults and children, Missouri and U.S., 2010-2011

Population	Missouri	United States
Adults (19-65)	19.4%	21.4%
Low-Income ⁹ Adults	37.9%	39.5%
Children (0-18)	10.2%	9.7%
Low-Income ¹⁰ Children	17.6%	14.8%

Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured¹¹

Insurance coverage is inversely related to income. Among nonelderly adults, 40 percent of those under 139 percent of the federal poverty level (FPL) are uninsured in Missouri, compared to only 4 percent of those with incomes above 400 percent FPL. Most uninsured individuals are part of working families. A majority of uninsured, nonelderly Missourians (54%) have at least one full-time worker in their families, but they were not offered or could not afford coverage through the workplace.¹²

⁵ In 2009, the Current Population Survey revealed that 15.3% of Missourians were uninsured, compared to 14.4% based on 2010-2011 estimates from the 2011 and 2012 Current Population Survey. Urban Institute and Kaiser Commission on Medicaid and the Uninsured. 2012. Health insurance coverage of the total population, states (estimates based on the Census Bureau's March 2011 and 2012 Current Population Survey). Available: <http://www.statehealthfacts.org/comparetable.jsp?ind=125&cat=3&sub=39&yr=274&typ=2&rgnhl=27>

⁶ Ibid.

⁷ Ibid.

⁸ Ibid.

⁹ Less than 200% Federal Poverty Level (FPL).

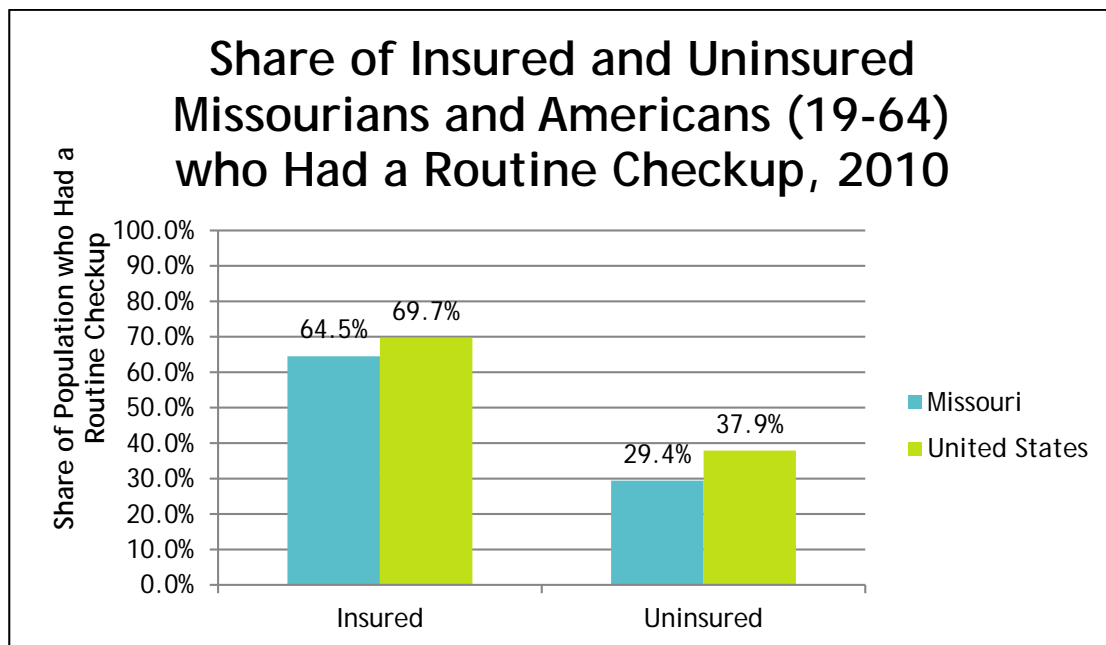
¹⁰ Ibid.

¹¹ Ibid.

¹² Ibid.

Financial and Insurance Barriers to Care: Uninsured adults are less likely to obtain needed care than those with insurance. Although Missouri has lower uninsured rates than the U.S., adults who are uninsured in Missouri still have poor access to routine care. Less than a third of uninsured Missourians (29.4%) had a routine checkup in 2010, compared with almost two thirds of insured adults (64.5%). Since 2000, the percent of uninsured Missourians who had a routine checkup decreased by 18.6 percent, while the percentage among insured Missourians decreased by 7.9 percent. Overall, Missouri had a lower percentage of both insured and uninsured individuals that received routine checkups compared with the national averages.¹³

Figure 1. Share of Insured and Uninsured Missourians and Americans (19-64) who had a Routine Checkup, 2010



Source: Kenney, G., Zuckerman, S., Going, D., McMorro¹⁴

Access to Care

In 2010, 604,000 Missourians, or 13.3 percent of the population, reported not seeing a doctor because of cost. While this is lower than the U.S. average, (14.6%), Missouri ranked 27th on this indicator of access to care.¹⁵ Missouri ranked sixth nationally in providing access to needed mental health care for children. In Missouri, the percentage of children ages 2 to 17 with emotional, mental or behavioral health needs who received mental health care or counseling in the past year (2007) was 73.9 percent compared to the U.S rate of 60 percent.

Preventive Care for Pregnant Women and Children: Missouri has made strides to ensure that pregnant women and children receive recommended preventive care. With nearly nine out of 10 pregnant women (87.2%) receiving prenatal care in the first trimester, Missouri ranked third in the

¹³ Kenney, G., Zuckerman, S., Going, D., McMorro, S. May, 2012. Virtually every state experienced deteriorating access to care for adults over the last decade. Urban Institute. Available: <http://www.urban.org/UploadedPDF/412560-Virtually-Every-State-Experienced-Deteriorating-Access-to-Care-for-Adults-over-the-Past-Decade.pdf>

¹⁴ Ibid.

¹⁵ Ibid.

nation in 2006, just after Massachusetts and Maine; the U.S. rate was 83.2 percent.¹⁶ Also promising, Missouri ranked in the top ten in 2005-2006 on two indicators related to support for children with special needs.¹⁷

While Missouri has relatively good access to prenatal care, according to 2009 data from the Missouri Department of Health and Senior Services, 16.8 percent of Missouri mothers smoked during pregnancy.¹⁸ By comparison, in 2008, 12.8 percent of U.S. women smoked during the last three months of pregnancy. Although 42.1 percent of Missouri mothers who smoked three months prior to getting pregnant quit smoking during their pregnancy, many started smoking again after delivery (25.9% of Missouri mothers smoked after delivery).¹⁹ Smoking during pregnancy is associated with an increased risk of ectopic pregnancy, vaginal bleeding, placental abruption, placenta previa, stillbirth, birth defects, premature birth, and low birth weight.²⁰

There is also room for improvement on child immunization rates and access to preventive medical and dental care for children. Only 70.3 percent of Missouri's children aged 19 months to 35 months were current on recommended immunizations in 2010, ranking the state 41st in the United States. In comparison, the U.S. rate is 75 percent.²¹ In 2007, 87.1 percent of children in Missouri had a preventive medical care visit in the past year, and 75.4 percent of children aged 1-17 had a preventive dental care visit in the past year. The state ranked 31st and 47th, respectively, on these two indicators.²²

Preventive Cancer Screenings: In 2010, 65.2 percent of all Missourians over the age of 50 had ever received a sigmoidoscopy or colonoscopy (both are effective in detecting colorectal cancer), similar to the 64.2 percent overall percentage for the United States. A majority of women over 40 in Missouri (71.3%) received a mammogram within the past two years, and 80.1 percent of women over 18 received a pap smear within the past three years. Comparative rates for the United States as a whole were 75.4 percent and 80.9 percent, respectively (Missouri ranked 38th for both indicators).²³

Appropriate and High Quality Care: The Agency for Healthcare Research and Quality (AHRQ) evaluates quality²⁴ based on the most current National Healthcare Quality Report, which measures performance on a variety of indicators in three domains: types of care, settings of care, and care by clinical area. Missouri's performance on home health care measures is very strong,

¹⁶ KFF. 2012. State Health Facts. Available: <http://statehealthfacts.org/index.jsp>

¹⁷ Commonwealth Fund. 2011. Op. cit.

¹⁸ Missouri Department of Health and Human Services. 2012. Data, Surveillance Systems and Statistical Reports. Available: <http://health.mo.gov/data/>

¹⁹ Centers for Disease Control and Prevention. December 19, 2011. Pregnancy Risk Assessment Monitoring System (PRAMS). Available: <http://www.cdc.gov/prams/index.htm>

²⁰ March of Dimes Association. April, 2010. Alcohol and drugs. Available: http://www.marchofdimes.com/pregnancy/alcohol_smoking.html

²¹ Ibid.

²² Commonwealth Fund. 2011. Op. cit.

²³ KFF. Op.cit.

²⁴ Quality is evaluated as very weak, weak, average, strong, or very strong.

whereas performance on heart disease measures is weak. Overall, AHRQ rates Missouri as average on health care quality compared to other states.²⁵

On several health care quality performance measures that evaluate the mobility of nursing home long-stay residents, Missouri performs very well. For example, Missouri ranks 10th on the percent of home health care patients with improved mobility (2009). On the other hand, Missouri performs more poorly on other quality indicators. For example, in 2008, the rate of hospitalizations for chronic conditions (age 18 and over) that considered potentially avoidable was 820 per 100,000, compared to a national rate of 732 per 100,000. Missouri has seen little improvement on this indicator since 2000. The leading state on this indicator, Utah, had a rate of 339 per 100,000, less than half of Missouri's rate.²⁶

Health Status

Healthy Living: Missouri lags behind or is just even with the national average on a number of healthy lifestyle indicators associated with morbidity and mortality.

Smoking rates are the most troubling: one quarter of Missouri adults smoked in 2011, ranking the state 43rd in the nation. The overall adult smoking rate in the U.S. is 20.1 percent. Missouri also had the third lowest percentage of smokers who attempted to quit smoking in 2011.²⁷ The adverse health outcomes associated with smoking are well-known: increased rates of lung cancer, coronary heart disease, stroke, chronic obstructive lung diseases, and many other cancers and conditions associated with increased morbidity and mortality.²⁸

Evidence suggests that there is a correlation between tobacco control policies and smoking prevalence among the general population. There is also a very strong negative correlation between the level of cigarette taxes and smoking prevalence.²⁹ Missouri has not enacted global smoke-free legislation for workplaces, restaurants, and bars; instead, Missouri has designated smoking areas, which still presents risks for inhaling secondhand smoke. Additionally, in 2011, Missouri had the lowest excise tax per pack of 20 cigarettes in the nation, \$0.17, compared with a national average of \$1.46.³⁰ Missouri has an opportunity to influence smoking behavior through more stringent tobacco control policies (e.g., smoke-free workplace) and increasing the excise tax on cigarettes and other tobacco products. Other options for curbing the prevalence of smoking in Missouri are explored in Issue Brief #11, "Ending Addiction."

Missouri's combined overweight and obesity rate was slightly higher than the U.S. average (64.8% vs. 63.3%) in 2011.³¹ The rate for children was similar to the national rate (31.0% vs.

²⁵ Agency for Healthcare Research and Quality. 2012. 2011 State Snapshots Home. Available: <http://statesnapshots.ahrq.gov/snaps11/index.jsp?menuId=1&state=MO>

²⁶ Ibid.

²⁷ KFF. Op.cit.

²⁸ Centers for Disease Control and Prevention. January 10, 2012. Health Effects of Cigarette Smoking. Available: http://www.cdc.gov/tobacco/data_statistics/fact_sheets/health_effects/effects_cig_smoking/

²⁹ Wilson, M. et al. 2012. Impact of tobacco control interventions on smoking initiation, cessation, and prevalence: a systematic review. *Journal of Environmental and Public Health*, 2012. DOI: 10.1155/2012/961724

³⁰ Tynan, M., Promoff, G., MacNeil, A. March 30, 2012. State Cigarette Excise Taxes-United States 2010-2011. Centers for Disease Control and Prevention. Available: <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6112a1.htm>

³¹ KFF. Op. cit.

31.6%).³² The percentage of adults in Missouri who ate three or more vegetable servings each day was lower than the national rate in 2009 (27.3% v. 32.5%), and Missouri also had a lower percentage than the national average of adults who engage in moderate or vigorous physical activity three to five times per week (49.6% v. 51.4%) in 2011.

Missouri does not currently have an additional sales tax on soft drinks, nor does it have an additional sales tax for chips and pretzels. More than half of all states now have an additional sales tax on soft drinks, and almost half have an additional sales tax for chips and pretzels sold in vending machines. According to 2011 state law, Missouri does not prohibit sugar sweetened beverages in school vending machines, nor does Missouri require physical education for all grades, Kindergarten through 12. Research shows a positive correlation between restrictions on sugar sweetened beverages in schools and reduced consumption of these beverages.³³ While Missouri could improve population health by imposing legislation to limit the sale of high-calorie sugary beverages in schools and require participation in physical education for all grades, it is encouraging that Missouri does mandate BMI screening in schools.³⁴

Quality of Life: In 2007, adults in Missouri experienced an average of 3.4 days per month³⁵ with limited activity due to health difficulties, lower than the national rate of 3.6 days. Missouri ranked 16th on a mental health quality-of-life indicator. The 2011 rate for adults who reported having one or more poor mental health days in the past 30 days was 33.8 percent in Missouri, compared to the national rate of 35.8 percent.³⁶

Mortality: Missouri has had some success reducing rates of premature mortality in recent years, but overall life expectancy still ranks in the bottom third of all states at 77.4 years.³⁷ Missouri's infant mortality rate, measured as death in the first year of life, dropped from 8.5 deaths per 1,000 live births for the 2003-2005 period to 7.5 in 2009.³⁸ Vital statistics from the Missouri Department of Health and Senior Services indicate that the infant mortality rate dropped to 7.0 in 2010, 6.3 in 2010, and 6.0 in 2012, a promising trend.³⁹

Missouri's breast cancer mortality rate for women is declining. In 2009, the rate was 23.0 per 100,000 compared to 26.7 in 2003. While rates are still higher in Missouri than the national average (22.2), Missouri is steadily closing the gap, improving from a 2003 ranking of 39th to a 2009 ranking of 34th.⁴⁰

On the other hand, child mortality for children ages 1-14 was 21 per 100,000 in 2009, ranking the state 37th; additionally, Missouri had the 12th highest teen (15-19) mortality rate in 2009,

³² Childhood obesity rates for children 10-17 in 2007. Ibid.

³³ Increased consumption of sugar sweetened beverages are considered to be a strong contributing factor to the increase in childhood obesity over the past few decades. Levy, D., Friend, K., Wang, Y. March, 2011. A review on literature on policies directed at the youth consumption of sugar sweetened beverages. *Advances in Nutrition*. DOI: 10.3945/an.111.000356

³⁴ Ibid.

³⁵ 30 days.

³⁶ Ibid.

³⁷ Ibid.

³⁸ Commonwealth Fund. Op. cit.

³⁹ Rates are calculated based on the previous 12 months ending with August (e.g., 2010 is the average for September 2009-August 2010). Missouri Department of Health and Human Services. Op. cit.

⁴⁰ KFF. Op. cit.

with 71 deaths per 100,000 teenagers, compared to a national average of 53 deaths per 100,000. Missouri also had a high rate of suicide in 2009, with 14.2 suicide deaths per 100,000 compared to 11.8 for the U.S. overall.

Missouri ranked 36th in 2009 for motor vehicle deaths per 100,000. As of July 2012, Missouri lacked comprehensive legislation on cellphone use and texting while driving. Texting is banned only for drivers 21 and younger, and there is no handheld cellphone ban for young drivers or cellphone ban for bus drivers. The majority of all U.S. states have banned texting while driving and cell phone use for young drivers.⁴¹ There is no conclusive evidence that cellphone bans actually improve crash rates, despite a strong correlation between cellphone use while driving and increased crash risk;⁴² however the precautionary principle may be sufficient justification to enact more comprehensive cellphone legislation in Missouri.

Federal Health Care Reform

Health status is influenced by a variety of factors including socioeconomic status, lifestyle choices, genetics, and access to health care. While health insurance coverage is not the only determinant of health, access to necessary health care services is an important part of improving the health of Americans and significantly improves access to health care. In addition to providing protection for consumers of health care, the goal of national health care reform is to ensure that all Americans have access to affordable health insurance. As a result, the ACA should improve the health status of Missourians.

The ACA includes provisions to expand coverage, reform health insurance markets, increase access to appropriate and affordable health care, promote understanding of cost-effective care and the use of evidence-based medicine, and support states and communities in advancing healthy living and preventive health practices. Although the ACA is national in scope, implementation will rely heavily on the states. In addition to new regulations and state requirements, the ACA includes extensive opportunities for states and communities to compete for federal grants and funding for improvements and demonstration projects. To date, Missouri has received more than \$11.6 million in grants from the Prevention and Public Health Fund. Additionally, community health centers in Missouri have received more than \$77 million in funding under the ACA.⁴³ More examples of funding as a result of the ACA are described later on in this brief.⁴⁴

Supreme Court Ruling and Impact

On June 28, 2012, the Supreme Court ruled on the constitutionality of the ACA (*National Federation of Independent Business vs. Sebelius*). The Supreme Court upheld the constitutionality of the individual mandate, but ruled that the Medicaid expansion provisions, which required states to expand coverage or lose all federal Medicaid funding, was unconstitutional. While the Supreme Court did not strike down the ACA provision for Medicaid

⁴¹ KFF. Op. cit.

⁴² Insurance Institute for Highway Safety. July, 2012. Cellphones. Available: http://www.iihs.org/research/topics/cell_phones.html

⁴³ Healthcare.gov. October 25, 2012. How the healthcare law is making a difference for the people of Missouri. Available: <http://www.hhs.gov/healthcare/facts/bystate/publichealth/mo.html>

⁴⁴ Unless otherwise referenced, descriptions of the provisions of the ACA in this brief have been summarized by HMA from the published legislation. Available: <http://housedocs.house.gov/energycommerce/ppacacon.pdf>

expansion, in practice, the decision makes Medicaid expansion optional for states.⁴⁵ States are largely divided along party lines over the decision to expand Medicaid in 2014. Missouri's Democratic governor supports Medicaid expansion but will face significant opposition from the Republican majority in the legislature.⁴⁶

Expanding Insurance Coverage

The new law contains a range of provisions for expanding access to private and public sources of insurance coverage. The individual mandate, which was found constitutional by the Supreme Court, requires most individuals to have health insurance beginning in 2014 (Section 1501). Unless an individual is in a very low-income bracket or applies for a waiver, most individuals without health insurance will be required to pay an assessment, or fee. Additionally, adult children up to the age of 26 are now able to be covered under their parents' policies (Section 2714). As of December 2011, 55,000 young adults in Missouri were able to gain coverage through their parents' health insurance as a result of the ACA.⁴⁷

Employer-based insurance will remain the primary source of coverage for the non-elderly population. Employers with 50 or more employees will be required to offer coverage or will be forced to pay a fee or assessment (delayed until 2015 for employers with 100 or more employees and until 2016 for employers with 50-99 workers). Starting in 2014, individuals who do not have access to affordable employer coverage will be able to purchase coverage through a new state Health Insurance Exchange, with premium and cost-sharing discounts available to eligible individuals and families with incomes up to 400 percent of FPL (Sections 1311-1313, 1322, 10104). Small businesses will also be able to purchase coverage through an Exchange beginning in 2014. Missouri has chosen to let the federal government run Missouri's Exchange.^{48, 49}

New insurance regulations will also improve access to health insurance for individuals with pre-existing conditions. The ACA prohibits pre-existing condition exclusions for all Americans in 2014. This means insurance companies are prohibited from denying coverage to Americans with pre-existing conditions and individuals and small-business employees will have access to affordable coverage options in the Exchanges, with subsidies for those with incomes below 400 percent of FPL. Insurers will not be allowed to base premium rates on any risk factors other than age, with a maximum rate variation of 3:1, smoking, and geography.

Access to Preventive Care

The ACA includes several provisions to improve access to preventive care, especially for vulnerable populations like the elderly. The ACA also promotes increasing the use of appropriate, cost-effective care based on evidence-based medicine through the establishment of the National Prevention, Health Promotion and Public Health Council, a Prevention and Public

⁴⁵ Kaiser Family Foundation (KFF). August 2012. A guide to the Supreme Court's Decision on the ACA's Medicaid Expansion. Available: <http://www.kff.org/healthreform/upload/8347.pdf>

⁴⁶ Crisp, E. November 30, 2012. Gov. Jay Nixon favors Medicaid expansion. St. Louis Dispatch. Available: http://www.stltoday.com/print/a-section/nixon-favors-medicaid-expansion/article_1a2cc49e-25bf-546c-8752-a94dc053c505.html

⁴⁷ Healthcare.gov. Op. cit.

⁴⁸ Gordon, E. November 13, 2012. Missouri, Kansas reject state-run health insurance exchanges. Kaiser Health News. Available: <http://www.kaiserhealthnews.org/stories/2012/november/13/missouri-kansas-health-insurance-exchanges.aspx>

⁴⁹ KFF. April, 15, 2011. Summary of new health reform law. Available: <http://www.kff.org/healthreform/upload/8061.pdf>

Health Fund, and a grant program that supports the delivery of evidence-based and community-based prevention and wellness services (e.g., Community Transformation Grants).

Coverage of Preventive Care by Health Plans: The ACA requires health plans⁵⁰ to cover many preventive services without an associated co-payment or co-insurance for adults, women (including pregnant women), and children. Since September 23, 2010 health plans have been required to cover 16 preventive services for adults without any cost-sharing, including colorectal screening for adults over 50, immunization vaccines (e.g., influenza), and blood pressure screening. Women now have access to 22 preventive services without any cost-sharing. For example, women over 40 can receive breast cancer mammography screenings every 1 to 2 years. Eight of these prevention-related services became effective August 1, 2012. For children, there are 27 covered preventive services that are accessible without cost-sharing as required by the ACA. These services include a comprehensive immunization program, medical history for all children throughout development, and behavioral assessments for children of all ages. All covered preventive services for children were effective starting on September 23, 2010.⁵¹

Coverage of Preventive Care by Medicare and Medicaid: Starting January 1, 2013, the new law increased by one percentage (1%) point the portion of expenses the federal government covers in state Medicaid programs, the Federal Medical Assistance Percentage (FMAP), to states that cover certain evidence-based preventive services, including immunizations and tobacco cessation products, with no cost-sharing to Medicaid enrollees (Section 4106). Starting January 1, 2011, many preventive services are now available to Medicare (Part B) recipients free of charge. For example, these services include screenings for prostate cancer and cholesterol.⁵²

Expanding Medicaid

As of October 2012 more than 883,000 Missourians were enrolled in Missouri HealthNet, Missouri's Medicaid program.⁵³ Currently, non-working parents can qualify for Medicaid in Missouri only if their income is below 19 percent of FPL, which was \$4,380 for a family of four in 2012; other non-disabled adults cannot qualify for Medicaid regardless of income level.⁵⁴ The ACA requires states to expand Medicaid to nearly all individuals under the age of 65 who are not otherwise covered by Medicaid or Medicare and who have incomes at or below 138 percent of the FPL, equivalent to \$15,415 for an individual in 2012; however, the Supreme Court's ruling on the ACA makes this provision optional for states.⁵⁵ The federal government will fund 100 percent of the costs of expansion from 2014-2016; the federal share will then gradually phase

⁵⁰ The preventive services provision only applies to individuals enrolled in job-related health plans or individual health insurance policies created after March 23, 2010. Plans may be "grandfathered", meaning that these benefits may not be available to everyone without cost-sharing. For more information about "grandfathered" plans, please refer to <http://www.healthcare.gov/law/features/rights/grandfathered-plans/index.html>.

⁵¹ Healthcare.gov. September 27, 2012. Preventive services covered under the Affordable Care Act. Available: <http://www.healthcare.gov/news/factsheets/2010/07/preventive-services-list.html>

⁵² Ibid.

⁵³ Missouri Department of Social Services. 2012. Caseload Counter. Available: <http://dss.mo.gov/mis/clcounter/>

⁵⁴ KFF. Op. cit.

⁵⁵ KFF. August 2012. A guide to the Supreme Court's Decision on the ACA's Medicaid Expansion. Available: <http://www.kff.org/healthreform/upload/8347.pdf>

down to 90 percent of expansion costs in 2020 and beyond. As a point of reference, the FY 2013 FMAP for Missouri is 61.37 percent.⁵⁶

On November 29, 2012, Missouri Governor Jay Nixon announced plans to include Medicaid expansion in the FY2014 budget, estimating that an additional 300,000⁵⁷ Missourians will be eligible for health insurance coverage through Medicaid as a result.⁵⁸ Citing a study by the University of Missouri School of Medicine,⁵⁹ Governor Nixon asserted that Medicaid expansion will have a positive economic benefit to the state.

If Medicaid expansion were to be approved by the legislature—which is unlikely—it is estimated that Missouri’s uninsured population would decrease by 61.3 percent, compared to a 29.2 percent decrease if the state does not expand Medicaid.⁶⁰ Other provisions of the ACA will expand Medicaid coverage to an estimated 103,000 Missourians even if the state decides not to expand the program.⁶¹ The ACA also provides funding for the CHIP program through 2015 and continues the authority of the program through 2019 (Sections 2101, 2102). Because Missouri’s Medicaid program already extends coverage to children up to at least 150 percent FPL, Medicaid expansion will have a more limited impact on children’s coverage. However, coverage for children who are eligible for, but not enrolled in, Medicaid or CHIP is likely to expand as parents become eligible for Medicaid or gain access to coverage through a health insurance exchange.⁶²

Improving Access to Maternal, Infant and Child Health Care

The ACA stipulates spending \$1.5 billion over five years in competitively awarded grants to states to implement home-visiting programs in communities identified with relatively high rates of medically indigent and vulnerable mothers and children (Section 2951). As of December 2012, Missouri had been awarded \$2.1 million to implement evidence-based home visiting models in Pemiscot, Dunklin, Butler, and Ripley counties, identified as the top four high risk counties in the state.⁶³

⁵⁶ Federal Register. November 30, 2011. Table 1- Federal Medical Assistance Percentages and Enhanced Federal Medical Assistance Percentages. Available: <http://www.gpo.gov/fdsys/pkg/FR-2011-11-30/pdf/2011-30860.pdf>

⁵⁷ Estimates of projected new enrollment vary. A November 2012 study by the Urban Institute revealed a net increase in Medicaid enrollment in Missouri of 383,000 as a result of mandated ACA provisions (e.g., expanded coverage of children through Medicaid/CHIP) and a decision by Missouri to further expand Medicaid.

⁵⁸ Office of Missouri Governor Jay Nixon. November 29, 2012. Gov. Nixon announces plans to provide health care coverage for additional estimated 300,000 Missourians. Available: http://governor.mo.gov/newsroom/2012/Gov_Nixon_announces_plans_for_health_care_coverage_for_additional_300_000_Missourians

⁵⁹ Hicks, L. et al. November, 2012. The economic impacts of Medicaid expansion on Missouri. University of Missouri. Available: <http://www.mffh.org/mm/files/MUMedicaidExpansionReport.pdf>

⁶⁰ Holahan, J., Buettgens, M., Carroll, C., Dorn, S. November, 2012. The cost and coverage implications of the ACA Medicaid Expansion: national and state-by-state analysis. *The Urban Institute*. Available: <http://www.kff.org/healthreform/upload/medicaid-coverage-and-spending-in-health-reform-national-and-state-by-state-results-for-adults-at-or-below-133-fpl.pdf>

⁶¹ Ibid.

⁶² Kenny G., Pelletier J. 2010. How Will the Patient Protection and Affordable Care Act of 2010 Affect Children? Available: from <http://www.urban.org/uploadedpdf/412129-PPACA-affect-children.pdf>.

⁶³ Health Resources and Services Administration (HRSA). 2012. Maternal, Infant, and Early Childhood Home Visiting Program. Available: <http://mchb.hrsa.gov/programs/homevisiting/index.html>

Improving the Appropriateness and Quality of Care

The ACA created a Patient-Centered Outcomes Research Institute (PCORI), a nonprofit corporation, to identify research priorities and conduct research that compares the clinical effectiveness of medical interventions and programs for diseases, disorders, and health conditions (Section 6301). The Mid America Heart Institute in Kansas City, Missouri, was awarded \$646,498 for a PCORI Pilot Project.

The Center for Medicare and Medicaid Innovation (CMS Innovation Center) is another product of the ACA (Section 3021). The goal of the CMS Innovation Center is to test innovative payment and service delivery models with the goal of better health care, better health, and lower costs through improvement. Grant funding is available to pursue initiatives and programs that align with the goals of the Center. Below is a summary of grants awarded to Missouri from the CMS Innovation Center.⁶⁴

Table 2.

Grant	Recipient	Program/Project Name	Award Amount
Healthcare Innovations ⁶⁵	The University of Missouri	Leveraging Information Technology to Guide High Tech High Touch Care (LIGHT2)	\$13,265,444
Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents	The University of Missouri	n/a	n/a
Medicaid Emergency Psychiatric Demonstration	State of Missouri	n/a	\$74 million
Health Home Program under Section 2703 of the ACA/ State Plan Amendment (SPA) Health Home	State of Missouri	Community Mental Health Center (CMHC) Health Home program and the Primary Care Health Home	n/a
Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration	FQHCs throughout Missouri	n/a	n/a

Better coordination of primary and behavioral health care is also a goal of federal health care reform. Local communities had the opportunity to compete for grants to promote coordinated and integrated services to select populations through the co-location of primary and specialty care services in community-based mental and behavioral health settings (Section 5604). Missouri did not receive a grant award from the Substance Abuse and Mental Health Services Administration

⁶⁴ CMS Innovation Center. 2012. Centers for Medicare and Medicaid Services (CMS). Available: <http://innovations.cms.gov/index.html>

⁶⁵ Three other Healthcare Innovations projects include Missouri. Lead applicants on these projects are the Feinstein Institute for Medical Research, Rutgers, and the University of North Texas Health Science Center.

(SAMHSA) for the program, Co-Locating Primary Care and Specialty Care in Community-Based Mental Health Settings,⁶⁶ but is participating in CMS' health home program through the implementation of two health home models.

Health Status

Among the many provisions in the ACA related to improving health, several offer states opportunities to leverage community assets within and beyond traditional medical settings in order to promote healthy living. The law also provides resources to improve quality of life for individuals with psychiatric care needs and targets resources to prevent conditions and illnesses associated with premature mortality.

Community-focused efforts in health care reform are designed to encourage a holistic approach to prevention and wellness. For example, the CDC awarded competitive Community Transformation Grants to state and local governments to encourage the development and improvement of community infrastructure and evidence-based prevention programs that support healthy lifestyles in neighborhoods, schools, worksites, and other non-health care settings (Section 4201). In 2011, the Mid-America Regional Council Community Services Corporation in Missouri received \$705,708 in funding from CDC's Community Transformation Grant to serve Jackson County, which has a population of approximately 674,000. Program initiatives focus on tobacco-free living, active living and healthy eating, preventive services, and healthy and safe physical environments.⁶⁷

Conclusion

Missouri has a smaller uninsured population than the U.S. average, but there is a large discrepancy in access to services for uninsured Missourians compared to insured Missourians. With an estimated uninsured population of 883,000, Missouri could significantly decrease this number and simultaneously improve access to services by expanding Medicaid. There are still opportunities for Missouri to take advantage of federal grant money and other resources available as a result of the ACA. In the first few years after the ACA passed, Missouri was not granted several big funding opportunities from the federal government. The state should continue to focus on winning ACA grant money and leveraging these available federal resources. Missouri ranks in the bottom quartile of all U.S. states on many indicators of health status. Many of these indicators of poor health status in Missouri are preventable conditions (e.g., smoking and obesity), yet the state is not utilizing health policies of proven effectiveness to reduce smoking incidence and consumption of sugar sweetened beverages.

⁶⁶ SAMHSA. February 7, 2011. Co-locating primary care and specialty care in community-based mental health settings. Available: http://www.samhsa.gov/healthreform/docs/Co-locating_Primary_Care_Community_MH_508.pdf

⁶⁷ CDC. November 15, 2012. Community Transformation Grants. Available: <http://www.cdc.gov/communitytransformation/index.htm>

Section

3

Uninsured Prescription: Policy Options for Covering Missouri's Uninsured

Issue Statement

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) and the Patient Protection and Affordable Care Act of 2010 (ACA) are designed to substantially reduce the number of uninsured Americans. Both pieces of legislation offer funding, financial incentives, and a number of unprecedented policy reforms to increase access to health insurance through the nation's existing system of coverage. This paper provides an overview of how CHIPRA has influenced health coverage for Missouri's children and summarizes where the state is in implementing provisions of the ACA.

Background

The number of Americans without health insurance has continued to grow over the last decade. The recent recession, along with lingering high unemployment, has significantly increased the number of uninsured nationwide. According to Census Bureau figures, 48.6 million Americans, or 15.7 percent of the population, were uninsured in 2011.¹ This figure is down slightly from the 2009 rate of 50.7 million,² which represented an all-time high since the Census Bureau began

tracking the statistic in 1987. Another 29 million Americans were estimated to be "underinsured" in 2010.³ This figure has grown by 3 million adults from 2007 estimate.⁴ The current national unemployment rate of 7.7 percent is down from 9.6 percent in 2009.⁵

As Missouri has slowly begun to rebound from the Great Recession, the number of uninsured has decreased from 914,000 in 2009, (15.3% of the population) to 877,000 (14.8 %) in 2011. At the same time, the number of Missourians covered by Medicaid, the publicly funded health insurance program for the poor and disabled, decreased from 891,000 in 2009 to 836,000 in 2011, a 6.2 percent decrease in enrollment since 2009.⁶

Average Premium per Enrolled Employee for Employer Sponsored Health Insurance, 2011

	MO	US
Single Coverage	\$5,019	\$5,222
Family Coverage	\$13,888	\$15,022

Employer Share of Premium Cost, 2011

Single Coverage	77%	79%
Family Coverage	71%	74%

Source: www.statehealthfacts.org

While the majority of Missourians with health insurance are covered through their employers, since 2007, both nationally and in Missouri, this number has actually decreased. In Missouri,

¹ U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplements, September 2012, Table HI01

² U.S. Census Bureau, "Income, Poverty and Health Insurance Coverage in the United States: 2009 Summary of Findings", September 16, 2010.

³ Schoen, C., et al. "Affordable Care Act Reforms Could Reduce the Number of Underinsured US Adults by 70 Percent" Health Affairs, 30, no.9 (2011).

⁴ Schoen, C. et al. "How Many Are Underinsured? Trends Among U.S. Adults, 2003 and 2007." Health Affairs. 27, no.3-4, (2008).

⁵ www.bls.gov, Regional and State Employment and Unemployment. November 2012

⁶ U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplements, September 2012, Table HI05

individuals with employer- sponsored coverage decreased 7.3 percent, between 2007 and 2011.⁷ While Missouri's average premiums for employer-sponsored coverage are lower than the national average, Missouri's employers pay a lower proportion of the premium for both family and single coverage when compared to the national average. This means that in a weak economy, employed and insured Missourians pay proportionately more of their wages to purchase health insurance than the national average.

The uninsured population in Missouri consists mostly of working adults, with many in households headed by someone working full-time or part-time for a small company. Large numbers of adults living in poverty are ineligible for Medicaid because they do not have dependent children; and even low-income working parents are only covered up to 35 percent of the federal poverty level (FPL), and non-working parents are covered up to 19 percent of FPL.⁸ Others are excluded because of their immigration status. In terms of young adults, since most are relatively healthy, many do not purchase health insurance. People with serious medical conditions who attempt to buy coverage as individuals rather than through their employers are frequently priced out of the private insurance market or turned down when they apply for coverage.

The primary barrier to covering the uninsured is cost. However, careful consideration should be given to the fact that Missouri is already paying for the uninsured, both directly and indirectly. Missourians pay taxes to support publicly funded programs such as Medicaid and Medicare. Employers and employees pay higher premiums to compensate for the losses that providers incur in treating the uninsured and providing charity care— this is known as “cost shift.” Ultimately, the most serious cost is borne by the uninsured themselves. Over a third of the uninsured report needing care in the previous year but not getting it, and nearly half of the uninsured report postponing care — rates at least three times higher than those with insurance.⁹ The uninsured frequently receive late-stage diagnoses of cancer and other life-threatening diseases. Delayed treatment can lead to worse outcomes and adds to the medical bills that burden the uninsured and their families, frequently leaving them in debt. So increasing coverage of the uninsured offers Missourians the opportunity to better manage health insurance costs and health outcomes more directly.

Two key laws, the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) and the Patient Protection and Affordable Care Act of 2010 (ACA), play a major role in Missouri's health coverage programs by offering a number of policy options and tools, along with funding, to help substantially reduce the number of uninsured and provide individuals and their families with greater security in terms of access to affordable health care and improved quality of life.

Children's Health Insurance Program Reauthorization Act of 2009

Missouri is one of a dozen states with fairly generous income eligibility criteria for low-income children. Through the MO HealthNet program, which includes the state's Medicaid and

⁷ U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplements, Historical Table HIB-4.

⁸ www.statehealthfacts.org

⁹ “Myths About the Uninsured” Kaiser Commission on Medicaid and the Uninsured. <http://www.kff.org/uninsured/upload/myths-about-the-uninsured-fact-sheet.pdf> Accessed on January 11, 2013

Children's Health Insurance Program (CHIP), Missouri covers low-income children up to 300 percent of FPL. For enrolled children in families with incomes above 150 percent of FPL, a premium based on a sliding fee scale related to income is required for participation.

Currently, more than 496,100 children are covered by MO HealthNet.¹⁰ Even so, approximately 10 percent of Missouri children remain uninsured. Missouri's Medicaid and CHIP participation rate of 84.5 percent (the proportion of the eligible children who are enrolled) is close to the national average of 84.8 percent.¹¹ Nationally, it is estimated that 65 percent of uninsured children are eligible but not enrolled in Medicaid or the Children's Health Insurance Program (CHIP).¹² CHIPRA is designed to help the state enroll these children. CHIPRA provides enhanced federal funding and incentives, new tools to simplify enrollment and member retention, increased outreach efforts, and expanded coverage options.

CHIPRA has substantially increased the federal contribution to state CHIP programs. Missouri's federal allotment increased by 58 percent, from \$81.9 million to \$129.3 million for fiscal year 2009. Annual allotment increased again in 2010 to \$166.2 million before decreasing to \$112.7 million and \$117.6 million in 2011 and 2012 respectively.¹³ Additional funding mechanisms to support the program include a contingency fund to provide states with additional money if there is a CHIP funding shortfall; enhanced funding for interpreter and translation services; and a federal bonus payment to those states that implement five of eight enrollment simplification and member retention strategies.

The CHIPRA provisions that provide opportunities to reduce the number of uninsured children in Missouri are described below.

Enrollment Simplification and Member Retention

CHIPRA encourages states to enroll children through an Express Lane Option that takes advantage of the fact that many eligible but unenrolled Medicaid and CHIP children currently participate in other means-tested public programs, such as the Women, Infant and Children's Program (WIC), National School Lunch Program providing free and reduced-price meals, and Supplement Nutrition Assistance Program (SNAP; formerly known as food stamps). This option permits states to use current income information from these programs to identify and then automatically enroll eligible children, subject to the parents' consent and citizenship verification by the state. To assist in this process, CHIPRA gives states the ability to access relevant federal and state databases, including the National Directory of New Hires to assess income status.¹⁴ States can also verify citizenship by submitting names and social security numbers of individuals declaring citizenship to the Social Security Administration. These new options help parents by

¹⁰ Missouri Department of Social Services, Family Support Division, MO HealthNet Division, Monthly Management Report. November 2012.

¹¹ www.statehealthfacts.org

¹² Kenney, G., et al. "Who and Where Are the Children Yet to Enroll in Medicaid and the Children's Health Insurance Program?" Health Affairs 29, No 10 (2010).

¹³ "FY 2009 to FY 2012 CHIP Allotments, in Millions, by State" Center for Children and Families. Georgetown University Health Policy Institute. Updated: 8/16/12.

¹⁴ The National Directory of New Hires is a nationwide database of information on all newly hired employees, quarterly wage reports, and unemployment insurance claims.

eliminating time required on multiple program applications and providing quicker access to coverage for their children.

Building on the Express Lane and Auto-Enrollment options, CHIPRA makes a bonus payment available to states implementing five of eight simplified enrollment and member retention strategies:

1. Twelve months of continuous coverage before a member must renew eligibility.
2. Elimination or simplification of asset tests
3. Elimination of the face-to-face interview requirement to initially enroll and at renewal.
4. Use of Medicaid-CHIP joint application and renewal forms and a joint information verification process.
5. Administrative verification at renewal through the use of completed forms or ex parte determinations (i.e., assessment of whether children who are no longer eligible under their current Medicaid categories may be eligible in other Medicaid categories before termination of benefits).
6. Use of presumptive eligibility (i.e., a state option to make a preliminary determination that a child is Medicaid eligible based on the parent's declaration that family income is below the state's income eligibility guidelines. The family has 30 days to submit income verification to the state. During this time, a child can receive medical services through Medicaid).
7. Implementation of CHIPRA's new Express Lane Eligibility Option described above.
8. Implementation of CHIPRA's new options for Premium Assistance (described in Coverage Options below).

Missouri currently incorporates two of the eight options: the elimination of the face-to-face interview and the use of the joint Medicaid-CHIP application. Missouri partially complies with the elimination or simplification of asset tests, the use of presumptive eligibility, and the option to provide premium assistance.¹⁵

Outreach Efforts to Enroll More Children

CHIPRA provides \$100 million in federal funds, with no state match requirement, for outreach and enrollment in fiscal year 2009 through fiscal year 2013. Approximately \$90 million in grant funds is available to state and local governments, Indian Health Services providers, and other eligible entities including community-based organizations. Another \$10 million is allocated for a national enrollment campaign. This is significant as many states, given tight budgets due to the recession, have drastically reduced or even curtailed funding for outreach and enrollment.

Coverage Options

Under CHIPRA, states have the option to eliminate the five-year waiting period for lawfully residing immigrant children and pregnant women in Medicaid and CHIP. States may also continue coverage of children up to 300 percent of FPL and receive the enhanced CHIP federal

¹⁵ www.covermissouri.org

match. States have the flexibility to expand income eligibility over 300 percent of FPL, but the federal matching rate drops to the Medicaid level. The FY 2013 federal matching rate in Missouri is 73 percent for CHIP and 61 percent for Medicaid.¹⁶ Missouri has not opted to eliminate the five-year waiting period for lawfully residing immigrant children and pregnant women in Medicaid and CHIP. CHIPRA also provides states with the option of covering dependents of state employees. As of 2013, Missouri had not adopted this coverage policy.

CHIPRA also helps states provide premium assistance to Medicaid- and CHIP-eligible children who could be covered through their parents' employer-sponsored insurance. This coverage may be subsidized by Medicaid/CHIP funds if the employer contributes at least 40 percent of the costs and the benefit package is actuarially equivalent to the Medicaid/CHIP benefit package. CHIPRA amends the Employee Retirement Income Security Act so that losing or gaining Medicaid or CHIP coverage is a qualifying event for immediate enrollment in an employer plan. This means that a child may enroll in a parent's employer-based plan without waiting for the annual open enrollment period. In addition, CHIPRA includes a new buy-in option whereby states can establish a purchasing pool for employers with fewer than 250 employees and at least one employee with a CHIP-eligible child. The purchasing pool must offer at least two CHIP benchmark products. CHIPRA also assists families whose income level requires them to pay a monthly premium for their children's participation in MO HealthNet. The law establishes a 30-day premium payment grace period before terminating a child's coverage, and states must provide families with a seven-day notice of termination and their right to appeal.

The Patient Protection and Affordable Care Act of 2010

The ACA became law in March 2010 and builds upon many CHIPRA efforts to cover the uninsured. While CHIPRA's focus is health insurance coverage for children, the ACA's focus is coverage for most U.S. citizens and legal residents regardless of age or income. Beginning in 2014, the ACA requires that most U.S. citizens and legal residents obtain health insurance, expands Medicaid coverage to non-Medicare individuals under age 65 up to 133 percent of FPL,¹⁷ and provides premium subsidies in the form of tax credits for people with incomes up to 400 percent of FPL. If all states were to expand Medicaid as provided in the ACA, by 2022 an additional 21.3 million more would be covered by Medicaid, and the total reduction in the number of uninsured Americans would be 25.3 million.¹⁸ With the Medicaid expansion and other coverage provisions in ACA, the number of uninsured would be cut by 48 percent compared to without the ACA.¹⁹

The primary ACA provisions that impact the uninsured are described below, in order of their effective dates.

¹⁶ www.statehealthfacts.org

¹⁷ The ACA also requires a 5% income disregard when calculating eligibility for Medicaid, which effectively raises the income level to 138% FPL. The Supreme Court ruling on the ACA makes the expansion of Medicaid optional for states.

¹⁸ Holahan, John, et al "The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis" Urban Institute and Kaiser Commission on Medicaid and the Uninsured. <http://www.urban.org/UploadedPDF/412707-The-Cost-and-Coverage-Implications-of-the-ACA-Medicaid-Expansion.pdf> Accessed on January 13, 2013.

¹⁹ Ibid.

Maintenance of Current State Medicaid and CHIP Eligibility Levels, Effective March 2010

In order for states to continue to receive federal Medicaid and CHIP funding, they must maintain their current eligibility levels until 2014 for adults and 2019 for children. This means that states that expanded their eligibility levels above the mandatory federal requirement cannot reduce the levels. For example, Missouri, which currently covers CHIP eligible children up to 300 percent of FPL, cannot reduce the coverage to 200 percent of FPL. This provision protects current Medicaid and CHIP enrollees from losing coverage as states struggle to balance their budgets as a result of the recession.

Outreach Efforts to Enroll More Children: The ACA increases CHIPRA funds for outreach and enrollment of eligible but unenrolled Medicaid and CHIP children from \$100 million to \$140 million, with no state match requirement. The ACA also extends the period in which these funds are available through 2015.

Temporary Federal High-Risk Pool, Effective July 2010: The temporary federal high-risk pools provided insurance for individuals with pre-existing medical conditions who have been uninsured for at least six months. This program was set to expire in January 2014 when insurers are required to cover all individuals with pre-existing conditions.

Missouri already operates a state high-risk pool, Missouri Health Insurance Pool, funded by premiums paid by enrollees and assessments paid by health insurers. In 2011, the state high-risk pool covered about 4,000 individuals. Missouri ran the temporary federal high-risk pool as a separate program called the Pre-existing Condition Insurance Plan (PCIP). In 2010, Missouri was awarded a Federal allotment of \$81 million to fund the program through the life of the program which ends in FY2014.²⁰

Health Plan Benefit Changes, Effective September 2010:

- No lifetime limits on essential health benefits;
- No rescission of coverage after a policyholder becomes sick or injured (except for fraud/intentional misrepresentation);
- Coverage of certain preventive health services and immunizations without cost to covered individuals (for non-grandfathered health plans);
- No discrimination in favor of higher-wage employees (self-insured plans continue to be subject to prior nondiscrimination rules);
- No pre-existing condition exclusions for enrollees under 19 years of age; and
- Extension of family plan coverage to adult children up to 26 years of age (Missouri already covered adult children through 25 years of age).

Small Business Health Insurance Tax Credit, Effective for 2010: The ACA includes provisions to make health insurance more affordable for small businesses. Employers with fewer than 25 full-time employees and average annual salaries of no more than \$50,000 are eligible for a

²⁰ Missouri Health Insurance Pool Annual Report 2011.

http://www.mhip.org/doc/AnnualReports/2011_AnnualReport.pdf Accessed on January 16, 2013.

federal tax credit to offset as much as 35 percent of the health insurance cost (25% for nonprofits). In Missouri, an estimated 85,100 small businesses could qualify for this tax credit.²¹ Additionally, this tax credit increases in 2014 to 50 percent of the employer's health insurance cost (35% for nonprofits). The credit is available to an employer for two years beginning in 2014.

Tax Credits to Subsidize the Cost of Premiums for Individuals and Families, January 2014. To make coverage affordable for moderate-income people, tax credits will be available for individuals and families with incomes between 100 percent and 400 percent of FPL. The value of the tax credits are based on income, can be taken in advance or applied when filing taxes, and they can be used only for coverage purchased through a Health Insurance Exchange.

Health Insurance Exchanges, January 2014: A key component of the ACA is the establishment of Health Insurance Exchanges to facilitate the selection and purchase of affordable private health insurance for the individual and small-group markets. The Exchanges serve as a portal where people can access and compare detailed consumer-friendly information on standardized private health insurance options. This is meant to foster competition between plans and ultimately contain or reduce coverage cost.

The ACA establishes two types of insurance exchanges, one for the individual market (American Health Benefit Exchanges) and one for the small-group market (Small Business Health Options Program or SHOP Exchanges). Exchanges can be administered by either the state or federal government or a nonprofit organization designated by the governmental entity. States can also decide to join a regional or interstate Exchange or establish subsidiary exchanges that serve distinct geographic areas. Beginning in 2017, states can decide to open their Exchanges to large employers (those with more than 100 employees).

The ACA also requires the Exchanges to certify that their products comply with federal standards for essential health benefits.

The Missouri General Assembly initially took steps in favor of a state-based exchange but was unable to pass legislation. In November 2012, Missouri voters approved Proposition E, a measure that allows the implementation of an Exchange only if authorized by state law or a vote of the people. As a result of this measure, Governor Nixon, in a letter to Secretary Sebelius, declared that a state-based exchange was no longer an option for Missouri. The federal government will establish a Federally Facilitated Exchange for states choosing not to implement a state-based exchange. As of December 2012, 25 states, including Missouri declined to establish a state-based exchange.²²

Insurance Reforms. The ACA makes many important changes in insurance laws to ensure that private insurance is accessible and affordable for higher-risk individuals. Among the most important is a requirement that premiums cannot be based on health status or any other factor except age, family size, tobacco use, and geography, and the premium difference for age cannot vary by a ratio of more than 3:1. Further, no one can be denied coverage based on health status

²¹ "A Helping Hand for Missouri's Small Businesses: Health Insurance Tax Credits" Families USA and Small Business Majority. July 2010. <http://www.familiesusa.org/assets/pdfs/health-reform/MO-Helping-Small-Businesses.pdf> Accessed on January 16, 2013

²² "Status of State Health Insurance Exchange Implementation" Center on Budget and Policy Priorities. December 17, 2012. <http://www.cbpp.org/files/CBPP-Analysis-on-the-Status-of-State-Exchange-Implementation.pdf> Accessed on January 13, 2013.

or any other reason except fraud. The result will be that sicker, older individuals who previously found coverage to be unaffordable will now be able to buy more reasonably priced coverage.

Employer Requirements, Effective January 2014: While the ACA does not require employers to offer health insurance coverage to their employees, it provides strong incentives for employer with more than 50 employees to do so, beginning January 2014:

- There are no coverage requirements for employers with fewer than 50 employees.
- Employers who have 50 or more full-time equivalent employees and do not offer coverage may pay a penalty of \$2,000 per full-time equivalent employee for all full-time employees in excess of 30, even if only one full-time employee receives a tax credit through a Health Insurance Exchange.
- Employers with 50 or more full-time equivalent employees may pay a \$3,000 penalty for each full-time employee who opts out of the employer's health insurance coverage because it is unaffordable, meaning the premium exceeds 9.5% of family income.
- Employers with 50 or more full-time equivalent employees must offer health insurance plans that cover at least 60% percent of the total covered health benefit costs (also referred to as an actuarial value of 60%). Penalties may be assessed if the employer plan covers less than 60% percent of the cost of covered health benefits.
- Employers cannot impose insurance waiting periods of more than 90 days.
- Employers with more than 200 employees must automatically enroll employees in their health plans, although the employee can choose to opt out.
- Employers must report to the IRS whether they offer employees minimum essential coverage and for how many months such coverage was offered. Employers who self-insure may be required to report additional information.

Medicaid Expansion, Effective January 2014: States have the option²³ of expanding their Medicaid program to cover all non-Medicare individuals under age 65 with income up to 133 percent of FPL. Currently, only a handful of states cover childless adults in Medicaid. Governor Nixon supports the Medicaid expansion and has submitted proposals to the state legislature for consideration.

States are required to share in the cost of the Medicaid expansion; however, for 2014 through 2016, states will receive 100 percent federal funding to pay for the expansion, with the federal share gradually dropping to a 90 percent match in 2020. States also receive a 23 percentage point increase in their CHIP match rate, up to 100 percent, beginning in 2016. Missouri's CHIP match rate will increase to 97 percent. According to the Urban Institute, an estimated 485,000 Missourians could be covered by 2022 at an incremental cost of \$1.57 billion in state funds and \$19.4 billion in federal funds from 2013 to 2022.²⁴ Additionally, states have the option to expand

²³ The ACA required states to expand Medicaid coverage or lose all federal Medicaid funding. However, the Supreme Court in June 2012 declared this provision unconstitutional, thereby making Medicaid expansion an option for states.

²⁴ Holahan, J et al.

Medicaid eligibility to childless adults before January 2014, but will not receive enhanced funding for this early expansion.

Individual Mandate, Effective January 2014: The ACA requires that nearly all individuals and their families obtain health insurance—through an employer, a government program, the new Exchanges, or the individual insurance market. Those individuals who fail to secure coverage must pay a penalty, with exemptions available for people with financial hardship or religious objections, American Indians, those without coverage for three months or less, and those who are Medicaid-eligible.

The individual mandate has been controversial, and 20 states filed lawsuits challenging the constitutionality of the provision. Moreover, in August 2010, 71 percent of Missouri voters approved a ballot initiative banning the government from requiring individuals to purchase health insurance. However, the Supreme Court upheld the mandate in its landmark decision in June 2012, making this provision of the ACA the law of the land.

CHIPRA and ACA—Benefits and Costs

CHIPRA and the ACA provide generous funding, financial incentives, and unprecedented policy reforms to substantially reduce the number of uninsured in Missouri and across the nation. But, not surprisingly, these benefits come with costs.

In exchange for having coverage, newly insured people may be paying premiums they did not pay before, although often with the aid of substantial subsidies. Employers that did not offer coverage or offered coverage that does not meet the minimums requirements of the new law will pay more. Eliminating exclusions for pre-existing conditions and eliminating most risk factors as a basis for varying premiums will cause some lower-risk groups to pay more. But these higher costs to employers and individuals will be partially offset because the individual mandate requirement will bring many new younger, low-risk (low-cost) individuals—along with their premiums—into the insurance pool. Employers that incur increased costs to meet the new insurance requirements will either have to recover those costs by becoming more efficient, or they will pass along those costs to the purchasers of the goods and services they produce.

States that expand Medicaid coverage will pay more, but only a small proportion of the cost of doing so, since the federal government funds a minimum of 90 percent of the expansion costs. It is instructive to compare the amount that Missouri would spend for Medicaid if it expands coverage compared to what it would spend if it did not. According to Urban Institute estimates, for the period from 2013 through 2022 under the ACA, Missouri will spend \$43.3 billion if it does not expand coverage. If it does expand coverage, the estimated cost will be \$44.9 billion, a 3.6 percent increase. In contrast, the federal expenditure for Missouri Medicaid would rise from \$78.8 billion to \$96.6 billion, an increase of 22.6 percent.²⁵

Overall, CHIPRA and ACA offer unprecedented opportunities to cover the uninsured. In the case of ACA, by 2022, when the ACA is fully implemented, more than 25 million Americans would be newly insured if all states expand Medicaid coverage as permitted under the ACA. The comparable figure for Missouri would be 494,000, which would be a reduction in the number of uninsured of

²⁵ Holahan, John, et al

61.3 percent.²⁶ This substantial increase in insurance coverage benefits individuals and families by providing greater economic security and removes many concerns about pre-existing conditions, coverage rescissions, lifetime limits, and waiting periods, which can all lead to medical debt.

²⁶ Holahan, John, et al

Section

4

Coverage Issues for Missourians with Chronic Health Care Conditions

Issue Statement

This issue brief will examine the health status of the chronically ill and disabled in Missouri, how the Patient Protection and Affordable Care Act (ACA) of 2010 is changing the historic issues this population has faced in gaining health insurance coverage, Medicaid's role as a safety net for this vulnerable population, and initiatives being explored by Missouri and other states to improve the health status and health outcomes for Americans with chronic conditions.

Background

In the past, adults with chronic or disabling conditions have faced significant problems trying to obtain health insurance. As a result of the ACA, health insurance for chronically ill Americans is becoming more affordable and more readily available. Starting in 2014, the chronically ill and disabled will no longer be excluded from health insurance plans because of pre-existing conditions, nor will they be charged higher premiums to offset the costs of covering their high-cost medical conditions. The main issues for chronically ill Missourians are becoming less about health insurance coverage and more about how to ensure the best possible care and outcomes for these vulnerable individuals.

The Institute of Medicine (IOM) defines chronic illness or disease as a “condition that is slow in progression, long in duration, and void of spontaneous resolution, and it often limits the function, productivity, and quality of life of someone who lives with it.”¹ Chronic conditions include heart disease, cancer, arthritis, obesity, diabetes, stroke, chronic lung disease, and many other illnesses. Chronic conditions are common, even among the non-elderly population, and are the leading cause of death and disability in the United States. Data for 2005 indicated that 133 million Americans have at least one chronic condition and that more than 75 percent of health care costs are attributed to chronic conditions.² Additionally, in 2011, there were more than 37 million Americans with disabilities³ in the United States.⁴ While the burden of chronic illness and related disability is growing, costs of treatment are also growing.

Chronically Ill and Disabled Missourians

Disability

There were an estimated 822,470 Missourians with a disability in 2011, 13.9 percent of the state's total population. Only 17.8 percent of disabled Missourians were employed, which means

¹ Institute of Medicine. 2012. *Living well with chronic illness: a call for public health action*. Washington, DC: The National Academies Press, 1.

² Centers for Disease Control and Prevention (CDC). October 3, 2012. *Chronic Disease Prevention and Health Promotion*. Available: <http://www.cdc.gov/chronicdisease/index.htm>

³ The American Community Survey (ACS) identifies individuals with a disability by asking questions about six aspects of disability including: serious difficulty with four basic areas of functioning – hearing, vision, cognition, and ambulation. These functional limitations are supplemented by questions about difficulties with selected activities from the Katz Activities of Daily Living (ADL) and Lawton Instrumental Activities of Daily Living (IADL) scales, namely difficulty bathing and dressing, and difficulty performing errands such as shopping.

⁴ U.S. Census Bureau. 2012. *American Fact Finder*. Available: <http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml>

that more than 80 percent of Missouri's disabled individuals would be unable to receive insurance coverage through employer-sponsored health insurance.⁵

In 2011, the Commonwealth Fund evaluated long-term services and supports for older adults, people with disabilities, and caregivers. Across a spectrum of indicators evaluating Missouri's ability to serve those needing long-term services, Missouri ranked 13th overall. Notably, Missouri ranked very highly compared to other states in access and affordability of care (5th) and in providing support for family caregivers (9th). Missouri ranked much lower in quality of life and quality of care (32nd) and choice of setting and provider (31st).⁶

Chronic Conditions—Causes and Prevalence

Four common causes of chronic disease are modifiable risk behaviors:

1. Lack of physical activity;
2. Poor nutrition;
3. Tobacco use and smoking; and
4. Excessive alcohol consumption.⁷

Data from the 2011 Behavioral Risk Factor Surveillance System (BRFSS) indicated a high prevalence of behavioral risk factors for chronic conditions for adult Missourians that are related to the four noted above: 40.4 percent had high cholesterol, 34.3 percent had high blood pressure, 34.6 percent were overweight, and 28.4 percent engaged in no leisure time physical activity in the past month.⁸

In 2011, one-quarter of Missouri adults smoked, a higher proportion than in 42 states in the U.S. The overall adult smoking rate in the U.S. was 20.1 percent.⁹ The adverse health outcomes associated with smoking are well-known: increased rates of lung cancer, coronary heart disease, stroke, chronic obstructive lung diseases, and many other cancers and chronic conditions associated with increased morbidity and mortality.¹⁰

Evidence suggests that there is a correlation between tobacco control policies and smoking prevalence among the general population. There is also a very strong negative correlation between the level of cigarette taxes and smoking prevalence.¹¹ Missouri has not enacted global smoke-free legislation for workplaces, restaurants, and bars; instead, Missouri has designated smoking areas, which still presents risks for inhaling secondhand smoke. Additionally, in 2011, Missouri had the lowest excise tax per pack of 20 cigarettes in the nation, \$0.17, compared with

⁵ U.S. Census Bureau. 2012. American Fact Finder. Available: <http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml>

⁶ The Commonwealth Fund. 2011. State long-term services and supports scorecard. Available: <http://www.longtermsscorecard.org/>

⁷ CDC. October 3, 2012. Chronic Disease Prevention and Health Promotion. Op. cit.

⁸ Missouri Department of Health and Senior Services. December 19, 2012. Pathways to Chronic Disease Resources and Information. Available: <http://health.mo.gov/living/healthcondiseases/chronic/chronicdisease/index.html>

⁹ KFF. State Health Facts. 2012.

¹⁰ CDC. January 10, 2012. Health Effects of Cigarette Smoking. Available: http://www.cdc.gov/tobacco/data_statistics/fact_sheets/health_effects/effects_cig_smoking/

¹¹ Wilson, M. et al. 2012. Impact of tobacco control interventions on smoking initiation, cessation, and prevalence: a systematic review. *Journal of Environmental and Public Health*, 2012. DOI: 10.1155/2012/961724

a national average of \$1.46.¹² Missouri has the opportunity to influence smoking behavior through more stringent tobacco control policies (e.g., smoke-free workplace) and increasing the excise tax on cigarettes and other tobacco products. Other options for curbing the prevalence of smoking in Missouri are explored in a later issue brief in this series, entitled Ending Addiction.

Partly as a result of policy choices like those just discussed, the incidence of chronic illness is higher for Missourians than for U.S. citizens as a whole. In 2011, 10.2 percent of adults in Missouri had ever been told by a doctor that they have diabetes, higher than the U.S. average of 9.5 percent. Missouri had the 12th highest heart disease death rate in the country: 202.5 per 100,000.¹³ The state also had higher rates of arthritis amongst adults over the age of 18 (31.0% vs. 25.9% for the U.S.).¹⁴

Missouri's obesity rates were slightly above the U.S. average for adults (64.8% vs. 63.3%, respectively) in 2011¹⁵ and similar to the national rate for children (31.0% vs. 31.6%, respectively).¹⁶ Missouri does not currently have an additional sales tax on soft drinks, nor does it have an additional sales tax for chips and pretzels. More than half of all states now have an additional sales tax on soft drinks, and almost half have an additional sales tax for chips and pretzels sold in vending machines. According to 2011 state law, Missouri does not prohibit sugar-sweetened beverages in school vending machines, nor does Missouri require physical education for all grades, Kindergarten through 12. Research shows a correlation between restrictions on sugar sweetened beverages in schools and reduced consumption of these beverages.¹⁷ While Missouri could improve population health by imposing legislation to limit the sale of high-calorie sugary beverages in schools and require participation in physical education for all grades, it is encouraging that Missouri does mandate BMI screening in schools.¹⁸

The incidence of cancer in Missouri in 2008 was lower than more than half of the U.S. states, but the state had a higher-than-average cancer death rate in 2009, as well as larger disparities between white and black Missourians in cancer incidence.¹⁹

¹² Tynan, M., Promoff, G., MacNeil, A. March 30, 2012. State Cigarette Excise Taxes-United States 2010-2011. Centers for Disease Control and Prevention. Available: <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6112a1.htm>

¹³ Ibid.

¹⁴ CDC. December 19, 2012. Chronic Disease Indicators. Available: <http://apps.nccd.cdc.gov/cdi/Default.aspx>

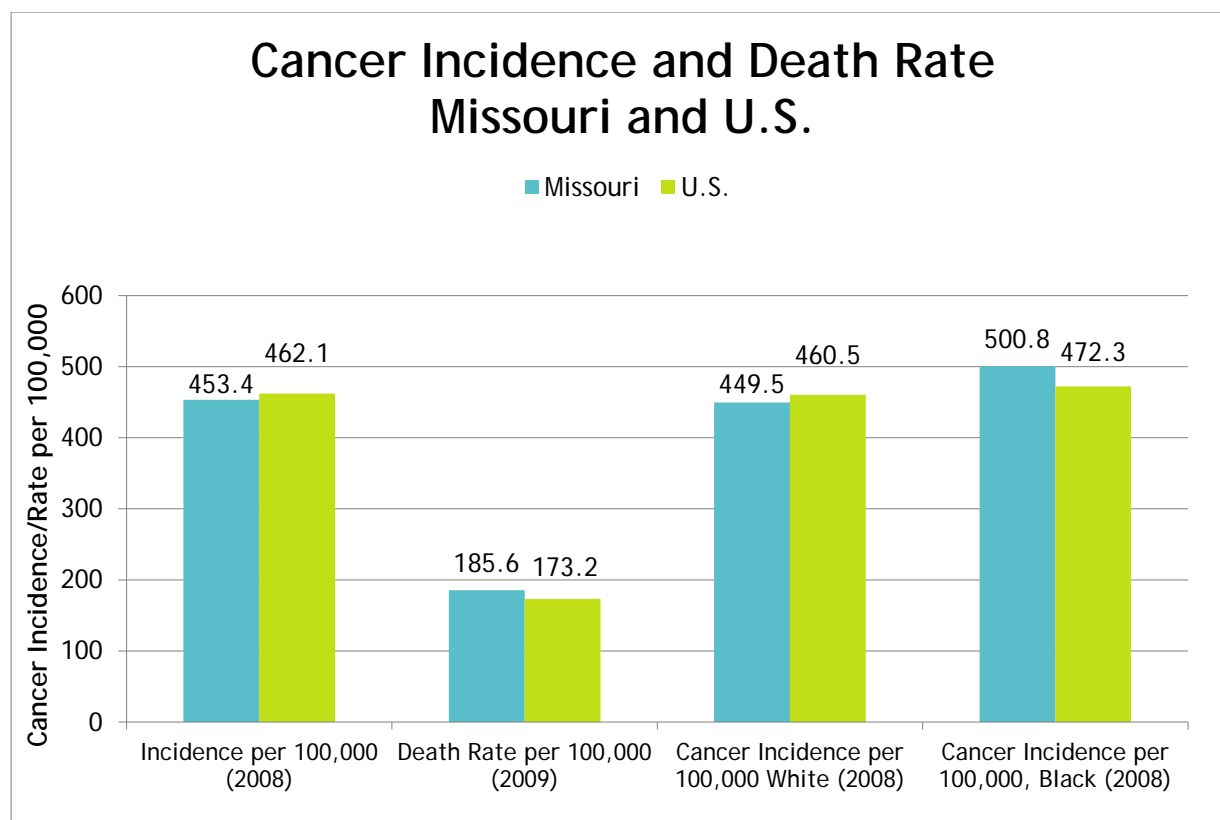
¹⁵ KFF. State Health Facts. 2012.

¹⁶ Childhood obesity rates for children 10-17 in 2007. Ibid.

¹⁷ Increased consumption of sugar sweetened beverages are considered to be a strong contributing factor to the increase in childhood obesity over the past few decades. Levy, D., Friend, K., Wang, Y. March, 2011. A review on literature on policies directed at the youth consumption of sugar sweetened beverages. *Advances in Nutrition*. DOI: 10.3945/an.111.000356

¹⁸ Ibid.

¹⁹ Ibid.



Source²⁰

Asthma prevalence in Missouri presents a mixed picture of health status. While overall self-reported current asthma prevalence in Missouri was very close to the U.S. rate in 2010 (8.8% for MO; 8.6% for the U.S.), in the same year Missouri had the highest rate in the country for adults aged 55-64, and the seventh highest rate in the country for non-Hispanic blacks.²¹ Additionally, asthma prevalence increased²² for both children and adults from 2000 to 2009. In 2007, almost 17 percent of adults with current asthma reported having no health coverage, though not significantly more than adults without asthma, and 17.8 percent of adults with asthma needed medical care in the past 12 months but could not get it.²³

Commercial Insurance: Historical Barriers and Reforms

According to a 2009 estimate, 10.2 percent of Missourians with a disability were uninsured.²⁴ There is a strong relationship between being uninsured and having a chronic condition. For

²⁰ Ibid.

²¹ KFF. State Health Facts. 2012.

²³ Missouri Department of Health and Senior Services. December 19, 2012. Pathways to Chronic Disease Resources and Information. Available: <http://health.mo.gov/living/healthcondiseases/chronic/chronicdisease/index.html>

²³ Missouri Department of Health and Senior Services. December 19, 2012. Pathways to Chronic Disease Resources and Information. Available: <http://health.mo.gov/living/healthcondiseases/chronic/chronicdisease/index.html>

²⁴ Center for Personal Assistance Services. 2009. Disability data for Missouri from the 2009 American Community Survey: health coverage. Available: http://www.pascenter.org/state_based_stats/disability_stats/acs_insurance.php?state=missouri

example, data from the 2009 Medical Expenditure Survey indicated that 13 percent of nonelderly uninsured Americans had cardiovascular disease; these estimates may be lower than actual prevalence because of historical barriers for the uninsured to access care.²⁵ There is also a strong correlation between being uninsured and not receiving routine care, which may exacerbate chronic conditions.²⁶ The goal of the Affordable Care Act is to reduce the number of uninsured individuals in the U.S. in general, but the act will be particularly effective in reducing the number of disabled and chronically ill uninsured individuals.

Why are they Uninsured? Historically, adults with chronic or disabling conditions who seek insurance coverage on their own outside of the employer setting have faced major barriers in trying to obtain health insurance coverage. In 2002, a study by the U.S. General Accounting Office found that people with physical health conditions of “generally moderate severity” were rejected for coverage 30 percent of the time, and people with mental health conditions of “generally moderate severity” were rejected for coverage 52 percent of the time.²⁷

Commercial insurers have been reluctant to offer coverage to people at high risk of needing expensive health care, like the chronically ill, because they are likely to incur disproportionately high medical expenses. As permitted by law, insurers often denied coverage to these individuals buying insurance on their own or charged a higher rate to individuals or small groups that included these individuals to reflect the increased risk, making coverage unaffordable. The problems of the chronically ill getting coverage have been exacerbated by the fact that chronic health conditions may result in disability that prevents employment—and therefore eliminates access to employer-sponsored coverage.

It is illegal for group insurers to deny coverage to anyone in an employer group because of their health status. Having a chronic illness prevents many people with such conditions from being employed or at least being employed by a firm that offers coverage. Employers may also discriminate against chronically ill people in hiring because they do not want to have the firm’s health insurance rates go up when they take on a high-risk employee.

Why do Insurers Deny Coverage? Medical underwriting is the process that commercial insurers use to determine the level of risk associated with an applicant for coverage in the individual and small-group markets. This process, while entirely rational and understandable from the insurers’ perspective, has created major access and affordability problems for individuals with disabilities and people with chronic health conditions.

Prior to the ACA, without specific state regulations to the contrary, commercial insurers in the individual market were able to:

- Deny a policy to someone with what they consider high medical risk.

²⁵ Kaiser Commission on Medicaid and the Uninsured (KCMU). November, 2012. The role of Medicaid for adults with chronic illness. KFF. Available: <http://www.kff.org/medicaid/upload/8383.pdf>

²⁶ Kenney, G., Zuckerman, S., Goins, D., McMorrow, S. May, 2012. Virtually every state experienced deteriorating access to care for adults over the last decade. Urban Institute. Available: <http://www.urban.org/UploadedPDF/412560-Virtually-Every-State-Experienced-Deteriorating-Access-to-Care-for-Adults-over-the-Past-Decade.pdf>

²⁷ Ibid.

- Grant coverage but with a temporary or permanent pre-existing condition exclusion (i.e., excluding coverage for any medical condition in existence when the policy takes effect).
- Grant coverage but with a higher premium.

In the small-group market (2 to 50 employees), federal law prohibited insurers from denying coverage to a group or excluding an individual considered high risk; however, federal law did not prohibit insurers from varying the premium for the entire group based on the risk of the individuals in the group. Any limitations on insurers' ability to risk-rate groups were determined by state regulation. As a result, public insurance programs like Medicaid and Medicare, and public health programs like those offered through community mental health centers, became the default payer for many people with chronic or disabling health problems.

Prior to the ACA, Missouri, like other states, adopted some insurance reforms to address problems of access to affordable coverage. For example, since 1991, the Missouri Health Insurance Pool has offered insurance coverage to individuals who cannot get health insurance in the market (e.g., those who are excluded because they have a pre-existing condition), but this coverage is still cost-prohibitive for many Missourians.²⁸

How does the ACA benefit disabled and chronically ill Missourians? The ACA is a major step forward in providing coverage for all people who have faced difficulties in acquiring affordable health insurance, including the chronically ill.²⁹

- *Removes health status from coverage determinations:* After 2014 no one can be denied coverage because of any personal characteristic like health status (i.e., pre-existing conditions), and insurers cannot charge higher premiums to anyone or any small group because of the health status of a person being insured. In fact, insurers can only vary rates only on the basis of age (with a limit of a 3-to-1 premium difference), geographic area, tobacco use, family size, and level of benefits. These provisions remove some of the barriers that have made coverage difficult to obtain for chronically ill Missourians. (Section 2704)
- *Standardized benefit plans:* To ensure that health benefit packages cover necessary services, regulations authorized under the law will specify medical services that all individual and small-group plans must cover. This provision protects chronically ill people—and everyone else—from having to purchase policies that do not provide coverage of needed services, although some may still find the level of cost-sharing to be a burden, depending on the health plan features. (Sections 1301-1304)
- *Individual mandate and subsidies:* The individual mandate, which was found constitutional by the Supreme Court, requires most individuals to have health insurance beginning in 2014 (Section 1501). Individuals without health insurance will be required to pay an assessment, or fee unless they receive a waiver or are exempt from the mandate

²⁸ Premiums range from \$165/month for 0-17 to \$3,615/month for 85 or older. Missouri Health Insurance Pool (MHIP). December 19, 2012. Available: <http://www.mhip.org/index.html>

²⁹ Unless otherwise referenced, descriptions of the provisions of the ACA in this brief have been summarized by HMA from the published legislation. Available: <http://housedocs.house.gov/energycommerce/ppacacon.pdf>

(e.g., an individual's income is below the poverty level and he/she does not qualify for Medicaid). Individuals who do not have access to affordable employer coverage will be able to purchase coverage through a Health Insurance Exchange with premium and cost-sharing credits available to eligible individuals and families with incomes up to 400 percent of FPL. In addition, people with income up to 250 percent of FPL can receive discounts on out-of-pocket health spending for covered health benefits. (Sections 1311-1313, 1322, 10104)

- *Health Insurance Exchanges:* Exchanges are mechanisms created to help individuals and small businesses purchase health insurance coverage. Beginning in 2014, an Exchange (also referred to as a Marketplace) will be established in each state to help consumers make comparisons between plans offering standardized benefits that are certified to meet benchmarks for quality and affordability. Missouri has chosen to let the federal government run the state's Exchange.³⁰ (Section 1311)
- *Medicaid Expansion:* Currently, non-working parents can only qualify for Medicaid in Missouri if their income is below 19 percent of FPL, approximately \$4,380 for a family of four in 2012. Other non-disabled adults under age 65 cannot qualify for Medicaid, regardless of income level.³¹ The ACA as originally passed required states to expand Medicaid to nearly all individuals under the age of 65 who are not otherwise covered by Medicaid or Medicare and who have incomes at or below 138 percent of FPL, equivalent to \$15, 415 for an individual in 2012. However, the Supreme Court's June 2012 ruling on the ACA makes this provision optional for states.³² On November 29, 2012, Missouri Governor Jay Nixon announced plans to include Medicaid expansion in the FY2014 budget, but it is not expected to be approved by the Republican majority legislature (Section 2001).

The aforementioned provisions go into effect in 2014. Several other ACA provisions became effective in 2010. New consumer protections in the insurance market include the following:

- *Lifetime limits:* Insurance companies are no longer able to place lifetime limits on the coverage they sell. This provision ensures that the 3.3 million Missouri residents with private insurance coverage³³ will not "outspend" their coverage over the lifetime of the coverage. After 2014, annual limits on coverage will also be prohibited for new plans. Until then, the Secretary of Health and Human Services can regulate annual limits. (Section 2711)
- *Bans on rescinding coverage:* Insurance companies are banned from dropping people from coverage when they get sick. (Section 2712)

³⁰ Gordon, E. November 13, 2012. Missouri, Kansas reject state-run health insurance exchanges. Kaiser Health News. Available: <http://www.kaiserhealthnews.org/stories/2012/november/13/missouri-kansas-health-insurance-exchanges.aspx>

³¹ KFF. State Health Facts. 2012.

³² KFF. August 2012. A guide to the Supreme Court's Decision on the ACA's Medicaid Expansion. Available: <http://www.kff.org/healthreform/upload/8347.pdf>

³³ KFF. State Health Facts. 2012.

- *Protections for children:* Insurance companies cannot exclude children from coverage because of a pre-existing condition, if the policy also covers the parents. Additionally, adult children up to the age of 26 can now be covered under their parents' policies. (Section 2714)

In combination, these federal reforms are a major step in making coverage accessible and more affordable for the chronically ill and disabled, and they will greatly reduce the number of uninsured.

Medicaid's Role in Covering Chronically Ill or Disabled Adults

As of October 2012, more than 883,000 Missourians were enrolled in MO HealthNet, Missouri's Medicaid program.³⁴ Elderly and disabled Missourians comprised 27 percent of all MO HealthNet enrollees in SFY 2011, but they accounted for nearly 67 percent of all expenditures. Breaking this down further, 18.5 percent of Medicaid enrollees were disabled and accounted for 48.2 percent of all expenditures, with total spending of more than \$3.1 billion.³⁵ For Missouri's Medicaid program, in FY 2009, the average yearly cost to cover the disabled population was \$14,986 per person, while the average yearly cost to cover a nonelderly, non-disabled person was \$3,513. The national average yearly Medicaid costs were slightly higher for the disabled population, \$15,840, but lower for the nonelderly, non-disabled population (\$2,900 per member per year).³⁶

According to a 2009 estimate, 10.2 percent of Missourians with a disability are uninsured.³⁷ Disabled individuals may have to endure long waiting times before qualifying for Medicare coverage. In 2002, 1.2 million Americans were estimated to be in the 29-month³⁸ waiting period between establishing disability and having Medicare coverage begin, making Medicaid or commercial health insurance the only coverage options for these individuals.³⁹ Because of the previously discussed historic difficulties disabled individuals faced in obtaining commercial health insurance, Medicaid has often been the only option for the disabled. Even with the passage of the ACA, Medicaid will continue to cover many disabled Missourians.

As in all states, Missouri's Medicaid program has become the primary insurer of people whose medical conditions result in disability and the inability to work. Estimates for 2008-2009 indicated that 51.7 percent of low-income adults 21 or older in Missouri at or below 250 percent of FPL with activity of daily living (ADL) disabilities were enrolled in Medicaid, higher than the U.S.

³⁴ Missouri Department of Social Services. 2012. Caseload Counter. Available: <http://dss.mo.gov/mis/clcounter/>

³⁵ Missouri Department of Social Services. August 28, 2012. Annual Report 2012. Available: <http://dss.mo.gov/re/pdf/2011-dss-annual-report.pdf>

³⁶ KFF. State Health Facts. 2012.

³⁷ Center for Personal Assistance Services. 2009. Disability data for Missouri from the 2009 American Community Survey: health coverage. Available: http://www.pascenter.org/state_based_stats/disability_stats/acs_insurance.php?state=missouri

³⁸ To receive Medicare, a disabled individual must first be approved for disability benefits through the Social Security Administration. Disability benefits are paid on the 6th month after the effective date of the disability. Individuals are then eligible for Medicare 24 months after the first disability benefit pay-out. The total waiting period from the disability effective date equates to 29 months. U.S. Social Security Administration. December 13, 2012. Disability. Available: <http://www.ssa.gov/pgm/disability.htm>

³⁹ Williams, B., Claypool, H., Perry, M., et. al. (October 2004). *Waiting for Medicare: Experiences of Uninsured People With Disabilities in the Two-Year Waiting Period for Medicare*. Commonwealth Fund and Christopher Reeve Paralysis Foundation. Available http://www.commonwealthfund.org/usr_doc/786_williams_waiting_for_medicare.pdf

average of 49.9 percent.⁴⁰ However, many individuals with chronic health conditions are not disabled, and not all individuals with a disability qualify under basic Medicaid income standards.

Over time, federal Medicaid policy has evolved to allow states considerable flexibility to expand Medicaid coverage to additional groups with chronic or disabling conditions. In addition, Congress has enacted specific optional programs to allow states to reach targeted groups. For example, in Missouri the Breast and Cervical Cancer Treatment Program allows Missouri to extend coverage to women with higher incomes (e.g., up to \$30,260 for a 2-person household) who have been diagnosed with breast or cervical cancer through a federally funded screening program.⁴¹ While these optional Medicaid programs assist some Missourians with chronic conditions, Medicaid's limited coverage of nonelderly adults still leaves many with chronic conditions without health insurance. The ACA was supposed to address this problem by extending coverage to nearly all Americans.

As previously mentioned, the ACA originally required states to expand Medicaid, but the Supreme Court's June 2012 ruling on the ACA made this provision optional.⁴² Missouri Governor Jay Nixon has stated his support Medicaid expansion, but approval for expansion is needed from the Republican majority legislature.⁴³ If states elect to expand Medicaid, the federal government will fund the full costs of expansion from 2014 to 2016; the Federal Medical Assistance Percentage (FMAP) for the expansion population will then gradually phase down to cover 90 percent of expansion costs in 2020 and beyond. As a point of reference, the FY 2013 FMAP for Missouri is 61.37 percent.⁴⁴

If Medicaid expansion was approved by the legislature, it is estimated that Missouri's uninsured population would decrease by 61.3 percent between 2013 and 2022, compared to a 29.2 percent decrease if the state does not expand Medicaid.⁴⁵ Medicaid expansion would greatly increase access to routine care for the chronically ill uninsured population.

Managing the Burden and Cost of Chronic Care and Disabilities

Cost containment initiatives in many states are beginning to focus heavily on the Aged, Blind, Disabled (ABD) Medicaid population, Medicaid recipients with chronic conditions, and individuals who are dually eligible for Medicaid and Medicare (dual eligibles). The ABD population historically accounts for a disproportionate share of Medicaid spending, and full benefit duals (i.e., individuals with full Medicaid benefits *and* Medicare benefits) in Missouri

⁴⁰ The Commonwealth Fund. 2011. State long-term services and supports scorecard. Available: <http://www.longtermcarecard.org/>

⁴¹ Missouri Department of Social Services. March 1, 2012. MO HealthNet Division. Available: <http://dss.mo.gov/mhd/index.htm>

⁴² KFF. A guide to the Supreme Court's Decision on the ACA's Medicaid Expansion. 2012.

⁴³ Office of Missouri Governor Jay Nixon. November 29, 2012. Gov. Nixon announces plans to provide healthcare coverage for additional estimated 300,000 Missourians. Available: http://governor.mo.gov/newsroom/2012/Gov_Nixon_announces_plans_for_health_care_coverage_for_additional_300_000_Missourians

⁴⁴ Federal Register. November 30, 2011. Table 1- Federal Medical Assistance Percentages and Enhanced Federal Medical Assistance Percentages. Available: <http://www.gpo.gov/fdsys/pkg/FR-2011-11-30/pdf/2011-30860.pdf>

⁴⁵ Holahan, J., Buettgens, M., Carroll, C., Dorn, S. November, 2012. The cost and coverage implications of the ACA Medicaid Expansion: national and state-by-state analysis. *The Urban Institute*. Available: <http://www.kff.org/healthreform/upload/medicaid-coverage-and-spending-in-health-reform-national-and-state-by-state-results-for-adults-at-or-below-133-fpl.pdf>

were three times more likely than Medicare-only beneficiaries to have five or more chronic conditions in 2007.⁴⁶

States are actively engaged in efforts to adopt more cost effective strategies for managing care for people with chronic and disabling conditions. Some states now require some or all ABD recipients to enroll in managed care organizations (MCO) or primary care case management (PCCM) arrangements to receive Medicaid services.⁴⁷ States are also pursuing long-term care coverage through managed care arrangements, often pursuing full integration of acute and long-term care services in a single managed care arrangement. For example, Texas is further expanding its STAR+PLUS Program in 2013. STAR+PLUS is a Medicaid managed care program that integrates acute care services and long-term services and supports for Texas' ABD population.⁴⁸

Missouri has a long history of implementing initiatives to improve health outcomes and contain costs for Missourians with chronic conditions. Examples of these are the following:

- *MHIP*: The Missouri Health Insurance Pool (MHIP) was established by, and operated according to, legislation enacted by the Missouri General Assembly in 1991. MHIP offered health insurance options to individuals who could not obtain health insurance in the standard market (e.g., exhaustion of COBRA benefits or certain health conditions). MHIP was funded by premiums paid by its enrollees and assessments paid by health insurers and health management organizations (HMOs) that issued coverage to Missouri residents. There was no limit on the number of individuals who enrolled in MHIP. It offered individual health coverage through five major medical plans. In addition to the state high-risk pool, the MHIP also operated the federal high-risk pool program called the Pre-existing Conditions Insurance Pool (PCIP). Both programs ended in 2014 as a result of the ACA prohibiting insurers from denying coverage because of pre-existing health conditions.
- *Missouri Health Improvement Act of 2007*: The Missouri Health Improvement Act of 2007 transformed the Division of Medical Services into the MO HealthNet Division (i.e., Medicaid). The Act also strongly supports health prevention and promotion as a strategy for overall cost management, providing funding for all Medicaid participants to be enrolled in health improvement plans, to have health homes, and to receive health risk assessments. Missouri's two State Plan Amendment (SPA) Health Homes (described in the next section) align with the goals of the Act.⁴⁹

⁴⁶ U.S. Department of Health and Human Services. June 13, 2012. Medicare-Medicaid enrollee state profile, Missouri. Available: <http://www.integratedcareresourcecenter.com/PDFs/StateProfileMO.pdf>

⁴⁷ Howell, E., Palmer, A., Adams, F. July, 2012. Medicaid and CHIP risk-based managed care in 20 states: experiences over the last decade and lessons for the future. Available: <http://www.urban.org/UploadedPDF/412617-Medicaid-and-CHIP-Risk-Based-Managed-Care-in-20-States.pdf>

⁴⁸ Texas Health and Human Services Commission. December 28, 2012. STAR+PLUS overview. Available: <http://www.hhsc.state.tx.us/starplus/overview.shtml>

⁴⁹ National Academy for State Health Policy. September, 2012. Missouri. Available: <http://www.nashp.org/med-home-states/missouri>

MO HealthNet Programs

Missouri policy strongly supports prevention of institutional care to maximize quality of life and program cost containment. Missouri has ten home- and community-based service waivers to enable targeted populations to receive long-term care services and supports in their own homes, rather than enter an institutional setting. For example, the Missouri Children with Developmental Disabilities Waiver, also known as the Sarah Lopez Waiver, allows children with significant medical needs who would be considered MO HealthNet-eligible if they resided in an institution, to receive certain services in the home. These children are unable to qualify for traditional Medicaid because their family incomes are too high, but their care is a significant financial burden. The waiver allows Missouri to consider only the child's income to make the eligibility determination, allowing these children to remain in their homes.⁵⁰ Other examples of MO HealthNet programs designed to minimize the burden of chronic disease are described below.

- *Medicaid Managed Care*: MO HealthNet requires some populations⁵¹ to enroll in managed care health plans in the Eastern, Central, and Western regions of the state. As of October 2012, 419,245 Medicaid enrollees (47%) were enrolled in a managed care health plan. Individuals that receive Supplemental Security income (SSI) or meet the medical definition for SSI have the option to not enroll or disenroll from a managed care health plan.⁵² National trends indicate that enrollment in Medicaid managed care will continue to grow.
- *Chronic Care Improvement Program (CCIP)*: Beginning in November 2006, Missouri initiated the CCIP, which operated under MO HealthNet and was administered by APS Healthcare. CCIP was an enhanced primary care case management program that incorporated the principles of disease management, care coordination, and case management to serve patients identified through a risk-assessment and disease-stratification model. It also included an Internet-based plan of care for health and disease management, which worked in tandem with the chronic care program to help coordinate care for Medicaid patients. The program implemented its community-based care management model, which placed health coaches and nurse care managers in community health centers and provider locations throughout the state. Approximately 140,000 of Missouri's 825,000 Medicaid recipients were eligible for this program. More than 53,000 persons had been enrolled in this program by late 2007.⁵³ Funding for this forward-thinking program was eliminated in July 2010 because of budget

⁵⁰ Section 1915(c) waivers include: Adult Day Care Waiver, Autism Waiver, Aged and Disabled Waiver, AIDS Waiver, Independent Living Waiver, Medically Fragile Adult Waiver, DD Comprehensive Waiver, Missouri Children with Developmental Disabilities Waiver (Sarah Lopez Waiver), Division of DD Community Support Waiver, Partnership for Hope Waiver. Missouri Department of Social Services, MO HealthNet Division. August 24, 2012. About the MO HealthNet Division. Available: <http://dss.mo.gov/mhd/general/pages/about.htm#waiv>

⁵¹ Parents/Caretakers, Children, Pregnant Women, and Refugees; MO HealthNet children in the care and custody of the state and receiving adoption subsidy assistance; and CHIP. MO HealthNet Division. December 20, 2012. Managed Care. Available: <http://dss.mo.gov/mhd/mc/index.htm>

⁵² Ibid.

⁵³ Wolken, L. November 2, 2007. Medicaid Program offers "Coaches" to nurse chronic ailments. Columbia Missourian. Available: <http://www.columbiamissourian.com/stories/2007/11/02/medicaid-program-offers-coaches-nurse-chronic-ailm/>

reductions. A report commissioned by the MO Health Oversight Committee in 2010 showed that the increased enrollment in CCIP in 2008 and associated costs were not offset by increased medical savings. While the report cautioned that disease management interventions may not show cost savings over the short-term, there was not a positive return on investment for the overall CCIP program in CY2008.⁵⁴

- *Show Me Healthy Woman (SMHW)*: The SMHW program is run by the Bureau of Cancer and Chronic Disease Control, part of the Missouri Department of Health and Senior Services. SMHW offers free breast and cervical cancer screenings to women who are considered high risk, including women with low incomes, women over 50, women with little or no health insurance, women who are rarely or never screened, rural women, women of color, and women with disabilities. WISEWOMAN (Well-Integrated Screening and Evaluation for Women Across the Nation) provides annual screenings and education to participants in the SMHW program. Annual screenings measure blood pressure, cholesterol, HDL, blood glucose, and body mass index. Risk counseling is provided in order to promote healthy living and lifestyle adjustments to improve health.⁵⁵

During 2009 and 2010, several reports were commissioned to provide the Missouri Department of Social Services with valuable information about the efficiency and effectiveness of the MO HealthNet program. These reports included information about the highest-cost Medicaid recipients and strategies for better managing costs and improving health outcomes. For example, in CY 2008, 5.4 percent of all Medicaid beneficiaries represented 52.5 percent of total program costs, with dual eligibles representing approximately half of these high-cost beneficiaries. The report's recommendations included using a Section 1115 waiver as an opportunity for Missouri to implement experimental, demonstration, or pilot projects. In July 2010, CMS approved Missouri's Section 1115 demonstration project, Missouri Gateway to Better Health, which continued funding for primary and specialty care for uninsured residents in St. Louis.⁵⁶

Health Care Reform Opportunities

The ACA created the Federal Coordinated Health Care Office (Medicare-Medicaid Coordination Office) in order to improve coordination between Medicare and Medicaid programs for dual-eligibles. Sponsored by the Centers for Medicare and Medicaid Services (CMS), the Medicare-Medicaid Coordination Office is tasked with removing historical barriers between Medicare and Medicaid to facilitate care coordination. Several programs described below, including health homes for dual eligibles and the financial alignment initiative, are housed in this office.

Missouri Health Home Initiative: The ACA established a federal grant program to implement and evaluate the Patient Centered Medical Home (i.e., health home) model for accessible and high-quality primary care that is cost-effective, sustainable, and scalable. The health home

⁵⁴ WasDyke, A., Cook, M. February 2, 2010. MO HealthNet Chronic Care Improvement Program (CCIP) financial and clinical evaluation. Mercer. Available: <http://dss.mo.gov/mhd/oversight/pdf/financial-evaluation10feb02.pdf>

⁵⁵ Missouri Department of Health and Senior Services. December 19, 2012. Pathways to Chronic Disease Resources and Information. Available: <http://health.mo.gov/living/healthcondiseases/chronic/chronicdisease/index.html>

⁵⁶ Missouri Department of Social Services. August 28, 2012. Annual Report 2012. Available: <http://dss.mo.gov/re/pdf/2011-dss-annual-report.pdf>

model supports primary care practices by increasing available resources and improving care coordination. In 2011, Missouri became the first state to receive approval from CMS for a State Plan Amendment (SPA) Health Home. In January 2012, Missouri implemented two Health Home Models for dual eligible Missourians, the Community Mental Health Center (CMHC) Health Home program and the Primary Care Health Home. The CMHC program targets Medicaid recipients with co-morbid mental health and chronic physical health conditions, and the Primary Care program targets Missourians with two or more chronic conditions, or one chronic condition with risk of developing another chronic condition.⁵⁷ As of May 2012, there were 35,117 Missourians currently enrolled in a Health Home program, including 11,979 dual eligibles. More than 25 percent of CMHC Health Home enrollees have been diagnosed with chronic obstructive pulmonary disease (COPD), asthma, or diabetes mellitus. Additionally, more than 80 percent of enrollees have a BMI greater than 25, and about 50 percent are smokers.⁵⁸ Missouri is expecting savings of \$44.6 million in FY 2013 as a result of the program.⁵⁹ In May 2012, Missouri submitted a proposal to CMS in response to the financial alignment initiative to participate in a managed fee-for-service model, which would allow Missouri to share in cost savings from the two Health Home programs. At the time of publication, Missouri had not yet entered a Memorandum of Understanding with CMS for the financial alignment initiative.⁶⁰

Accountable Care Organizations: This program provides financial incentives to reduce the growth of Medicare expenditures and improve health outcomes by promoting Accountable Care Organizations (ACOs). Participating ACOs must be accountable for quality, cost, and overall care of Medicare fee-for-service beneficiaries. ACOs are groups of physicians, other providers, and suppliers that have a legal relationship that enables them to distribute financial incentive payments. They must also meet criteria related to evidence-based medicine and patient engagement, quality and cost, and care coordination. On January 10, 2013, CMS announced the addition of 106 new ACOs to participate in the Shared Savings Programs. The group included two ACOs in Missouri: Kansas City Metropolitan Physician Association ACO and Mercy ACO.⁶¹ In December 2013, another 123 new ACO organizations were announced, including six listed as serving Missouri.⁶²

Independence at Home Demonstration Program: This Medicare demonstration grant program, sponsored by the CMS Innovation Center, funded 18 projects starting in 2012 to test models of care that promote independence at home through comprehensive primary care services at home. These projects are focused on developing primary care teams of physicians, nurse practitioners,

⁵⁷ KCMU. August, 2012. Medicaid health homes for beneficiaries with chronic conditions. Available: <http://www.kff.org/medicaid/upload/8340.pdf>

⁵⁸ Missouri HealthNet and Department of Mental Health. October, 2012. Missouri Community Mental Health Center Healthcare Homes, six month review. Available: <http://dmh.mo.gov/docs/medicaldirector/CMHC-SixMonthReview.pdf>

⁵⁹ Missouri Office of Administration. 2012. FY 2013 Budget Information. Available: <http://oa.mo.gov/bp/facts2013.htm>

⁶⁰ Missouri Department of Social Services, MO HealthNet Division. May 31, 2012. Financial model to support state efforts to integrate care for Medicare-Medicaid enrollees managed fee-for-service demonstration proposal. Available: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MOProposal.pdf>

⁶¹ CMS Innovation Center. 2013. Centers for Medicare and Medicaid Services (CMS). Available: <http://innovations.cms.gov/index.html>

⁶² CMS. Shared Savings Program - Program News and Announcements. February 2014. Available: <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/News.html>

and others to deliver care to Medicare beneficiaries with multiple chronic conditions in the home and to coordinate care across all treatment settings. Missouri did not receive any funding for this program.⁶³

Community-Based Care Transitions Program: This Medicare demonstration program is aimed at providing transition services at specific locations to beneficiaries who are at high risk of re-hospitalization or a substandard transition to post-acute care. Community-based organizations in partnership with hospitals that have high readmission rates were eligible to apply for funding under this program. The program began on January 1, 2011, and runs for five years. No Missouri community-based organizations received funding under this program.

Medicare Special Needs Plans: Special Needs Plans (SNPs) are Medicare Advantage plans that target enrollment of beneficiaries who are dual-eligible, nursing home residents, or individuals who have chronic disabling conditions. Missouri has several Medicare Special Needs Plans (SNPs), including SNPs for dual eligibles (D-SNP) and individuals with chronic or disabling conditions (C-SNP).⁶⁴ The ACA reauthorized D-SNPs through December 31, 2012, after which time all D-SNPs must have contracts with the state Medicaid agency to improve coordination of services between Medicare and Medicaid, pursuant to the Medicare Improvement for Patients and Providers Act of 2008. These provisions also impose more standardized enrollment, quality, and payment rate criteria.⁶⁵

Bundled Payments for Care Improvement: This pilot program was established to discourage fragmented care and to align financial incentives with high quality care. Instead of Medicare reimbursing providers for each service rendered during an episode of care or illness, providers will be able to bundle services together into one payment. At the time of publication, awards had not yet been published by the CMS Innovation Center.⁶⁶

Implications for Missouri

Missouri has a large population of chronically ill and disabled residents. It is important for Missouri to recognize the challenges presented by this population, and the state must continue to explore opportunities to improve the health of these Missourians. While many are covered through Medicaid and Medicare, more than 10 percent remain uninsured. Even with the subsidies available through the health reform law, some chronically ill people may find that the coverage is too costly, given their premiums and out-of-pocket costs. Another concern is that people with greater health care needs, such as the chronically ill, will participate in new coverage offerings at higher rates than healthier populations, which may result in higher-than-average insurance costs. This concern may be unjustified, however, because it would be realized only if a significant proportion of lower-risk individuals decided not to conform to the ACA mandate to have coverage and chose to pay the penalty instead.

⁶³ CMS Innovation Center. 2013.

⁶⁴ KFF. State Health Facts. 2012.

⁶⁵ Centers for Medicare and Medicaid Services (CMS). March 27, 2012. Special Needs Plans. Available: <https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/index.html>

⁶⁶ CMS Innovation Center. 2013.

Missouri has developed several programs to better serve Medicaid recipients with chronic conditions and disabilities, but data is limited on the effect of these programs, making it difficult for policymakers to promote such programs. Missouri has taken advantage of several provisions of the ACA benefiting Medicaid and Medicare recipients with chronic conditions and disabilities and also missed out on several funding opportunities. There are numerous policy considerations for Missouri for the future, including:

- Implementing policies to reduce the prevalence of chronic conditions (e.g., tobacco policy).
- Expanding Medicaid to non-disabled adults below 133 percent of FPL to reduce the number of uninsured Missourians, especially reducing the number of uninsured Missourians with chronic conditions.
- Continuing to test evidence-based models, like the health home model, to improve care coordination for vulnerable populations.

Missouri should consider these opportunities as well as other strategies to control costs and improve outcomes (e.g., enhanced disease management for MO HealthNet beneficiaries with chronic conditions). Most importantly, the state needs to continue to invest in prevention, the most cost-effective way to minimize the burden of chronic disease.

Section

5

Electronic Health Records and Health Information Exchange

Issue Statement

The American health care system offers some of the most advanced and effective care in the world—but it also is often criticized as fragmented and inefficient, for a lack of emphasis on quality, and as being difficult for consumers to compare price and quality. The U.S. spends more per capita on health care than any other developed country, but achieves equal or lower results in terms of health outcomes and access to services for its population on average.

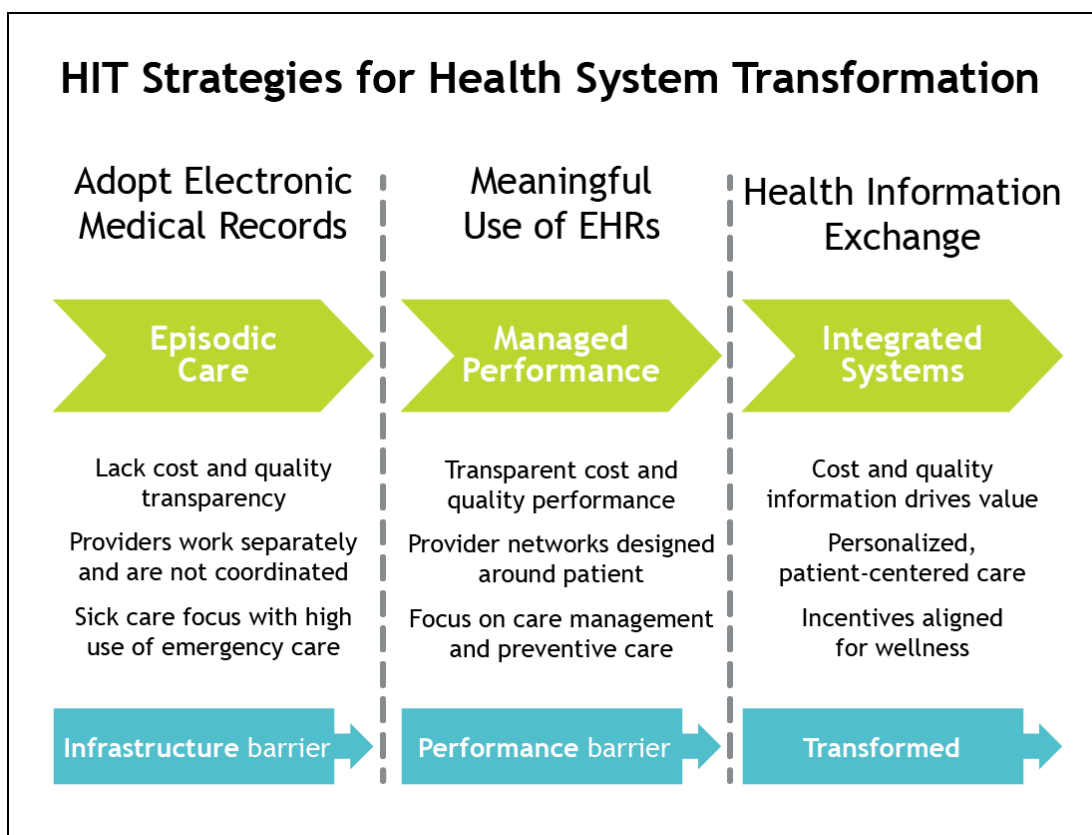
Modern health information technology (HIT) offers unprecedented opportunities to improve health care for Americans, and has the potential to contribute to a system with better quality at a lower cost. Policymakers from all spheres have demonstrated a strong interest in using electronic health records (EHR) and an electronic health information exchange (HIE) to achieve a health care system that is more efficient, effective, safe, accessible, transparent, and affordable for Americans.

The Vision: Leveraging HIT to Transform Health Care Delivery Systems

Widespread adoption of EHRs and electronic HIEs (see Appendix A for definitions of common terms) have the potential to improve individual and population health outcomes, make information about quality and costs transparent, and provide data necessary to study and improve care delivery. Well executed HIEs have the potential to help consumers and patients manage their own health, help doctors and hospitals gather relevant information to best treat an individual patient in a more timely manner, improve tracking of chronic disease management, and improve early detection of infectious disease outbreaks.

Many health care institutions have been investing in high-tech systems for years, but the priority has tended to be automating administrative or back-office work within the institutions. The legacy systems have been criticized for trapping personal health information inside an institution and perpetuating episodic rather than integrated care (Figure 1). New systems are being designed to overcome these barriers and, going forward, will better allow health care providers to adopt interoperable EHRs that have the capability to exchange electronic health information with other sources.

Figure 1.



The meaningful use of EHR technology supports cost and quality transparency, productive interchange between provider and patient, and health care providers' ability to provide cost-effective care management and use clinical decision support tools to reduce cost and quality variances (Figure 1). Health care providers who use EHRs in a meaningful way have the potential to improve health system performance as a result of:

- Higher quality care through adherence to treatment protocols and guidelines;
- Reduction in adverse drug events and detection of pending patient error;
- Fewer duplicative treatments and tests;
- Administrative efficiencies through decreased paperwork;
- Improved population health and coordination of clinical care as a result of timely and appropriate access to individual and community health information;
- Early detection of infectious disease outbreaks around the country;
- Disease management tracking; and
- More complete data sources for use in research and policy.¹

¹ J. Walker, „Electronic Medical Records and Health Care Transformation,“ *Health Affairs*, 24, no.5 (2005).

Ultimately, the electronic sharing of health information across different sites enables the aggregation and tracking of episodes of care around clinical data, and facilitates new models of integrated care delivery (e.g. medical homes) to align incentives for wellness and organize care around the patient.

HIE also facilitates transparency to more easily identify unnecessary costs, and supports new payment and delivery models such as accountable care organizations, groups of physicians and other providers who take joint responsibility for the health outcomes and overall cost of care for their patients. EHRs and HIE are important prerequisites for redesigning health care delivery systems and improving overall health system performance.

The Current Reality: Overcoming Barriers and Building on Strengths

Despite the clear benefits of adopting EHRs and the strong activities Missouri Medicaid has made in enrolling Eligible Providers (EP) and Eligible Hospitals (EH), significant barriers remain. The technology exists, but it remains far from universally deployed throughout the health care system, particularly for small and medium-sized physician practices and community health centers. Some of the most significant barriers to adopting EHRs include:

- *Misaligned financial incentives:* The purchasers of EHRs—typically hospitals, physician practices, and other direct care settings—absorb purchase and maintenance costs but do not necessarily see equivalent return on their investment. Financial benefits more frequently accrue to health plans, employers, and coverage programs that see a decrease in redundant health care services, avoidable hospitalizations, and medical errors.
- *Privacy and security concerns:* Storing, moving, and sharing health information in electronic form raises questions about how to protect patient privacy and data security.
- *Standards for system interoperability are used inconsistently:* Data and technical standards exist but are frequently implemented differently. And many large systems, including state Medicaid programs, remain reluctant to overhaul legacy systems.
- *Publicly funded programs face unique challenges:* States can promote EHRs and HIE in publicly funded programs, including Medicaid and state employee benefit programs. But disparate and antiquated data systems, the way those systems are financed from multiple sources, and limited workforce and other resources to support HIT initiatives are frequent barriers to increased adoption of HIT.

As a result of these barriers, nationally, approximately 68 percent of physician practices report using an EHR. In Missouri, there is limited information about the status of HIT and EHR adoption among health care providers. In response to the most recent informal survey that was conducted in 2010, the following percentages of Missouri health care providers report they have implemented and use an EHR:

- 83% of hospitals;
- 54% of family physicians, and another 18% report they will soon;
- Less than 10% of rural health clinics;

- 95% of Federally Qualified Health Centers; and
- 92% of chain pharmacies and 64% of independent pharmacies.²

All Critical Access Hospitals and small rural hospitals in Missouri have implemented and are using EHRs according to a study done by the Office of the National Coordinator (ONC)³

The state of Missouri and the private sector have launched several collaborative initiatives to overcome barriers to HIT, continue to accelerate the adoption of EHRs, and the development of electronic HIE (Figure 2). The state is in a strong position to continue to build on these existing initiatives, continue to align them with statewide priorities for health system transformation, and obtain federal support to further expand EHR and HIE capacity.

Federal Framework: Stimulating State-Level Initiatives

The federal government has taken a more visible role in guiding and supporting state-level HIT initiatives in recent years. In 2009, the federal role expanded considerably as a result of the Health Information Technology for Economic and Clinical Health (HITECH) Act, which was enacted as part of the American Recovery and Reinvestment Act of 2009 (ARRA). The HITECH Act provides significant opportunities for states to access federal funds to plan, design, and implement the infrastructure to support statewide HIE and the adoption and use of EHRs. Federal HITECH funding opportunities include:

- *State HIE Cooperative Agreement Program*: A \$564 million grant program to support states or State Designated Entities in establishing health information exchange capability among health care providers and hospitals in their jurisdictions.
- *HIT Extension Program*: A \$677 million grant program to establish a nationwide system of Regional Extension Centers (RECs) to offer technical assistance, guidance, and best practices to assist providers in becoming meaningful users of EHRs.
- *Medicare and Medicaid EHR Meaningful Use Incentives*: Up to \$44 billion in Medicare and Medicaid incentive payments for eligible health care providers who meaningfully use certified EHR technologies. Missouri has been able to obtain over \$5.5 million enhanced matched federal dollars for the planning and implementation of the EHR incentive program, and has issued more than \$95 million (100% federal funding) in EHR incentive payments to Eligible Providers (EP) and Eligible Hospitals (EH).^{4,5} Additionally, Missouri has received \$13.8 million in federal funding for HIE planning and implementation.⁶

Figure 2 details Missouri's HIE infrastructure.

² MO-HITECH Health Information Exchange Operational Plan: FINAL (June 30, 2010), page 57.

³ ONC Data Brief #5, November 2012, pg 4.

⁴ State of Missouri, HIT Implementation Advanced Planning Document, Section 9, page 7, November 30, 2010.

⁵ States Payment Status Report, Medicare and Medicaid Payments by State, CMS, pg. 3, October 31, 2012

⁶ MO HIT Assistance Center. Missouri Health Information Exchange. Available: <http://assistancecenter.missouri.edu/?q=node/36>

Figure 2. Missouri's Current Health Information Exchange Infrastructure

Project Name	Sponsor	Location	Description
<i>Private Statewide Initiatives</i>			
Hospital Industry Data Institute (HIDI)	Missouri Hospital Association	MO, AK, GA, KA, OK, TN, VA, WA, WY	Data services for 900 hospitals nationwide
Missouri Quality Improvement Network (MOQUIN)	Missouri Primary Care Association	Statewide	Clinical quality measures reporting, monitoring, improvement for FQHCs
Missouri Telehealth Network (MTN)	University of Missouri	Statewide	Connecting 200 hospitals, FQHCs and mental health centers in 58 counties
<i>Private Regional HIE Initiatives</i>			
CareEntrust	Kansas City area businesses	Kansas City Bi-State Area	Online health record for 100,000 employees and dependents
Kansas City Bi-State HIE (KCBHIE)	Mid-American Regional Council (MARC) and Kansas City area providers	Kansas City Bi-State Area	Emerging network of existing data networks
Kansas City Quality Improvement Consortium (KCQIC)	UAW-Ford Community Health Care Initiative	Kansas City Bi-State Area	Agency for Healthcare Research and Quality Chartered Value Exchange
KC CareLink	BCBS of Kansas City, Health Care Foundation of Kansas City, and other funders	Kansas City Bi-State Area	Connecting 14 safety net providers serving 185,000 patients
Lewis and Clark Information Exchange (LACIE)	Heartland Health	Four-state corner area (MO, KS, NE, IA)	First fully operational multi-state HIE in the country
Midwest Health Initiative (MHI)	St. Louis Area Business Health Coalition (BHC)	St. Louis MSA and 16 counties west	Database of claims representing 1.2 million lives for quality reporting
St. Louis Integrated Health Network	St. Louis Regional Health Commission (RHC)	St. Louis region	Network master patient index across 18 safety net providers serving 200,000 patients
Tiger Institute for Health Innovation	University of Missouri and Cerner Corporation	University of Missouri Health Care locations	Connecting UM Health Care hospitals, clinics and pharmacies
<i>Public Initiatives</i>			
State of Missouri, Missouri Health Connection (MoHealth Connection)	MO Dept. of Health and Senior Services (DHSS), Mental Health (DMH), and Social Services MO HealthNet Division (Medicaid)	Statewide	Public/private collaborative agreement to implement HIE for shared clients
Missouri Health Strategic Architectures and Information Cooperative (MOHSAIC)	Department of Health and Senior Services (DHSS)	Statewide	Integrated statewide network of client demographic and health information
Public Health Information Network (PHIN)	Department of Health and Senior Services (DHSS)	Statewide	MOHSAIC reports public health information to CDC
MO HealthNet	MO Dept. of Social Services MO HealthNet Division (Medicaid)	Statewide	Connecting to other HIE partners

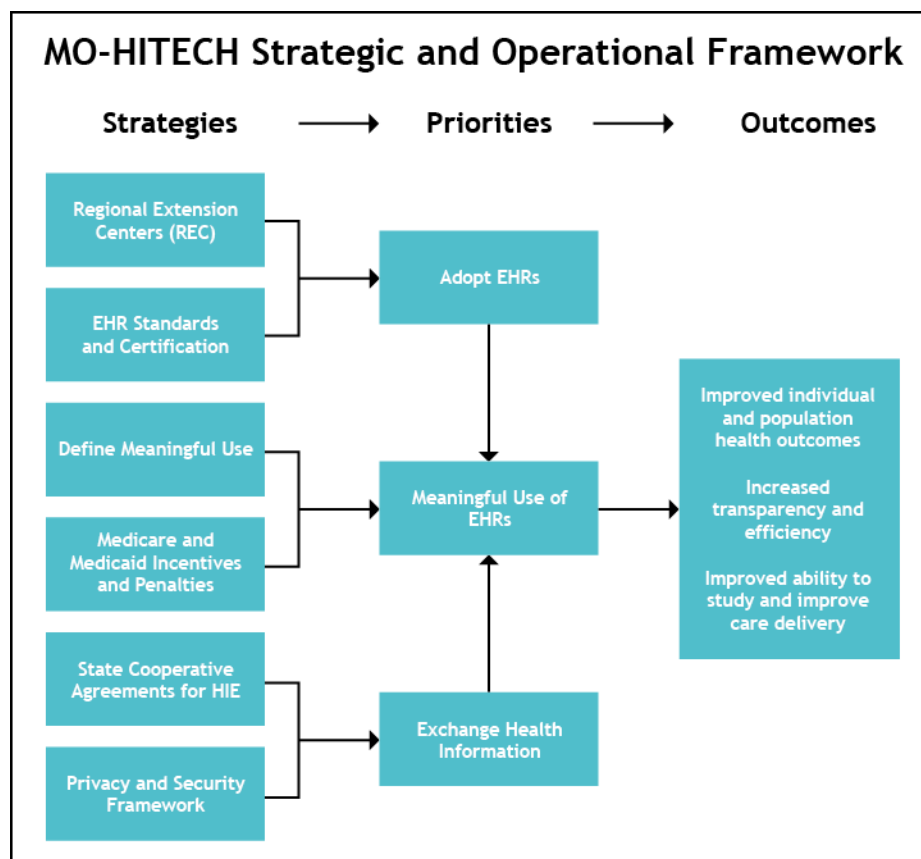
Source: MO-HITECH HIE Operational Plan: Final (June 30, 2010); MoHealth Connection Strategic and Operational Plan 2012 Updates

Combined, these programs build the foundation for every American to be linked to an EHR, with the goal of creating a more modern, interconnected, and improved system of care delivery. Eventually, the federal vision is to connect state-level HIE initiatives to a National Health Information Network (NHIN) that securely connects providers, health systems, consumers and communities to electronically share health information. This “network of networks” is not envisioned as a national, centralized repository or data store. Instead, the federal vision is that these interconnected networks will share common services and adhere to standards and requirements to enable interoperability, while information remains stored within the organizations where it was created.

State Leadership: MO-HITECH

On November 4, 2009, following the passage of the federal HITECH Act, Governor Jay Nixon created the Missouri Office of Health Information Technology (MO-HITECH) to promote the development and implementation of an effective HIT infrastructure for the State of Missouri. In 2011, after initial planning was completed by MO-HITECH, a new public/private partnership was created, Missouri Health Connection (MHC) and responsibility for the development and implementation of HIT was transferred from MO-HITECH. MHC is guided by a strategic plan and an operational plan that reflect priorities in the federal HITECH Act, including the widespread adoption and meaningful use of certified EHR systems and the development of a statewide HIE infrastructure (Figure 3).

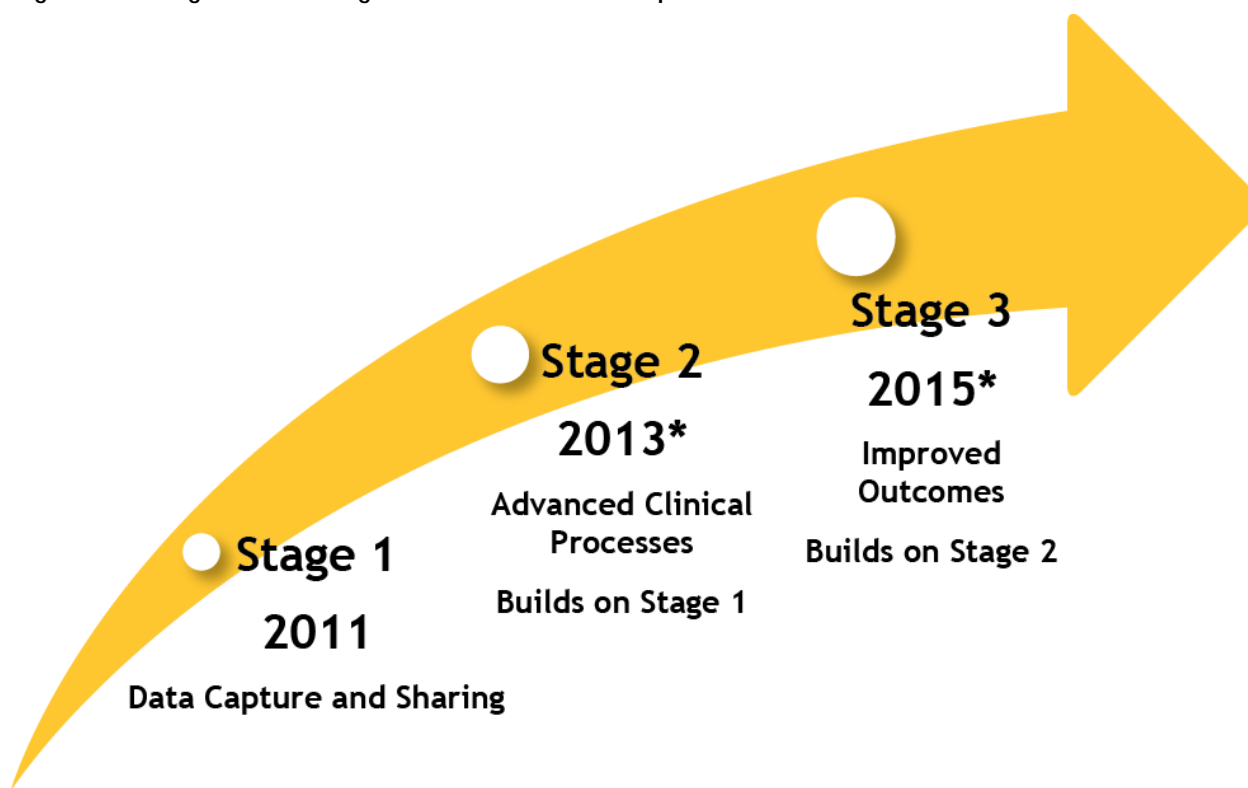
Figure 3.



Missouri's specific strategies to adopt and use EHRs and exchange health information electronically are intended to complement and advance federal HITECH priorities. MO-HITECH strategies include:

- *Creating a Regional Extension Center (REC)*: On April 6, 2010, the Missouri HIT Assistance Center was awarded \$6.8 million to serve as a REC for the state of Missouri and help 1,200 primary care providers select, adopt, implement, and meaningfully use EHRs. The Center is a partnership among several organizations led by the University of Missouri and including the Missouri Primary Care Association, Kansas City Quality Improvement Consortium, Missouri Telehealth Network, and Primaris (Missouri's Quality Improvement Organization). The Center also plans to continue to partner with the Hospital Industry Data Institute, a subsidiary of the Missouri Hospital Association, to serve 55 critical access and rural hospitals around the state. The Center's partner organizations have been active participants in the MO-HITECH initiative, which is committed to working with the Center to identify opportunities for collaboration, provider education, and technical assistance, among others.
- *Defining Meaningful Use*: On July 28, 2010, the Office of the National Coordinator (ONC), within the United States Department of Health and Human Services, issued a Final Rule that provides guidelines to health professionals and hospitals on how to adopt and use electronic health record technology in a meaningful way. Meaningful use requires: (1) use of a certified EHR technology in a meaningful manner, which includes the use of electronic prescribing; (2) use of a certified EHR technology that is connected in a manner that provides for the electronic exchange of health information to improve the quality of health care; and (3) use of a certified EHR to submit information on clinical quality and other outcome measures. One of the critical requirements for meaningful use is that, to be eligible for EHR incentive programs, a provider must use an ONC-certified EHR. Certification criteria are spelled out in federal rules so eligible health professionals and hospitals may be reasonably assured that the systems they adopt are capable of performing the required functions.
- *Three Stages of Meaningful Use* - Meaningful use has three stages with goals for each stage. During Stage 1 (2011 and 2012), providers must meet certain objectives/measures and 80 percent of patients must have records in the certified EHR technology. The reporting period for the first year is 90 days and one year subsequently. Figure 4 below shows the three stages of Meaningful Use and the associated timeline for implementation.
 - Stage 1: Data Capture & Sharing - Electronic capture of health information in a structured format, Stage 1 begins in 2011.
 - Stage 2: Advanced Clinical Processes - Quality improvement at the point of care and electronic exchange of information, Stage 2 scheduled to begin in 2013
 - Stage 3: Improved Outcomes - Improvements in quality, safety, and efficiency clinical decision support & patient self-management tools, Stage 3 is scheduled to begin in 2015

Figure 4. - Stages of Meaningful Use and Planned Implementation Timeline



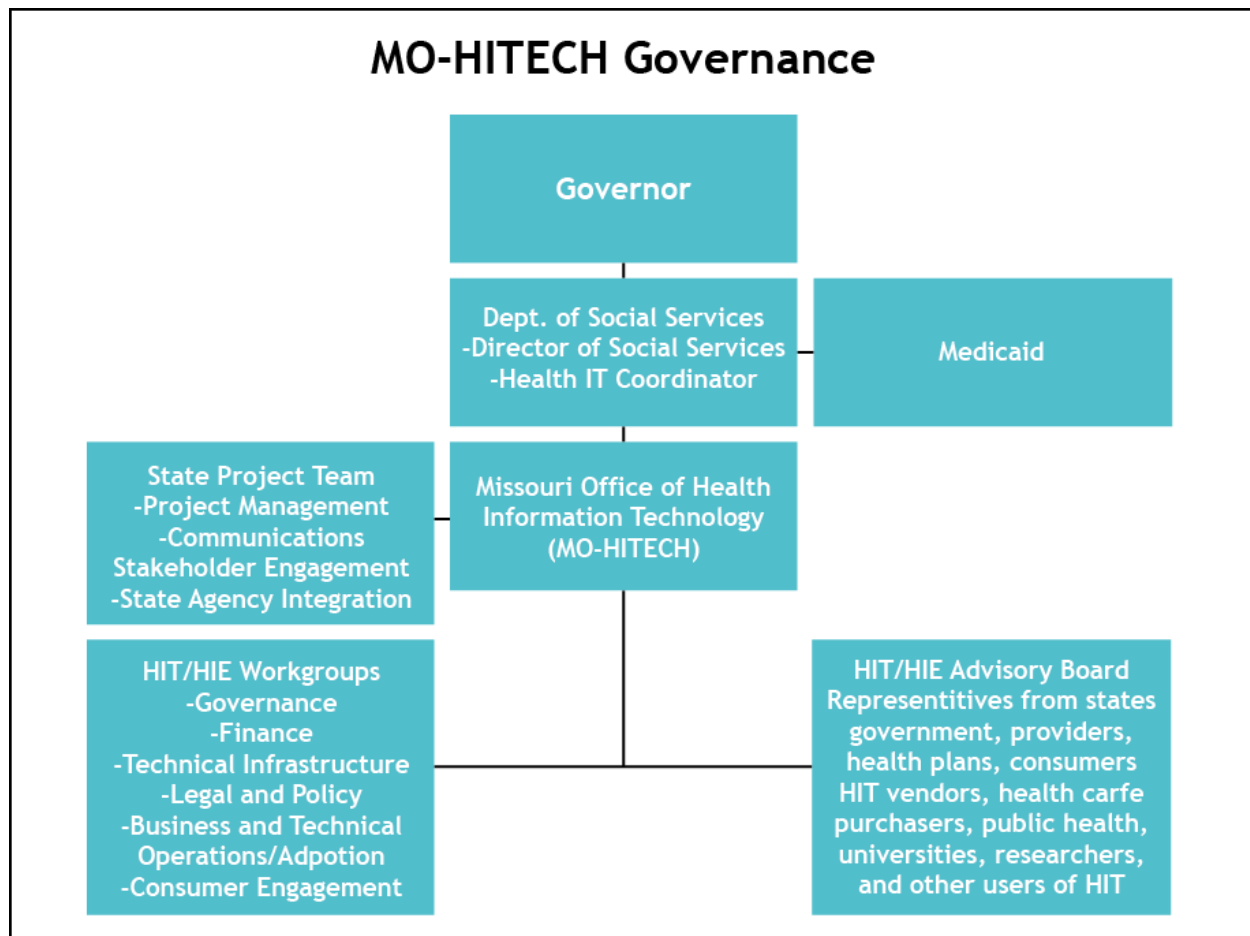
* Stages 2 and 3 will be defined in future CMS rulemaking. Source: Missouri HIT Assistance Center, Overview: What is Meaningful Use? Available: <http://assistancecenter.missouri.edu/?q=node/17>

In 2012, the Office of the National Coordinator (ONC) released a Final Rule on Meaningful Use Stage 2 (MU2), which not only defined the next phase of meaningful use, but also clarified and corrected Stage 1 meaningful use items.

- Implementing Medicaid Meaningful Use Incentives:** The HITECH Act authorizes the Centers for Medicare and Medicaid Services (CMS) to provide reimbursement incentives for eligible professionals and hospitals who are successful in becoming "meaningful users" of certified EHR technology. Eligible physicians can earn up to \$44,000 in Medicare incentive payments over five years, or up to \$63,750 over six years, but not both. Missouri's Medicaid program (MO HealthNet) is responsible for the administration and oversight of Medicaid meaningful use incentive payments. Current public health and clinical quality reporting and Missouri's HIE goals will be integrated into MO HealthNet meaningful use definitions. Missouri's statewide HIE goals, objectives, and capacities have been integrated into statewide Medicaid planning efforts and incorporated into Missouri's State Medicaid HIT Plan. The goal of the Medicaid HIT Plan is to coordinate MO HealthNet incentives with federal Medicare meaningful use definitions to avoid duplicating provider payments and facilitate provider enrollment in the most appropriate incentive program. Missouri implemented the EHR incentive program in 2011 and continues to enroll providers and issue incentive payments in accordance with federal regulations and guidelines

- Establishing a State Level Framework for HIE:** On February 12, 2010, ONC awarded a \$13.8 million grant to the Missouri Department of Social Services to help build the state's HIE capacity. As noted above, the state established a state-level authority for HIT planning and implementation, called the Missouri Office of Health Information Technology (MO- HITECH). MO-HITECH originally coordinated the state's entire HIT and HIE development activities through a state project team representing multiple state agencies, including MO HealthNet workgroups that develop HIT/HIE policy recommendations and an advisory board representing a diverse group of HIT stakeholders as indicated in (Figure 5).

Figure 5.



Source: MO-HITECH HIE Operational Plan (June 2010)

Over the past two years, HIE has been led by a Statewide Health Information Organization, originally called the Missouri Health Information Organization (MHIO). Since its initial Strategic and Operational Plans were submitted, MHIO became an independent entity and rebranded to an entity called Missouri Health Connection (MHC). Specifically, MHC is now a 501(c)3 private, nonprofit organization. The MHC Board of Directors represents health care leaders from across Missouri including members from state government, private health

care organizations, private practice physicians, professional organizations, and consumer advocacy groups.

Significant outreach work by MHC over the past two years has helped with recognition of the MHC name and logo. MHC continues to move forward in branding the organization as responsible for developing the process and connectivity to enable Missouri's health care community to exchange data, both statewide and nationally.

Progress to Date and Next Steps: Implementing a Statewide Health Information Network

Missouri's Electronic Health Record (EHR) Incentive Program

A cornerstone of the HIT program implemented in Missouri is the EHR Incentive Program. The Missouri Department of Social Services, Division of MO HealthNet manages the incentive program and implemented incentive payments in 2011. Providers in Missouri are given access to a portal created by the State's contractor, Xerox to enroll and provide necessary documentation to support the implementation of a qualified EHR system. MO HealthNet and its vendor have worked to upgrade the EHR Portal and have provided online user manuals for providers and hospitals to use to facilitate the use of the portal. Through October 2012, incentive payments have been disbursed to 1,489 Eligible Providers (EP) and 75 Eligible Hospitals (EH), for a total of \$95,805,155 in payments. The program also developed an audit strategy for validating providers Attestation, Implementation and Upgrade (AIU) status and Meaningful Use for Stage 1. Additionally, the State contracted with an entity to begin the audit process. In 2013, the plan is to continue to enroll remaining qualified EPs or EHs, update the program to prepare for Meaningful Use Stage 2 rules, and increase auditing.

Missouri's Health Information Exchange

The MO-HITECH initiative has transitioned to a nonprofit statewide Health Information Organization (HIO) overseen by a stakeholder board of directors and supported by executive, management, and administrative-level staff.

The objective of Missouri's Statewide HIO, Missouri Health Connection is to develop and oversee statewide policy guidance, as well as share core technical infrastructure and services. Specifically, the MHC's objectives are to:

- Define clear and consistent goals for participation in the statewide HIE;
- Define and adopt business, technical, and operational policies that participants comply with as participants in the statewide HIE;
- Act as the agent for distribution of state and federal grant funds for statewide HIE development;
- Ensure the availability of statewide technology services;
- Coordinate with the Missouri HIT Assistance Center;
- Establish business models for a sustainable, self-financing statewide HIO; and

- Have the authority through contractual relationships to ensure compliance, enforce policies, and resolve disputes relating to participation in the statewide HIE.

MHC plans to leverage HIT to transform health care delivery systems and improve overall health system performance.

The Missouri HIE landscape is characterized by local and regional HIE services being developed by regional HIOs all working with MHC to establish the statewide health information network. Missouri's strategy calls for the creation of a statewide HIO (Missouri Health Connection), as well as the leverage and support of existing and new regional HIOs. While most HIE efforts in Missouri are nascent, there have been substantial investments already in innovative approaches, and it is desired to integrate these efforts and enable them to continue to develop. MHC continues to work with both local HIOs and providers to bring them into the statewide HIE. Additionally, in 2012, work has been done with the State of Illinois to establish intrastate HIE connectivity. Missouri has adhered to national standards and intends to participate in the NHIN, providing access to all national services compatible with NHIN protocols and enabling robust border state HIE.

MHC will also continue the integration of state government health information assets into the statewide HIE. The state government has substantial integration capabilities within its systems and is progressing in the development of web services architecture with an Enterprise Service Bus (ESB). Working with state government to enable interoperability with the state government ESB will provide tremendous opportunities to leverage state government capabilities through statewide HIE.

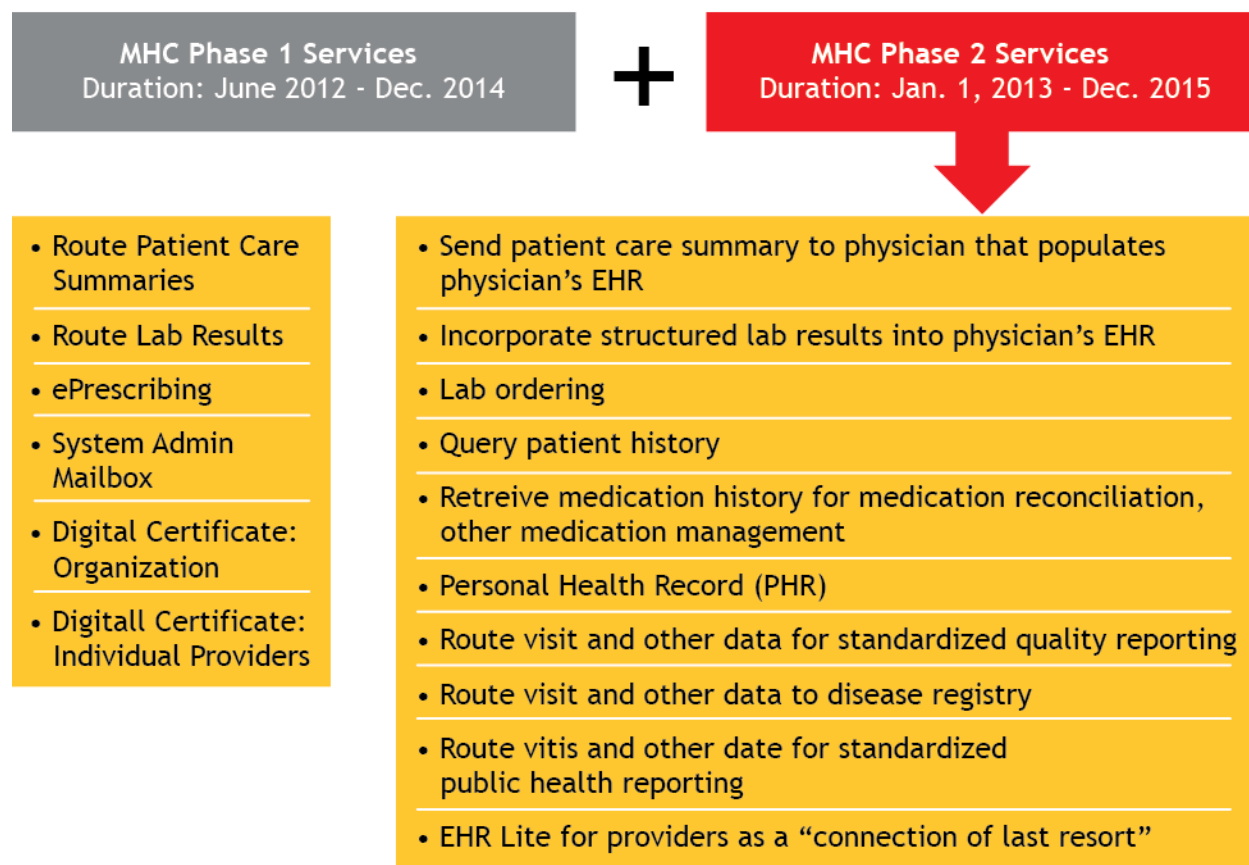
MHC has spent the last year implementing the HIE strategy designed by MO-HITECH in 2011. There have been no significant changes to MHC's overall HIE Strategy in 2011 or 2012. In 2012, the following HIE-related activities were completed by MHC:

1. Hired a permanent President and CEO, to lead the MHC;
2. Contracted with InterSystems Corporation to build the MHC Information Network using the InterSystems HealthShare™ platform and serve as the technology vendor for MHC;
3. Updated the Strategic and Operational Plan and submitted to ONC. Updates included:
 - Development of a sustainability plan for MHC;
 - Development of the MHC Privacy and Security Plan;
 - Development of the MHC HIE Program Evaluation Plan;
4. Launch of DIRECT secure messaging to facilitate HIE;
5. Participation in a National HIE Testing Initiative with other states, vendors, and HIEs;
6. Begin working with BJC HealthCare, Burrell Behavioral Health, Mercy, Nevada Health Clinic, and SSM HealthCare as the first participants in Missouri's groundbreaking electronic medical information network in September 2012;

7. Partnered with the University of Missouri, Sinclair Nursing School of Nursing, to help nursing homes better communicate with hospitals and rehab facilities securely to improve the care of their patients and reduce the rate of re-hospitalizations;
8. Received a \$230,000 grant from the Missouri Foundation for Health to fund educational and outreach efforts about the Statewide Health Information Network being developed. The effort will focus on creating a provider, consumer and consumer-advocate educational campaign;
9. Successfully tested and became one of the first states in the nation to exchange Direct Secure Messaging with another state HIE. MHC and the Illinois State Health Information Network (ILHIE) completed successful testing in December 2012, passing a major milestone toward full implementation of MHC.⁷

Missouri Health Connection continues to drive towards full implementation of HIE in the state. The strategic plan designates two Phases of the deployment (Figure 6).

Figure 6. High level HIE Implementation Timeline



Source: MHC Strategic and Operational Plan Update; June 08, 2012

⁷ Missouri Health Connection. Missouri Health Connection and Illinois Health Information Exchange Lead the Nation in Cross-State Connectivity, January 3, 2013.

Phase 1 Direct Secured Messaging core service includes a secure mailbox that enables sending and receiving authenticated encrypted health care information including patient care summaries and structured lab results.

Value-added or optional services for Direct Secured Messaging, at an additional cost, include:

- Cloud-based archiving system for mailbox data;
- ePrescribing capabilities;
- High-volume, automated Direct secured messaging feeds.

Phase 2 Health Information Network services include: Bi-directional query from MHC customers' EMR to other MHC customers' EMR, as well as secured messaging between MHC customers' EMRs. The service will support communication/interoperability between the EMRs even if they are different systems and vendors.

Both Phase 1 and Phase 2 secured messaging services will enable MHC customers to do the following:

- Send patient care summaries to a physician that populates the provider's EHR;
- Incorporate structured lab results into a provider's EHR; order labs;
- Query patient history;
- Retrieve medication history;

Phase 2 services may also include the following:

- Maintain personal health records (PHR) for patients;
- Route visit and other data for standardized quality reporting;
- Route visit and other data to disease registry;
- Route visit and other data for standardized public health reporting.

Additionally, MHC will offer a web portal access option to allow providers who do not have EMRs, or who are affiliated with health care organizations that have not yet selected MHC's network, to use the Internet to connect at a basic level.⁸

Conclusions

As demonstrated in this report, Missouri has taken steps forward in promoting the use of EHR by its providers and encouraging the exchange of data between providers, consumers, state government, and across state boundaries. The Department of Social Services, MO HealthNet Division has implemented EHR incentive payments and continues to work to improve the operations and technology supporting that program. Additionally, auditing of the EHR payments has begun, and audit results are scheduled to be reported to CMS. HIE efforts in

⁸ Missouri Health Connection Strategic and Operational Plan Update, Section IV, A, pg. 16-17.

Missouri are also moving forward in a careful, strategic way following a stakeholder-developed and approved HIE strategy and phased implementation plan. Under the leadership of a new President and CEO, combined with the hiring of a proven technology leader, Missouri continues to promote the Missouri Health Connection State Health Information Network and recruit early adopter providers.

Significant actions have been taken to attempt to reduce the barriers to implementing a Statewide Health Information Network.

Appendix A: Definitions of Common Terms

The rate of innovation in HIT over the past decade is unprecedented. The mainstream use of the Internet and the transfer of proven technology from other sectors into health care have created new and powerful policy solutions. Many of these concepts are intertwined, and there is logic in how they fit together, each element building on another, as described below:

Electronic Health Record (EHR)

As defined in the American Reinvestment and Recovery Act (ARRA), an Electronic Health Record (EHR) means an electronic record of health-related information on an individual. It includes patient demographic and clinical health information such as medical histories and problem lists. It also has the capacity to provide clinical decision support; support physician order entry; capture and query information relevant to health care quality; and exchange electronic health information with, and integrate such information from, other sources.

EHR Meaningful Use

Meaningful use meets the following requirements: (1) use of a certified EHR technology in a meaningful manner, which includes the use of electronic prescribing; (2) use of a certified EHR technology that is connected in a manner that provides for the electronic exchange of health information to improve the quality of health care; and (3) use of a certified EHR technology to submit information on clinical quality and other measures as selected by the Secretary of the U.S. Department of Health and Human Services (HHS).

Health Information Technology (HIT)

As defined in ARRA, Health Information Technology (HIT) means hardware, software, integrated technologies or related licenses, intellectual property, upgrades, or packaged solutions sold as services that are designed for or support use by health care entities or patients for the electronic creation, maintenance, access, or exchange of health information.

Health Information Exchange (HIE)

As defined by the Office of the National Coordinator, Health Information Exchange (HIE) means the electronic movement of health-related information among organizations according to nationally recognized standards. A Health Information Organization (HIO) oversees and governs HIE.

Nationwide Health Information Network (NHIN)

A national effort to establish a network to improve the quality and safety of care, reduce errors, increase the speed and accuracy of treatment, improve efficiency, and reduce health care costs.

Office of the National Coordinator for HIT (ONC)

The principal advisor to the Secretary of HHS on the development, application, and use of health information technology is the Office of the National Coordinator for HIT (ONC). This office coordinates HHS's HIT policies and programs internally and with other relevant executive branch agencies. The ONC develops, maintains, and directs the implementation of HHS' strategic plan to guide the nationwide implementation of interoperable HIT in the public and private health care sectors.

Section 6

Addressing Medicaid Fraud and Abuse: Facts and Policy Options

Issue Statement

Health care fraud is a national problem, prevalent in federal and state as well as private insurance programs... [F]raud is on the rise and the criminals who perpetrate it have become more organized and sophisticated.

— Deputy Secretary William Corr, U.S. Department of Health and Human Services

Testimony before House Committee on Appropriations Subcommittee on Labor, Health and Human Services, U.S. House of Representatives, March 4, 2010.

While the true annual cost of health care fraud and abuse is unknown, the National Health Care Anti-Fraud Association estimates conservatively that at least 3 percent of spending for health services—more than \$80 billion each year—is lost to health care fraud in the private and public sectors.¹ Other estimates are even higher – as much as \$272 billion lost to fraud and abuse in 2011 including \$98 billion lost from Medicare and Medicaid.² If the proportion of state-funded Medicaid spending that is lost to fraud and abuse is the same, the cost to the state of Missouri's Medicaid program could range from \$36 million to \$120 million per year (3% and 10% of \$1.2 billion).³ Thus, the state has a large stake in efforts to prevent, detect and prosecute health care fraud. This issue brief discusses what health care fraud is, summarizes some of the attempts at the federal and state levels to address fraud, and identifies some emerging approaches that hold the promise of reducing fraud and abuse in the future.

What is Health Care Fraud?

Legal authorities and experts generally define fraud as a false representation of fact or a failure to disclose a fact that is material to a health care transaction, along with some damage to another party that reasonably relies on the misrepresentation or failure to disclose.⁴ Medicaid regulations differentiate between fraud and abuse, as follows:

- “Fraud” means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to her/himself or some other person. It includes any act that constitutes fraud under applicable federal or state law.
- “Abuse” means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet

¹ Daniel R. Levinson, Inspector General, Office of the Inspector General, testimony before Senate Special Committee on Aging, U.S. Senate, May 6, 2009, available at <http://www.hhs.gov/asl/testify/2009/05/t20090506d.html>; National Health Expenditure Estimates available at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet.html>.

² Donald M. Berwick, MD, MPP and Andrew D. Hackbarth, MPhil, “Eliminating Waste in US Health Care,” *JAMA* 307, no. 14 (2012), 1513-1516.

³ The MO HealthNet budget for fiscal year 2012 was appropriated at \$6.8 billion, with about \$1.2 billion coming from state general revenue, \$3.5 billion from federal funds, and the remainder from other funds. See Department of Social Services Financial Summary available at: <http://oa.mo.gov/bp/budg2013/SocialServices.pdf>.

⁴ Hanson and Cassidy, “Fraud Control: New Tools, New Potential,” *Journal of AHIMA* 77, no.3 (March 2006): 24-30.

professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program.⁵

While the types of health care fraud are unlimited, common examples are described below.

Billing for More Expensive Services Than Were Actually Rendered (Upcoding)

Upcoding occurs when a health care provider bills for a more complex service than was actually performed. For example, a Missouri psychiatrist settled a case of alleged fraud for \$440,000 that involved billing Medicaid for 20-minute counseling sessions when he actually spent only five minutes with patients.⁶ More recently, U.S. Department of Health and Human Services (HHS) Secretary Kathleen Sebelius and Attorney General Eric Holder, sent a letter to five major hospital trade associations in September 2012, citing possible abuses related to electronic health records (EHRs) including the use of EHRs to facilitate upcoding as a means to enhance profits.⁷ The letter was sent two days after a front-page New York Times article detailed how EHRs contributed to a \$1 billion rise in Medicare billing in 2010 compared to five years earlier, much of it centered in hospital emergency rooms where patients were classified as sicker or needing more care.⁸

Prescription Drug Fraud and Diversion

Prescription drug fraud is manifested in many ways. One example is a pharmacy that bills for a higher-cost brand name drug when a substantially lower-cost generic or brand name drug was dispensed. In a 2008 case, a national drug store chain agreed to pay \$35 million in a settlement with the federal government and 42 states, including Missouri, to resolve allegations that the chain improperly switched its billings from dispensed tablets to capsules on three widely used medications to gain higher reimbursement.⁹ In a 2010 drug manufacturer fraud case, AstraZeneca was found to have engaged in off-label marketing to promote its antipsychotic drug Seroquel. Missouri recovered \$8.9 million from this \$520 million nationwide Medicaid fraud settlement.¹⁰ In yet another manufacturer example, Merck settled criminal and civil charges that it marketed Vioxx for unapproved uses in the United States. Missouri received \$13 million as a result of that settlement.¹¹ In addition to financial losses, the growing problem of prescription drug diversion also leads to patient harm and even death due to addiction, overdoses, and unsafe drug interactions. “Doctor shopping” where an individual obtains prescriptions from multiple prescribers and fills them at multiple pharmacies is one form, but there are other forms that can be quite complex and could include complicit physicians or pharmacists.¹²

⁵ 42 C.F.R. §455.2.

⁶ “Attorney General Koster settles with St. Louis physician in Medicaid fraud case—state to receive more than \$400,000,” Attorney General Koster News Release, October 12, 2010.

⁷ Reed Abelson and Julie Creswell, “U.S. Warning Hospitals on Medicare Bill Abuses,” *The New York Times*, September 24, 2012.

⁸ See Reed Abelson, Julie Creswell and Griff Palmer, “Medicare Bills Rise as Records Turn Electronic,” *The New York Times*, September 21, 2012.

⁹ “Nixon obtains \$813,000 for taxpayers in Medicaid fraud settlement with Walgreens,” Attorney General Nixon News Release, June 4, 2008.

¹⁰ “Attorney General Koster announces Missouri recovers \$8.9 million in pharmaceutical company settlement -- AstraZeneca to pay \$520 million to states and federal government,” Attorney General Koster News Release, June 15, 2010.

¹¹ “Missouri to Receive more than \$13 Million in Settlement from Merck,” Attorney General Koster News Release, November 22, 2011.

¹² Louis Saccoccio, CEO of National Health Care Anti-Fraud Association, “Examining Options to Combat Health Care Waste, Fraud and Abuse,” testimony before Subcommittee on Health, U.S. Energy and Commerce Subcommittee, November 28, 2012, available at <http://energycommerce.house.gov/sites/republicans.energycommerce.house.gov/files/Hearings/Health/20121128/HHRG-112-IF14-WState-SaccoccioL-20121128.pdf>.

Other types of health care provider fraud include:

- ***Phantom billing:*** Billing for services that were not actually performed. Examples include billing for blood tests when no samples were drawn, billing for X-rays when none were taken, billing for a dental filling when one was not done, or billing for home health care hours when they were not provided.
- ***Unbundling:*** Billing several services separately that should be combined into one billing to obtain additional reimbursement.
- ***Billing more than once*** for the same medical service or prescription.
- ***Fabricating claims*** from nonexistent clinics, nonexistent patients, or deceased patients.
- ***Kickbacks:*** Giving or accepting something in addition to normal reimbursement from a patient, other health care provider, or insurer, in return for medical services.
- ***Paying beneficiaries*** with no health problems to make unnecessary visits.
- ***False cost reports:*** Submission of Medicare or Medicaid cost reports by hospitals, nursing homes or other institutional providers that inflate the costs relating to patient care, mischaracterize reported costs or otherwise seek reimbursement for unreimbursable costs.
- ***Embezzlement:*** Theft of a recipient's funds by a Medicaid funded facility or an employee of that facility.

Medicaid Managed Care Fraud and Abuse

In recent years, states have increasingly turned to capitated managed care arrangements to provide care for Medicaid members raising potential fraud and abuse concerns that differ from those common in the fee-for-service environment. Areas of concern include managed care contract procurement irregularities, marketing and enrollment practices, and underutilization of services. As states add minimum medical loss ratio standards and other performance requirements and incentives to managed care contracts, there is also the potential for fraud related to medical loss ratio calculations and to performance measure reporting requirements.

Initiatives to Prevent and Deter Fraud

As the size and scope of Medicaid has grown, so have efforts to combat Medicaid fraud and abuse, moving from passive efforts to reclaim fraudulent payments to more aggressive efforts to detect and prevent fraudulent and abusive activities.¹³

Early Anti-Fraud Initiatives

In the first decade of its existence, Medicaid (created in 1965) operated with few tools to combat fraud and without any designated state or federal agency charged with monitoring criminal activity in the program. In 1977, however, Congress passed the Medicare-Medicaid Anti-Fraud and Abuse Amendments which established State Medicaid Fraud Control Units and first

¹³ T. R. Goldman, "Health Policy Brief: Eliminating Fraud and Abuse," *Health Affairs*, July 31, 2012.

mandated the exclusion of physicians and other practitioners convicted of program-related crimes from participation in Medicare and Medicaid.

State Medicaid Fraud Control Units. The HHS Office of Inspector General (OIG) provides administrative oversight over state Medicaid Fraud Control Units (MFCU). Forty-nine states and the District of Columbia operate Medicaid Fraud Control Units—most within the office of a state’s Attorney General.¹⁴ Each is separate and distinct from the Medicaid agency, but the Medicaid agency must have a “Memorandum of Understanding” with the state’s MFCU that outlines each agency’s responsibilities to the other. MFCUs may have statewide criminal prosecution authority or formal procedures for referring cases to local authorities related to detection, investigation, and prosecution of suspected provider fraudulent activities. Federal regulations prohibit the units from pursuing most cases of beneficiary fraud unless there is a conspiracy with a provider. Financing for a MFCU is 75 percent from the federal government with 25 percent matching funds from the state. The National Association of Medicaid Fraud Control Units provides technical assistance and training for the state MFCU staff and a national forum to improve the quality of Medicaid prosecutions.¹⁵

The Missouri Medicaid Fraud Control Unit (MFCU), located in the state Attorney General’s Office, is charged with identifying, investigating, and prosecuting Medicaid fraud and abuse by health care providers. Section 191.907 of the Missouri Revised Statutes allows any person who reports MO HealthNet fraud to receive 10 percent of the amount recovered by the state through the use of that person’s information. The Missouri MFCU also ranked within the top five in the nation for select recovery activities and set an all-time Missouri record for Medicaid fraud recovery by obtaining \$81.6 million in 2009.

Source: Attorney General Koster News Releases, December 30, 2009 and June 29, 2010.

List of Excluded Individuals/Entities. The HHS OIG maintains a list of excluded individuals/entities with convictions for program fraud and patient abuse, licensing board actions, or defaults on Health Education Assistance loans. When listed, individuals/entities are prohibited from receiving payment directly or indirectly from any federal health care program, including Medicare and Medicaid, for any items or services that they furnish, order, or prescribe. The prohibition also applies to health care providers, (e.g., hospitals, pharmacies, long-term care facilities, laboratories) that employ or contract with an identified individual/entity on the OIG’s list.¹⁶ State Medicaid agencies are required to block payments to the OIG’s excluded health care providers.

The Growth of Federal Oversight

Beginning in 1997, Congress appropriated funds specifically for activities to address fraud, waste, and abuse in federal health care programs including Medicaid.¹⁷ The **Payment Error Rate Measurement (PERM) Program** was later initiated by the Centers for Medicare and

¹⁴ Only North Dakota does not have a unit.

¹⁵ Medicaid Fraud Control Units, available at <http://www.namfcu.net>.

¹⁶ Exclusions Program, available at <https://oig.hhs.gov/exclusions/index.asp>.

¹⁷ Kathleen King, GAO Health Care Director, “Health Care Fraud: Types of Providers Involved in Medicare Cases, and CMS Efforts to Reduce Fraud, Testimony before the Subcommittee on Health, U.S. House Committee on Energy and Commerce, November 28, 2012, available at <http://energycommerce.house.gov/sites/republicans.energycommerce.house.gov/files/Hearings/Health/20121128/HHRG-112-IF14-WState-KingK-20121128.pdf>.

Medicaid Services (CMS) to comply with the Improper Payments Information Act of 2002. Under this program, CMS hires contractors to review Medicaid eligibility determinations and state payments under fee-for-service and capitated managed care programs, and to identify processing errors. Each state is reviewed once every three years. Sample errors that are flagged during PERM reviews include payments for unnecessary medical services and claims with insufficient documentation for ineligible individuals or from ineligible health care providers.¹⁸

In 2006, the Deficit Reduction Act (DRA) created the **Medicaid Integrity Program** – the first comprehensive federal program to ferret out Medicaid fraud and abuse. CMS responsibilities under this program include (1) hiring contractors to review Medicaid provider activities, audit claims, identify overpayments, and educate providers on program integrity issues; and (2) providing support to assist states in their activities to address fraud and abuse. A recent Government Accountability Office (GAO) report, however, found that this program’s hiring of separate review and audit contractors was inefficient and led to duplication while other oversight and support activities provided to states showed mixed results.¹⁹ CMS concurred, or concurred in part, with the GAO recommendations and pledged to take steps to address them.

The DRA also requires Medicaid health care providers and other contractors that receive or pay out at least \$5 million annually in Medicaid funds to report any actual or suspected instance of fraud, waste, or abuse. Also, these entities must adopt “**compliance plans**” that provide training for their staff and subcontractors related to the identification of fraud, waste, or abuse within the provider’s or entity’s organization.

Recent Initiatives

When the Obama Administration took office in 2009, it prioritized attacking health care fraud as part of its health reform agenda. In May 2009, the formation of the **Health Care Fraud Prevention and Enforcement Action Team (HEAT)** was announced. Administered by the Department of Health and Human Services (HHS) and the United States Department of Justice (DOJ), its goals are (1) to identify systemic vulnerabilities and geographic areas with potential for Medicare and Medicaid fraud; (2) to provide resources and other legal tools to aid civil enforcement efforts under the federal False Claims Act²⁰ and increase recoveries; (3) to improve data sharing to detect patterns of fraud; and (4) to disseminate best practices to address fraud and build partnerships between the public and private health care sectors.²¹ HEAT Medicare fraud “strike force” multi-agency teams comprised of investigators, prosecutors, and health care analysts have become operational in nine cities: Houston and Dallas, Texas; Brooklyn, New York; Baton Rouge, Louisiana; Tampa and Miami, Florida; Los Angeles, California; Detroit, Michigan; and Chicago, Illinois.²²

¹⁸ Payment Error Rate Measurement (PERM), available at <http://www.cms.gov/PERM>.

¹⁹ Medicaid Integrity Program: CMS Should Take Steps to Eliminate Duplication and Improve Efficiency, GAO-13-50, November 2012, available at: <http://www.gao.gov/products/GAO-13-50>.

²⁰ 31 U.S.C. §§ 3729 - 3733 available at <http://www.law.cornell.edu/uscode/31/3729.html>.

²¹ William Corr, HHS Deputy Secretary, Testimony before Committee on Appropriations, Subcommittee on Labor, Health and Human Services, Education, and Related Agencies, United States House of Representatives, March 4, 2010.

²² The Department of Health and Human Services and The Department of Justice Health Care Fraud and Abuse Control Program Annual Report for Fiscal Year 2011, February 2012, available at <https://oig.hhs.gov/publications/docs/hcfac/hcfacreport2011.pdf>.

The ***Patient Protection and Affordable Care Act (ACA) of 2010***, which enacted federal health care reform, also included significant provisions aimed at preventing health care fraud and abuse (Table 1). CMS believes that the changes “will not only help us crack down on criminals who are seeking to scam the system, but will also help us to save millions of taxpayer dollars in Medicare, Medicaid and CHIP – three vital programs that more than 100 million Americans count on for their health care... Using these new fraud prevention measures, CMS will be able to move from a ‘pay and chase’ approach to one that makes it harder to commit fraud in the first place.”²³

Table 1. Key Fraud and Abuse Provisions from the Affordable Care Act²⁴

New funding	Additional \$350 million to CMS to detect and fight fraud and abuse over 10 years from October 1, 2010, through September 30, 2020
Enhanced screening requirements	Includes licensure checks, criminal background checks, fingerprinting, and unscheduled and unannounced site visits for providers enrolling in Medicare, Medicaid, and CHIP
Required compliance plans	Medicare, Medicaid, or CHIP provider enrollment conditioned on having a compliance plan focused on preventing fraud
RAC audits expanded	Federal recovery audit contractor (RAC) efforts expanded to Medicaid, Medicare Advantage, and the Medicare Part D prescription drug program
New enforcement tools	New authority for HHS to impose stronger civil and monetary penalties for fraudulent activities and enforce temporary payment moratoria to prevent or combat fraud in Medicare, Medicaid, and CHIP

In March 2010, CMS also established a new ***Center for Program Integrity*** designed to oversee all CMS activities relating to national and statewide Medicare, Medicaid, and Children’s Health Insurance Program (CHIP) fraud and abuse issues. Its tasks include promoting program integrity through provider and contractor audits; identifying and monitoring program vulnerabilities; working with other CMS organizations to develop legislation to deter and reduce fraud, waste, and abuse; and providing support and assistance to states.²⁵

Finally, the State of Missouri created the ***Missouri Medicaid Audit and Compliance (MMAC) Unit*** in January 2011, charged with responsibility for detecting, investigating, and preventing fraud, waste, and abuse of the Medicaid, CHIP, and waiver programs by providers and beneficiaries. It is organized into four organizational components – Administration, Financial, Provider Review/Lock-In, and Investigations/Provider Enrollment. MMAC Unit activities include, but are not limited to, review of beneficiary service utilization and provider claims payment profiles to detect aberrant patterns; internal audits of claims pricing, quantity, and duration; provider and beneficiary eligibility; and review of established coverage parameters for health care services.²⁶

²³ HHS announces new tools and resources from the Affordable Care Act..., HHS News Release, September 20, 2010, available at <http://www.hhs.gov/news/press/2010pres/09/20100920e.html>.

²⁴ “Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions, and Compliance Plans for Providers and Suppliers,” Final Rule by CMS, February 2, 2011.

²⁵ Statement of Organization, Functions, and Delegations of Authority, Centers for Medicare & Medicaid Services, Department of Health and Human Service, Federal Register/Vol. 75, No. 56, Wednesday, March 24, 2010, available at <http://edocket.access.gpo.gov/2010/pdf/2010-6429.pdf>.

²⁶ MO HealthNet Manual, Section 2 – Provider Conditions of Participation, available at http://manuals.momed.com/collections/collection_aid/General_Section02.pdf.

Emerging Approaches to Prevent Health Fraud and Abuse

Data Analytics and Predictive Modeling

In an attempt to prevent fraud and abuse before it occurs, CMS is employing predictive modeling and other analytical technologies to identify improper claims for Medicare reimbursement and prevent their payment. Launched in July 2011, CMS' Fraud Prevention System (FPS) identifies aberrant and suspicious billing patterns before payment is made and generates automatic alerts on specific claims and providers that are prioritized for review and investigation by program integrity analysts. Like Medicare, Medicaid claims data provides a wealth of information that could be similarly used to uncover fraudulent schemes. Thus, the Small Business Jobs Act of 2010 requires CMS to expand the use of predictive analytic technologies to Medicaid and CHIP by April 2015.²⁷

Enhanced Provider Screening

Building on the ACA requirements for enhanced provider screening, CMS launched the Automated Provider Screening (APS) System in December 2011. The APS system is designed to make it easier for legitimate providers and suppliers to enroll as Medicare providers while screening out those that do not belong. In addition to replacing resource intensive manual review of applications, the APS system also creates three levels of provider risk – high, moderate and limited – with different screening levels for each level. For example, durable medical equipment providers and home health agencies are considered high risk due to the historically high incidence of fraud with these provider types. Individual provider risk scores, much like credit scores, are also being developed. CMS intends to pilot the application of state provider data through the APS system and share back findings with the states.²⁸ In an effort to produce shared service solutions to assist state Medicaid programs with provider screening, CMS also launched the Provider Screening Innovator Challenge in May 2012. This innovation competition, administered by NASA, will award prize money to expert software developers who create multi-state, multi-program provider screening software applications.²⁹

Cooperation and Information between Public and Private Payers

Both public and private sector payers are vulnerable to health care fraud and abuse and can benefit from the sharing of preventive and investigative information. Opportunities to share information include:

- Meetings hosted by the National Health Care Anti-Fraud Association (NHCAA) that bring together federal and state health care and law enforcement officials as well as private health plan representatives;
- Health care fraud task forces sponsored by many U.S. Attorney Offices;

²⁷ Presentation by Lyn Killman, Deputy Director, Medicaid Integrity Group; Kathy Oh, Pharm D, Division of Fraud Research and Detection, Center for Program Integrity, Centers for Medicare & Medicaid Services, "Application of Predictive Analytics in the Medicaid Program, Partnership with States," Annual Conference National Association for Medicaid Program Integrity, September 19, 2012; accessed at <https://www.namp.org/members/2012presentations/okcitypresentations.html>.

²⁸ *Ibid.*

²⁹ "Encouraging Innovation to Fight Medicaid Fraud," *The CMS Blog*, May 25, 2012; accessed at <http://blog.cms.gov/2012/05/25/encouraging-innovation-to-fight-medicare-fraud/>.

- The HHS OIG fraud prevention and detection website³⁰ that includes advisory opinions, alerts, bulletins, and other guidance; and
- Updates on state fraud and abuse activities provided by the National Association of Medicaid Fraud Control Units.³¹

A new voluntary public-private partnership to combat health care fraud was formally announced in July 2012. The National Fraud Prevention Partnership is a joint HHS and DOJ initiative bringing together anti-fraud associations, private insurers, and government and law enforcement agencies to share information on specific schemes, utilized billing codes, and geographical hot spots. One goal of the partnership is to pool public and private claims data for analysis by a trusted third-party contractor that can employ sophisticated data analytics to predict and detect health care fraud schemes.³²

Implications

Medicaid fraud and abuse drains millions of dollars from Missouri's health care system every year. As the state and the nation anticipate increased health insurance coverage for millions more Americans as a result of health care reform in 2014, it has never been more important to evaluate current health care fraud prevention strategies and look for areas of improvement. New and emerging data analytics, strategies, and provider screening applications hold the promise of preventing more fraudulent claims from ever being paid in the future and keeping dishonest players from enrolling as providers. An effective strategy should also include taking advantage of new information sharing opportunities by and among public and private sectors payers. At the same time, state Medicaid officials need to be sensitive to provider complaints regarding the increased administrative burden of Medicaid provider audits. Providers that may already be reluctant to participate in Medicaid due to low reimbursement rates could decide to drop out of Medicaid entirely if they determine that the Medicaid "hassle factor" is too great. Finding an appropriate balance between the goals of applying aggressive anti-fraud and abuse measures and promoting provider access will be a continuing challenge for both federal and state Medicaid officials.

³⁰ <http://oig.hhs.gov/fraud.asp>.

³¹ <http://www.namfcu.net>.

³² Louis Saccoccio, CEO of National Health Care Anti-Fraud Association, "Examining Options to Combat Health Care Waste, Fraud and Abuse," testimony before Subcommittee on Health, U.S. Energy and Commerce Subcommittee, November 28, 2012, accessed at <http://energycommerce.house.gov/sites/republicans.energycommerce.house.gov/files/Hearings/Health/20121128/HHRG-112-IF14-WState-SaccoccioL-20121128.pdf>.

Section

7

Meeting the Needs of Missourians Who Are Elderly or Have Disabilities: Long-Term Services and Supports

Issue Statement

One of the driving forces behind the projected increase in demand for long-term services and supports (LTSS) over the next 15 years is the aging of Baby Boomers.¹ In 2000, persons age 65 and over represented 13 percent of Missouri's total population and it is estimated that by 2030 this group will represent more than 20 percent of Missourians (21%).²

Most individuals prefer to receive LTSS in their own homes or in a community-based residential setting rather than a nursing home. Meeting this growing demand poses significant policy and financial challenges for Missouri in the years ahead.

Background

What are Long-Term Services and Supports?

In recent years, the terminology referring to the services and infrastructure to help the elderly and adults with disabilities remain independent has changed. Long-term services and supports (LTSS) is a term that has gained wider use than "long-term care" and is more descriptive of services these individuals need in their daily lives.³

LTSS refer to a broad range of services and supports for older people and other adults with disabilities who require assistance with activities of daily living. These individuals cannot perform such activities because of a disability or chronic health condition that is expected to continue for an extended period of time.

LTSS may involve, but are distinct from, medical care and nursing services. They consist primarily of assistance from another person but may also include assistive equipment such as wheelchairs and environmental modifications such as ramps.⁴

Who Needs Long-Term Services and Supports?

Persons in need of LTSS have physical, developmental, or mental limitations or disabilities. Individuals need LTSS when a chronic condition, trauma, or illness limits their ability to carry out basic self-care tasks. These tasks are called activities of daily living (ADLs) such as bathing, dressing or eating; or instrumental activities of daily living (IADLs) such as household chores, meal preparation, or managing money.

People of all ages may need LTSS; however, the risk of needing LTSS increases with age. The majority of the 11 million adults (age 18 and older) receiving LTSS in the U.S. are elderly (57%), and the balance are under age 65 and have a disability.⁵ Individuals with disabilities under the

1 The term "Baby Boomer" describes a person born between 1946 and 1964.

2 Missouri Department of Health and Senior Services. (June 30, 2011). Missouri State Plan on Aging (Fiscal Years 2012 through 2015). Accessed November 19, 2012. Retrieved from <http://health.mo.gov/seniors/seniorservices/pdf/stateplanaging%2020122015.pdf>.

3 National Health Policy Forum. (February 23, 2012). The Basics: National Spending for Long-Term Services and Supports (LTSS). Accessed January 7, 2013. Retrieved from <http://www.nhpf.org/library/details.cfm/2783>.

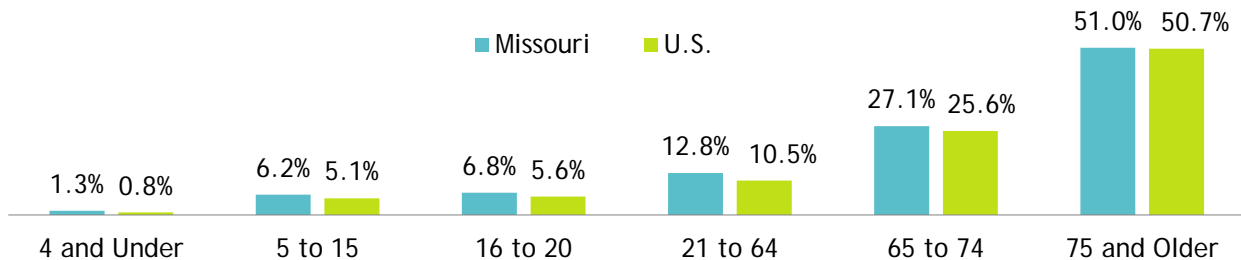
4 Reinhard, S., Kassner, E., Houser, A., and Mollica, R. (September 2011). Raising Expectations: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers. AARP, The Commonwealth Fund and The SCAN Foundation. Accessed January 7, 2013. Retrieved from http://assets.aarp.org/rgcenter/ppi/lts/lts_scorecard.pdf.

5 National Health Policy Forum. The Basics: National Spending for Long-Term Services and Supports (LTSS).

age of 65 have substantially different LTSS needs than the older adult population. These differences have led to fragmentation in LTSS funding and programming.

In 2011, approximately 14 percent (835,400) of non-institutionalized Missourians identified themselves as having a disability.⁶ More than 9 percent of Missourians identify themselves as having difficulty with self-care or independent living. Figure 1 displays the prevalence of disability by age in Missouri.

Figure 1. Prevalence of Disability by Age Group, 2011



Source: Erickson, et al. 2011 Disability Status Report: Missouri.

Where are Long-Term Services and Supports Provided and By Whom?

LTSS are often differentiated by the settings in which they are provided. In general, LTSS are provided either in nursing homes or in home and community-based settings. According to national estimates, 86 percent of all people who need LTSS live at home or in community residential settings rather than in nursing homes or other institutions.⁷ Home and community-based LTSS are delivered in a variety of settings, such as:

- Nutrition services may be delivered in the home or in congregate dining sites.
- Service sites can be located in senior centers and other community focal points, senior housing facilities, churches, schools, and government buildings.
- Home health services are delivered in the recipient's home, whether it is a free-standing dwelling, apartment, board and care home, assisted living facility, or other type of group housing option.
- Respite care can be delivered in the client's home, in a congregate setting such as a senior center or drop-in center, or in a residential setting such as a nursing home or other facility.

The paid LTSS workforce is comprised of a variety of professionals, reflecting the expansive continuum of long-term services and supports. Between 70 percent and 80 percent of paid LTSS is provided by approximately 4 million direct care workers nationwide; which include home health aides, certified nursing assistances, and personal care aides.⁸ Of these direct care

6 Erickson, W. Lee, C., & vonSchrader, S. (2012). 2011 Disability Status Report: Missouri. Cornell University Employment and Disability Institute. Accessed January 4, 2013. Retrieved from http://www.disabilitystatistics.org/StatusReports/2011-PDF/2011-StatusReport_MO.pdf?CFID=2578059&CFTOKEN=97914981&jsessionid=84308f3aab5695e1b2ec56242a7ec62762a7.

7 The SCAN Foundation. (April 2012). Who Needs and Who Uses Long-Term Care in the US? (Updated). Accessed January 4, 2013. Retrieved from <http://www.thescanfoundation.org/who-needs-and-who-uses-long-term-care>.

8 The SCAN Foundation. (October 2012). Who Provides Long-Term Care in the US? (Updated). Accessed January 11, 2013. Retrieved from <http://www.thescanfoundation.org/who-provides-long-term-care-us>.

workers, approximately 54 percent provide care in home and community settings.⁹ Historically, the majority of individuals receiving LTSS in the community have been cared for by family members or friends, otherwise referred to as informal (unpaid) caregivers. Three quarters of adults living at home or in the community receive care from family and friends alone; 14 percent receive a combination of care from family, friends, and formal caregivers; and only 8 percent receive all of their care from a formal caregiver.¹⁰

The Cost of Long-Term Services and Supports

In 2010, the spending for LTSS in the United States was \$207.9 billion, which is 8 percent of the U.S. personal health care spending.¹¹ This number, however, does not include the costs associated with care provided by informal caregivers. Nationally this care was valued at \$450 billion in 2009, up from \$375 billion in 2007.¹²

Paying for LTSS can exhaust the resources of the elderly and people with disabilities and their families, which often cause them to become Medicaid eligible. Nationally, the federal-state Medicaid program, the principal payer of LTSS, accounts for 62.2 percent of the total spending; followed by out-of-pocket spending (21.9%).¹³ Missouri's Medicaid spending on LTSS was \$2.34 billion in 2010 and this cost trend for LTSS overall will continue as the State's population ages.¹⁴ Table 1 summarizes Missouri's expenditures for LTSS between 2005 and 2010.

Table 1. Missouri Medicaid Long-Term Services and Supports Expenditures by Service, FY 2005- 2010.

Services	FY 2005 Expenditures	FY 2010 Preliminary Expenditures	Percent Change FY05-10
Nursing Home Services	\$803,678,068	\$908,286,740	+13.0%
ICF-ID	\$256,680,290	\$133,887,537	-47.8%
Personal Care	\$220,262,502	\$354,963,341	+61.1%
HCBS Waiver-DD	\$292,255,117	\$490,162,400	+66.7%
HCBS Waiver- A/D	\$91,583,250	\$115,153,263	+25.7%
Home Health	\$5,728,415	\$5,680,257	-0.8%
Programs for All-Inclusive Care for the Elderly (PACE)	\$4,995,880	\$4,913,700	-1.6%
Total LTSS	\$1,908,717,637	\$2,341,205,102	+ 22.6%

Source: Eiken, et al. Medicaid Expenditures for Long-Term Services and Supports: Update 2011.

⁹ Ibid.

¹⁰ Administration on Aging. (September 9, 2004). The National Family Caregiver Support Program Resource Guide. Accessed November 26, 2012. Retrieved from http://www.lewin.com/~media/lewin/site_sections/publications/2479.pdf

¹¹ National Health Policy Forum. The Basics: National Spending for Long-Term Services and Supports (LTSS).

¹² AARP Public Policy Institute. (June 2011). Valuing the Invaluable: 2011 Update the Economic Value of Family Caregiving in 2009. Accessed on January 4, 2013. Retrieved from <http://assets.aarp.org/rgcenter/ppi/ltc/fs229-ltc.pdf>.

¹³ National Health Policy Forum. The Basics: National Spending for Long-Term Services and Supports (LTSS). "Out-of-pocket" includes spending for nursing homes and home health services not covered by insurance, public programs, and other third parties. Medicare was excluded from the total LTSS reported expenditures.

¹⁴ Eiken, S., Sredl, K., Burwell, B., and Gold, L. (October 31, 2011). Medicaid Expenditures for Long-Term Services and Supports: Update 2011. Thomson Reuters. Accessed January 11, 2013. Retrieved from <http://www.hcbs.org/files/208/10395/2011LTSSExpenditures-final.pdf>.

In addition to the above expenditures, in 2009, there were approximately 865,000 Missourians who provided care to a family member or friend. The uncompensated value of this care is estimated to be \$8.9 billion.¹⁵

Paying for Long-Term Services and Supports

Nationally, the sources of payment for LTSS include Medicaid (62.2%), self-pay/out-of-pocket (21.9%), private insurance (11.6%), and other public funding (4.4%).¹⁶ This does not include the cost of care provided by family and friends. The following section describes the various funding mechanisms for LTSS.

Medicare

Medicare is the federal health insurance program for the disabled and adults age 65 and older. Medicare pays for medically necessary skilled nursing facility or home-based care following an inpatient hospitalization of at least three days. It does not pay for long-term nursing home care or other LTSS.

Medicaid

Medicaid is a program for persons who meet certain income and asset criteria or fit a defined eligibility category. The specific criteria are reflected in each state's Medicaid State Plan and must be approved by the Centers for Medicare and Medicaid Services (CMS). Medicaid services are paid for by a combination of state funding matched by federal funds. The percentage of federal matching funds for each state is based on a variety of factors and is revised annually by CMS. This percentage is termed the Federal Medical Assistance Percentage (FMAP). For FY13, Missouri's FMAP was 61.37 percent. In 2010, the federal government and states spent a total of \$122.6 billion on Medicaid payments for LTSS.¹⁷

Medicaid Institutional Care

Medicaid has traditionally been, and continues to be, the primary payer for LTSS. However, the services paid for by Medicaid have largely favored institutional care in nursing facilities, intermediate care facilities for the intellectually disabled (ICFs/ID), and hospitals. Prior to the option to provide alternative home and community-based services (HCBS) using a Medicaid waiver, there were few alternatives to institutional care. In some cases, providing modest HCBS and supports make it possible for a family to continue to provide care to a loved one at home.

Efforts have been made to reduce the Medicaid costs of LTSS. These include using less-costly HCBS waivers, creating state long-term care insurance partnership programs, and providing tax or other incentives for individuals and employers to encourage the purchase of private long-term care insurance policies.

15 Houser, A., Fox-Grage, W., and Ujvari, K. (2012). Across the States 2012: Profiles of Long-Term care and Independent Living. AARP Public Policy Institute. Accessed November 20, 2012. Retrieved from http://www.aarp.org/content/dam/aarp/research/public_policy_institute/ltc/2012/across-the-states-2012-missouri-AARP-ppi-ltc.pdf.

16 National Health Policy Forum. The Basics: Long-Term Services and Supports.

17 The Kaiser Commission on Medicaid and the Uninsured. Distribution of Medicaid Spending on Long Term Care, FY2010. Accessed January 4, 2013. Retrieved from <http://www.statehealthfacts.org>.

Medicaid Home and Community-Based Services Waivers

Medicaid 1915(c) HCBS waivers provide more flexibility to states and have been the major mechanism for states to fund home and community-based LTSS. Waivers are used to offer benefits that may not normally be available or to provide services in a different way than the Medicaid program, or to a different population, as defined in each state's Medicaid Plan. States must submit a waiver application to CMS in order to implement an HCBS waiver. Medicaid beneficiaries must meet the income and other eligibility criteria, usually a limit on assets, in order to qualify for Medicaid-funded services. Medicaid waivers are required to include a cost neutrality assurance. That is, the waiver cannot cost the state or federal government more on average than services would cost if they were paid for under the "regular" Medicaid program. States often utilize enrollment caps to limit the number of participants in each waiver program.

Medicaid 1915(i) Home and Community-Based Services State Plan Option

Section 6086 of the Deficit Reduction Act of 2005 (DRA) added section 1915(i) to the Social Security Act and established a new optional Medicaid benefit. Through the Medicaid state plan option, states are permitted to cover HCBS for Medicaid beneficiaries with disabilities or chronic conditions. Prior to the enactment of DRA, states were generally required to seek 1915(c) HCBS waiver authority to cover these services.

The state plan service package includes many similarities to options and services available through 1915(c) HCBS waivers. There are differences, the most significant of which are that 1915(i) does not require 1) states to prove cost neutrality; and 2) individuals to meet an institutional level of care in order to qualify for HCBS. Section 1915(i) provides states an opportunity to offer services and supports before individuals need institutional care, and also provides a mechanism to provide state plan HCBS to individuals with mental health and substance use disorders.

In order to further encourage states to adopt the new optional benefit, the Patient Protection and Affordable Care Act (ACA) of 2010 amended Section 1915(i). Among others, the most significant changes to the option are to:

- Increase income limits from 150 percent of the federal poverty level (FPL) up to 300 percent of the Supplemental Security Income (SSI) Federal benefit rate.
- Permit states to propose "other services" (not including room and board) for approval by the Secretary.
- Enable states to target the optional benefit to particular groups of people.

Program for All-Inclusive Care for the Elderly (PACE)

PACE provides comprehensive LTSS to Medicaid and Medicare enrollees. An interdisciplinary team of health professionals provides individuals with coordinated care. For most participants, the comprehensive service package enables them to receive care at home rather than in a nursing home.

Financing for the program is provided under a capitated arrangement, which allows providers to deliver all necessary services to participants rather than limit them to those reimbursable under Medicare and Medicaid. The PACE model of care is established as a provider in the Medicare program, which enables states to provide PACE services to Medicaid beneficiaries as a state option.

Long-Term Care Partnership Insurance Policies

In the early 1990s, the Robert Wood Johnson Foundation funded four states (California, Connecticut, New York, and Indiana) to develop a long-term care insurance partnership program. These programs were designed to test a new model of insuring long-term care through cost-sharing incentives that encourage individuals to purchase long-term care insurance. The objective was to reduce the states' Medicaid LTSS burden by having the partnership program pay for both institutional and home and community-based LTSS, with certain limitations on payment and duration of coverage.

In exchange, the programs offer policyholders the option to exempt some or all of their assets from Medicaid spend-down requirements. However, partnership policyholders are still required to meet Medicaid income eligibility thresholds before they may receive Medicaid benefits.

While the partnership programs have not attracted the desired numbers of middle- and low-income persons, the relative savings achieved by the programs in the four demonstration states prompted Congress to lift the moratorium on states' participation to permit other states to offer partnership programs.

The Missouri Department of Insurance, Financial Institutions and Professional Registration launched the "Own Your Future" campaign to educate the public about LTSS and the Long-Term Care Partnership Program.¹⁸ The first policies were offered in late summer 2008. As of 2010, Missouri had policies in effect at a level of 55 persons per 1,000 over age 40, exceeding the national average of 45 per 1,000.¹⁹

Other Methods of Payment

Very few private insurance policies are sold that cover either institutional or home and community-based LTSS. Few people can afford to pay for institutional or home and community-based LTSS using their income and assets (self-pay). At the same time, eligibility for publicly funded LTSS requires individuals to "spend down" their assets and pay a share of the cost, depending on their income level, in order to qualify for Medicaid coverage.

Value of Informal Care

Since the vast majority of persons in need of LTSS live in their own homes or other residential settings, and most of the care is provided by family and friends, the economic value of informal care provided is significant. Based on national data from 2009, the value of care provided by family and friends is estimated to be \$450 billion.²⁰ Recognizing the high value of these services, public health policymakers are sensitive to the need to provide supports to informal caregivers while not replacing their role with publicly funded services. Programs to provide modest supports such as information on and referral to ancillary services, temporary respite, education, and counseling for family caregivers are receiving increased consideration. Providing supports for informal caregivers is important because of individual preference to be cared for at home and because one of the most significant predictors of institutionalization is the health of the family caregiver.

18 Missouri Department of Insurance, Financial Institutions and Professional Registration. (May 19, 2010). Long-term Care Insurance. Accessed January 11, 2013. Retrieved from <http://insurance.mo.gov/consumer/LongTerm>.

19 Houser, et al. Across the States 2012: Profiles of Long-Term Care and Independent Living.

20 AARP Public Policy Institute. Valuing the Invaluable: 2011 Update the Economic Value of Family Caregiving in 2009.

Promoting Choice, Providing Options

While the overwhelming majority of people would prefer to stay in their own homes if they need LTSS,²¹ the type and availability of LTSS are largely a reflection of the programs and services for which the federal and state governments are willing to pay. Historically, Medicaid reimbursement has favored care in institutions such as nursing facilities and state hospitals, rather than care that can be delivered in the individual's home or in other community-based settings such as adult day care.

For over two decades, national and state health care leaders have made efforts to address the growing demands of the LTSS system. An influencing factor in these efforts was the 1999 Supreme Court ruling in *Olmstead v. LC*, which established that the unnecessary institutionalization of individuals eligible for publicly funded programs is prohibited under Title II of the Americans with Disabilities Act (ADA) of 1990. Additionally, the Pepper Commission, established in 1990 to develop reform recommendations for the U.S. health care system, cited long-term care as an essential element in need of reform given the aging population and the distribution of dollars expended on these services. The Pepper Commission established an objective to support public policies that among other things “give Americans of all ages access to coverage that provides them necessary long-term care and adequate financial protection...assure[s] quality care and choice of setting and...control[s] costs.”²² Through various federal and state initiatives the design of LTSS has begun to shift away from paying for institutional care and toward home and community-based care. The term most commonly used for this shift in site and cost of care is “rebalancing.”

Missouri was an early innovator in reforming its LTSS system and providing choice to Medicaid recipients.²³ Missouri Care Options, implemented in 1992, focused on shifting care from institutional settings and encouraging the development of a fuller continuum of home and community-based options; improving the opportunity to receive care in the least restrictive setting; improving the coordination of care; and providing an improved quality of life. Over the years, there have been other events, initiatives, and funding opportunities that have further contributed to this shift.

Following President George W. Bush's *Olmstead* order of June 2001, directing federal agencies to assist states in developing compliance plans, Missouri's Governor's Council on Disabilities developed an *Olmstead* Plan.²⁴

In 2005, the Missouri Department of Mental Health received a \$2.97 million, 5-year federal Development Disabilities System Transformation Grant to fund an initiative to provide community-based care options for persons with developmental disabilities needing LTSS.²⁵

21 AARP Public Policy Institute. (2009). Fact Sheet: Providing More Long-Term Supports and Services at Home: Why It's Critical for Health Reform. Accessed January 4, 2013. Retrieved from http://assets.aarp.org/rgcenter/health/fs_hcbs_hcr.pdf.

22 “A Call for Action” The Pepper Commission U.S. Bipartisan Commission on Comprehensive Health Care. Final Report September 1990. S. Prt. 101-114.

23 Missouri Department of Social Services. (March 28, 2012). The Missouri Balancing Incentive Payment Program Application. Accessed January 9, 2012. Retrieved from <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Balancing/Downloads/Missouri-APP.pdf>.

24 Center for Personal Assistance. (August 2009). The 1999 *Olmstead* Supreme Court Decision and Missouri. Accessed January 11, 2013. Retrieved from http://www.pascenter.org/state_based_stats/olmstead_home.php?state=missouri.

25 Missouri Department of Social Services. The Missouri Balancing Incentive Payment Program Application.

In 2006, Missouri was awarded a Mental Health Transformation State Improvement Grant to “create Communities of Hope whereby local communities throughout the state invest in the mental health of citizens and create an abundance of opportunities to promote community-based positive mental health services.”²⁶

In 2007, Missouri was one of the first states to successfully implement a five-year federal Money Follows the Person (MFP) grant. The State was awarded \$17.7 million to transition 250 nursing home residents to community settings and remove barriers that may prevent nursing home residents from returning to the community. In 2010, the State received a \$400,000 federal supplemental grant to further expand the MFP program. As of March 2012, 459 participants had been transitioned to the community. In addition, the State added options counseling and transition coordination through the Centers for Independent Living and the Area Agencies on Aging.

Since 2010, the Missouri Partnership for Hope program has provided individuals with developmental disabilities the opportunities to receive needed community-based LTSS using local, state, and federal resources.

Despite these efforts, Missouri ranked 31st out of 50 states on the *2011 State Long-Term Services and Supports Scorecard* for the Choice of Setting and Provider Dimension.²⁷ The low rank is due primarily to the State’s high percentage of nursing home residents with low care needs (20%), the lack of tools and programs to facilitate consumer choice (2.0 on scale of 0-4), and Missouri’s low rate of assisted living and residential care units of 26 per 1,000 population over age 65. One indicator earned a high rank (9th) in this dimension: Missouri’s Consumer Directed Services program serves 20.1 per 1,000 adults over age 18 with disabilities, more than twice the national median rate of 8.0 per 1,000.

Improving Access, Reducing Fragmentation

Section 2406 of the Patient Protection and Affordable Care Act states that the goals of Olmstead and the Pepper Commission have not been fully realized and there remains a pressing need to ensure all LTSS is affordable and high in quality. In passing the Act, Congress intended to “guarantee elderly and disabled individuals the care they need; and... long term services and supports should be made available in the community in addition to in institutions.”²⁸

While over half of Medicaid LTSS expenditures still go toward nursing home care, the national percentage of Medicaid spending on community-based services has more than doubled in 15 years, from 20 percent in 1995 to 45 percent in 2010.²⁹ Increased utilization of HCBS waivers and state plan options has caused a shift in Medicaid spending away from institutional care toward community-based services. Nationwide, the average number of HCBS beneficiaries was 10.1 per 1,000 in 2008, reflecting a 48 percent increase from 6.83 per 1,000 in 1999.³⁰

26 Ibid.

27 Missouri: 2011 State Long-Term Services and Supports Scorecard Results. AARP, The Commonwealth Fund, and the SCAN Foundation. Accessed January 11, 2013. Retrieved from <http://www.longtermsscorecard.org/~media/Files/Scorecard%20site/Missouri%20State%20Fact%20Sheet%20817.pdf>.

28 Patient Protection and Affordable Care Act, Section 2406. Sense of the Senate Regarding Long-Term Care. Accessed January 9, 2013. Retrieved from <http://democrats.senate.gov/reform/patient-protection-affordable-care-act-as-passed.pdf>.

29 Kaiser Commission on Medicaid and the Uninsured. (December 2012). Medicaid Home and Community-Based Services Programs: 2009 Data Update. Accessed January 8, 2013. Retrieved from <http://www.kff.org/medicaid/upload/7720-06.pdf>.

30 Houser, et al. Across the States: Profiles of Long Term Services and Supports.

Table 2 shows the progress that Missouri has made to expand home and community-based options. It is also significant that the number of people served in nursing homes has remained flat while, according to the U.S. Census Bureau, the population over age 65 in Missouri increased by 12 percent.

Table 2. Missouri's Progress in Expanding HCBS for Older People and Adults with Physical Disabilities

Type of Service	Medicaid Participants			Expenditures (millions)		
	1999	2008	Percent Change	2004	2009	Percent Change
HCBS	57,407	75,096	+30.8%	\$308	\$442	+43%
Nursing Homes	39,762	38,466	-3.26%	\$795	\$869	+9%

Source(s): Kassner, E., et al. (July 2008). *A Balancing Act: State Long-term services and supports Reform*. AARP Public Policy Institute. Houser, A., Fox-Grage, W., and Ujvari, K. (September 2012). *Across the States: Profiles of Long Term Services and Supports*. AARP Public Policy Institute.

Missouri ranks highly among states in terms of progress toward LTSS rebalancing efforts.

Table 3. Missouri Medicaid LTSS Rebalancing Statistics

	Missouri	Rank	U.S.
Medicaid HCBS participants per 1,000 (2008)	14.2	6	10.1
Medicaid HCBS Beneficiaries as a % of LTSS users (2008)	68%	14	64%
Medicaid HCBS spending as a % of LTSS spending (2009)	41%	29	44%

Source: Houser, A., Fox-Grage, W., and Ujvari, K. (September 2012). *Across the States: Profiles of Long Term Services and Supports*. AARP Public Policy Institute.

One means of rebalancing has been through increased opportunities for states seeking Medicaid Home and Community-Based Services (HCBS) waivers. Table 4 provides a list of Missouri's HCBS Medicaid waivers. Under these waivers, home and community-based care is not only delivered in a preferred setting, but also offers the potential of lowering per-person costs.

Table 4. Missouri Medicaid HCBS Waivers and Expenditures

Waiver Name	FY 2005 Expenditures	FY 2010 Preliminary Expenditures	% Change
MO Aged and Disabled	\$86,016,099	\$105,844,556	+23.0%
MO Intellectual Disability (ID) / Developmental Disability (DD) Comprehensive	\$287,752,924	\$477,447,732	+65.9%
MO AIDS	\$434,950	\$2,011,212	+362.4%
MO Independent Living	\$2,233,385	\$2,318,498	+3.8%
MO Div. of DD Community Support	\$4,191,566	\$11,711,432	+179.4%
MO Assisted Living*	\$0	\$0	N/A
MO Autism*	\$0	\$0	N/A
MO Children with DD (Lopez waiver)	\$310,627	\$1,003,236	+222.9%
MO Medically Fragile Adult	\$3,333,766	\$6,990,209	+109.7%
MO Partnership for Hope**	\$0	\$0	N/A

Waiver Name	FY 2005 Expenditures	FY 2010 Preliminary Expenditures	% Change
Waiver Total	\$384,273,317	\$607,326,875	+58.0%

*These two waivers were effective in FY 2010; however, expenditure data had not been reported via the CMS 64; **This waiver was implemented in FY 2011.

Source(s): Eiken, S. Burwell, B., Gold, L., and Sredl, K. (October 3, 2011). *Medicaid 1915(c) Waiver Expenditures: 2011 Update*.

Barriers to Accessing LTSS: Fragmentation

National recognition of the problem of fragmentation has led to streamlining, simplifying and improving access to services. Improvements have been supported at the federal level by various grant programs. Many states have taken advantage of federal funds to begin the process of easing access to LTSS at both the administrative and service delivery levels.

Administrative Fragmentation

The Aging and Disability Resource Center (ADRC) Counseling Program Grants, for example, are being used by states to create No Wrong Door/ Single Entry Point (NWD/SEP) LTSS systems. The NWD/SEP is intended to align and streamline administrative functions at the state level to ease the process of obtaining services for beneficiaries.

Legislation passed in 2007 noted that several Missouri agencies shared oversight responsibility for LTSS. Programs and services were organized according to diagnosis, age, type of disability, funding source, or type of service. This fragmentation makes it difficult for persons in need of LTSS to identify what services are offered, which ones they are eligible for, what is available in their community, and what they can afford. Often eligibility criteria are different, and multiple required applications ask for similar information.

In Missouri, Senate Bill 577 created the Missouri HealthNet Oversight Committee, charged with evaluating the redesign of the Missouri Medicaid program. This same statute created the Comprehensive Entry Point (CEP) Subcommittee to make recommendations to the Missouri Department of Health and Senior Services (DHSS) on the development of a comprehensive entry point system and to improve the availability of and access to information and services. In its October 2008 report, the CEP Subcommittee recommended streamlining and improving access to information and services through the legislative process.³¹

Concurrently, DHSS submitted a grant application to the Administration on Aging for funding a Person-Centered Hospital Discharge Planning Model in Missouri. The state received a grant award of \$1.6 million in September 2008.³² The federal Aging and Disability Resource Center (ADRC) grant initiative was launched to promote the integration of LTSS information and referral services; benefits and options counseling services; access to publicly and privately financed services; and benefits for those in need of long-term supports and their families.

In March 2012, Missouri submitted an application for the Medicaid State Balancing Incentive Payments Program, which would leverage existing ADRC resources and expand them statewide

31 Department of Health and Senior Services. (September 12, 2008). Comprehensive Entry Point Subcommittee Report.

32 Centers for Medicare and Medicaid Services. Person-Centered Hospital Discharge Model. Accessed January 11, 2013. Retrieved from <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Balancing/Real-Choice-Systems-Change-Grant-Program-RCSC/Person-Centered-Hospital-Discharge.html>.

in an effort to rebalance LTSS expenditures toward HCBS. The application was approved and Missouri estimates the targeted 2 percent FMAP increase will provide the State an additional \$100 million over the term of the project (July 2012 to September 2015). These funds will support the design and implementation of LTSS enhancements, develop community infrastructure across Missouri, and strengthen the community-based network of services across the continuum of care and populations.³³

Delivery System Fragmentation

In addition to making administrative changes to the front-end eligibility, many states are working to transform their fee-for-service LTSS systems to managed LTSS (MLTSS) as a way to reduce fragmentation between acute and primary care, behavioral health, and LTSS service delivery.³⁴ The number of states with MLTSS programs doubled from 8 to 16 between 2004 and 2012, and by 2014, 26 states are projected to have MLTSS programs.³⁵ MLTSS programs are very diverse and include:

- programs that make capitated payments to contractors primarily for LTSS,
- programs that make capitated payments to contractors for all or most Medicaid services, and
- fully integrated Medicare-Medicaid programs that include all Medicaid and Medicare services.

While Missouri is not pursuing a capitated MLTSS program, it is seeking to integrate and manage services through the health home authority. In January 2012, Missouri was the first state to implement two health home programs. These programs provide care coordination services to eligible Medicaid beneficiaries, including individuals dually eligible for Medicare and Medicaid. The Community Mental Health Center (CMHC) Health Home program targets Medicaid beneficiaries who have serious mental illness (SMI) or a mental illness or substance abuse disorder in combination with another chronic condition. The Primary Care (PC) Health Home program targets Medicaid beneficiaries who have specific somatic chronic conditions. Health home providers are required to coordinate services, including community based LTSS for beneficiaries.³⁶ One goal of the program is to reduce or eliminate the fragmentation experienced by some of its neediest beneficiaries when accessing services.

Opportunities under Health Reform

The ACA provides a number of opportunities for states to expand HCBS and decrease reliance on institutional care.

33 Missouri Department of Social Services. The Missouri Balancing Incentive Payment Program Application.

34 Barth, S., Ensslin, B., and Archibald, N. (December 2012). State Trends and Innovations in Medicaid Long-Term Services and Supports. Center for Health Care Strategies (CHCS).

35 Saucier, P., Kasten, J., Burwell, B., and Gold, L. (July 2012). The Growth of Managed Long-Term Services and Supports (MLTSS) Programs: A 2012 Update. Centers for Medicare and Medicaid Services. Accessed January 10, 2013. Retrieved from http://www.medicare.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/MLTSSP_White_paper_combined.pdf.

36 Missouri Department of Social Services. (May 31, 2012). Financial Model to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees, Managed Fee-For-Service Demonstration Proposal. Accessed January 10, 2013. Retrieved from <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MOProposal.pdf>.

Community First Choice (CFC) Option

Authorizes a new state plan option for providing community-based attendant services and supports to Medicaid beneficiaries requiring an institutional level of care with incomes up to 150 percent of FPL. Participating states will receive enhanced federal match for CFC services. (Section 2401 – effective date 10/1/2011) *As of December 2012, California has an approved CFC SPA and four other states have or intend to submit SPAs.*³⁷

HCBS through Medicaid State Plan Section 1915(i)

Amends existing Medicaid state plan authority to provide HCBS to targeted populations of individuals with income up to 300 percent of the federal benefit rate. Eliminates states' ability to institute caps or waitlists and waive state-wideness for the state plan option. (Section 2402 – effective 2011). *As of December 2012, 17 states either offer coverage through or plan to offer coverage through the 1915(i) state plan option.*³⁸

Money Follows the Person Rebalancing Demonstration

Extends the existing demonstration grant authority to award grants to states through 2016. (Section 2403 – effective 2010) *As of January 2013, 43 states and the District of Columbia have an MFP program.*³⁹

Protection for Recipients of HCBS against Spousal Impoverishment

Requires states to adopt rules preventing spousal impoverishment under certain waivers. (Section 2404 – effective January 1, 2014)

State Aging and Disability Resource Centers (ADRCs)

Allocates \$10 million annually to support ADRCs under the Older Americans Act. Funding is split between Part A: The Enhanced ADRC Options Counseling Program and Part B: The ADRC Sustainability Program Expansion Supplemental Program. (Section 2405 – effective 2010 through 2014) *As of December 2012, eight states received a Part A grant and 36 states were awarded Part B funding.*⁴⁰

State Balancing Incentive Program (BIP)

Authorizes an enhanced FMAP for states that achieve specified HCBS expenditure targets and undertake three specific structural reform designs to increase nursing home diversions and access to HCBS. (Section 10202 – effective October 1, 2011 through October 1, 2015) *As of January 2013, eight states have approved BIP applications.*⁴¹

Medicaid Health Home

Creates a new Medicaid state plan option to provide health homes for beneficiaries with chronic conditions or serious mental illness at 90 percent of FMAP during the first eight fiscal quarters

37 National Association of States United for Aging and Disabilities (NASUAD). (December 2012). State Medicaid Integration Tracker. Accessed January 10, 2013. Retrieved from http://www.nasuad.org/medicaid_integration_tracker.html.

38 Ibid.

39 Centers for Medicare and Medicaid Services. Money Follows the Person. Accessed January 1, 2013. Retrieved from <http://www.medicare.gov/Medicare-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Balancing/Money-Follows-the-Person.html>.

40 Barth, et al. State Trends and Innovations in Medicaid Long-Term Services and Supports.

41 Centers for Medicare and Medicaid Services. Balancing Incentive Program. Accessed January 11, 2013. Retrieved from <http://www.medicare.gov/Medicare-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Balancing/Balancing-Incentive-Program.html>.

the state plan amendment is in effect. The ACA also provides up to \$25 million per state for a planning grant. (Section 2703 – start date January 1, 2011) *As of December 2012, 7 states have approved health home SPAs and 19 additional states are pursuing health home SPAs.*⁴²

Implications

States continue to explore options to promote choice, examine how LTSS are accessed and received, and effectively leverage Medicaid funding. Evaluations of state performance find that there is wide variation across all dimensions of state LTSS performance.⁴³ While states that are taking a global approach by effecting change throughout multiple aspects of their LTSS systems have the highest performing systems, even the highest-performing states have room for improvement.⁴⁴

As an early actor in the area of rebalancing and a recent adopter of a number of the opportunities available under the ACA, Missouri is moving in the right direction. However, there continue to be opportunities to build upon existing programs and initiatives. Key strategies include:

- Monitor grant program progress in avoiding institutionalization and providing appropriate care.
- Track program evaluations to identify successful strategies and models of care.
- Plan for sustainability and integration of grant program models of care as federal programs expire.
- Work within the context of the state's Olmstead Plan to explore other opportunities for expanding home and community-based care.
- Evaluate existing HCBS programs coverage gaps and costs and consider the impact of new opportunities such as the DRA HCBS state plan option.
- Evaluate opportunities and costs of integrating financing for acute and LTSS.
- Work to expand supports to family caregivers to allow care recipients to remain at home or in the community.

Additional recommendations Missouri might consider with respect to LTSS rebalancing include:

- Develop a state profile for assessing the long-term services and supports programs based on the CMS profile template (technical assistance tool developed by CMS);
- Develop a comprehensive LTSS quality strategy to provide the framework for evaluating fiscal and administrative impacts of long-term services and supports program policies and;
- Explore alternative delivery system design(s).⁴⁵

42 NASUAD. State Medicaid Integration Tracker.

43 Reinhard, et al. Raising Expectations: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers.

44 Ibid.

45 Trail, M. and Kellenberg, R. Long-Term Care Rebalancing Considerations in Missouri.

Section

8

Treating the Whole Missourian: Mental Health and Substance Use Disorders

Issue Statement

A historic trend to deinstitutionalize the chronically mentally ill has resulted in decreasing the number of inpatient and residential psychiatric beds in public mental health hospitals from approximately 400,000 nationwide in 1970 to 50,000 in 2006. The loss of public inpatient psychiatric beds was only partially offset by the combined increase during the same time of an additional 50,000 private and general hospital psychiatric beds. Federal policy prohibits Medicaid reimbursement for care provided to beneficiaries in certain inpatient psychiatric institutions who are over age 21 or younger than 65. Given the policy dynamics, states continue to be challenged by the often inappropriate and increasing use of psychiatric emergency services among beneficiaries.¹

In addition, individuals with a serious mental illness are at dramatically higher risk of premature death due to chronic medical illness, in part because of limited access to quality primary care.² According to recent state studies, Medicaid beneficiaries with these illnesses have higher rates of co-occurring physical health conditions³ and higher total Medicaid costs (e.g., inpatient hospital, skilled nursing facility, pharmacy) than beneficiaries without serious mental illnesses.⁴

Substance use disorders often co-occur with mental illness; however, they have major independent negative effects on individuals' overall health and use of health services. Globally, nearly 4 percent of all deaths (2.5 million deaths per year) are alcohol-related. Alcohol misuse is one of the four greatest risk factors (along with tobacco use, poor diet, and physical inactivity) for the development of some cardiovascular diseases, cancer, chronic lung diseases, and diabetes.⁵

Missouri made significant strides over the past year to improve the effectiveness of behavioral health services to Medicaid beneficiaries. This issue brief focuses on the state's accomplishment and progress made in implementation of two key behavioral health opportunities available under the Patient Protection and Affordable Care Act (ACA):⁶

- **Medicaid Emergency Psychiatric Demonstration.** Missouri was one of 11 states awarded a three-year Centers for Medicare and Medicaid Services (CMS) demonstration grant⁷ for implementation of Medicaid psychiatric emergency services.

1 2010 memo from the American Medical Association (AMA) Council on Medical Service regarding Medicaid Coverage of Adults in Psychiatric Hospitals. Retrieved January 13, 2012, from <http://www.ama-assn.org/resources/doc/cms/a11-cms-report3.pdf>.

2 For a recent review, see Scott D, Happell B., "The high prevalence of poor physical health and unhealthy lifestyle behaviors in individuals with severe mental illness. *Issues in Mental Health Nursing* 2011;32(9):589-97

3 The Best Practices in Schizophrenia Treatment (BEST) Center of the Northeastern Ohio Medical University and the Health Foundation of Greater Cincinnati commissioned Health Management Associates to conduct a study documenting the business case for integrated physical and behavioral healthcare. Final report is available at <http://www.neomed.edu/academics/bestcenter/integratingprimaryandmentalhealthcare>.

4 Substance Abuse and Mental Health Services Administration (SAMHSA). (2010). *Mental Health and Substance Abuse Services in Medicaid, 2003: Charts and State Tables*. Rockville, MD: Center for Mental Health Services, SAMHSA. Available at <http://store.samhsa.gov/shin/content//SMA10-4608/SMA10-4608.pdf>.

5 World Health Organization. (2011). *Global Status Report on Alcohol and Health*. Available at: www.who.int/substance_abuse/publications/global_alcohol_report/msbgsruprofiles.pdf

6 Section 2703: State Option to Provide Health Homes For Enrollees With Chronic Conditions and Section 2707: Medicaid Emergency Psychiatric Demonstration Project.

7 The grant is not a lump sum distribution of funds. Rather, state Medicaid agencies may access federal matching funds to offset state expenses incurred in the delivery of inpatient psychiatry services in approved settings for an estimated number of Medicaid eligible individuals age 21 through 64 experiencing a psychiatric emergency medical condition.

- **Medicaid Health Homes for Individuals with Chronic Conditions.** Missouri became the first state in the nation to receive federal approval of an important new Medicaid service aimed at increasing the integration of physical and behavioral health services.

Background

Rationale for Medicaid Coverage of Emergency Psychiatric Services

As in many states, the historical influences of deinstitutionalization, the Medicaid Institution for Mental Disease (IMD) exclusion,⁸ and the Emergency Medical Treatment and Active Labor Act⁹ have greatly contributed in Missouri to reduce the availability of publicly operated psychiatric inpatient services. Currently all but four state-operated acute care beds are closed. This has resulted in substantial pressures on community hospitals in Missouri, as evidenced by an increase in the number and frequency of hospital emergency department (ED) visits due to mental disorders, an escalation in the number of inpatient episodes of care, and an increase in the practice of psychiatric boarding in EDs and general medical beds. Psychiatric boarding occurs when an individual with a mental disorder is kept in an ED for prolonged periods, or admitted to a medical unit, because appropriate mental health services are unavailable.¹⁰

Missouri successfully applied to participate in the Medicaid Emergency Psychiatric Demonstration to improve access to medically necessary care, as well as improve overall quality for Medicaid eligible adults aged 22 to 64 with an emergency medical condition, and in the process, reduce the problematic practice of psychiatric boarding. This brief describes the participating Missouri hospitals, evaluation objectives, and estimated federal funding the state will receive as a result of the demonstration.

Rationale for Improved Integration of Physical and Behavioral Health Services

Across the country, publicly funded primary care, acute care, and behavioral health care safety-net services operate as parallel systems, often with limited connection or interaction. The consequences of this fragmentation are significant. Research shows that individuals with serious mental illnesses die decades earlier than the general population, in part because of limited access to quality primary care (e.g., 60% of premature deaths for people with schizophrenia can be attributed to preventable or treatable medical conditions).¹¹ Because of limited access to quality primary care, many individuals with mental illness rely on emergency departments as a

8 Medicaid excludes from coverage inpatient treatment of adults aged 21-64 in any stand-alone, acute or long-term care institutions with 17 or more beds in which 50% or more of the beds are reserved for the treatment of mental illness (i.e., Institutions for Mental Diseases or IMDs).

9 The Emergency Medical Treatment and Active Labor Act (EMTALA) was passed in 1986 in response to concerns that emergency departments across the country were refusing to treat indigent and uninsured patients or inappropriately transferred them to other hospitals, a practice known as "patient dumping." EMTALA requires hospitals receiving Federal reimbursement to do the following for any patient presenting at an Emergency Department with an emergency medical condition (EMC), regardless of his or her ability to pay: (a) to screen and stabilize the patient's EMC; (b) to admit the patient to an inpatient bed if that level of care is needed, and the hospital has the capacity and capability to provide it; or (c) if the patient's EMC is outside the hospital's capacity and capability, to transport the patient safely to a hospital that can treat the patient. The receiving hospital may not refuse to accept a patient with an EMC that is within its capacity and capability to treat, whether or not it has a dedicated emergency department.

10 Missouri Emergency Psychiatric Demonstration Application Proposal, October 2011.

11 Parks, J., Svendsen, D., Singer, P. and Foti, M.E. Morbidity and Mortality in People with Serious Mental Illness. National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council Technical Report, October 2006.

primary source of care, which results in avoidable expense and poor continuity in treatment of chronic medical and behavioral issues.

For the past several years, Missouri's community mental health centers (CMHCs) have been working to provide more effective services to achieve integrated primary and mental health care and began using registered nurses onsite within CMHCs to address a wide-range of co-occurring physical health needs. In order to sustain the integrated services practices, Missouri submitted and received approval for two Medicaid Health Home State Plan Amendments (SPA).¹² The first health home SPA targets beneficiaries with serious mental illness (SMI) or behavioral health conditions, and the second health home SPA targets beneficiaries with multiple chronic conditions, including behavioral health. The former was approved on October 20, 2011, while the latter was approved on December 23, 2011; both SPAs went into effect on January 1, 2012.

Medicaid Emergency Psychiatric Demonstration

The Medicaid Emergency Psychiatric Demonstration was established under Section 2707 of the ACA to test whether Medicaid programs can support higher quality care at a lower total cost by reimbursing private psychiatric hospitals for certain services for which Medicaid reimbursement has historically been unavailable.

Missouri was one of eleven states awarded funding under a competitive process. The demonstration provides \$75 million in federal Medicaid matching funds to participating states over three years to enable private psychiatric hospitals to receive Medicaid reimbursement for treatment of psychiatric emergencies (i.e., suicidal or homicidal thoughts or gestures, provided to Medicaid enrollees aged 22 to 64 who have an acute need for treatment). Historically, Medicaid has not paid IMDs for these services without an admission to an acute care hospital first.

Implementation and Evaluation

Grant awardees were announced in March 2012. Missouri developed an operational plan which is being implemented consistent with evaluation and reporting methods approved by CMS. As a condition of participation, the state tracks monthly expenditures and inpatient days for each hospital and the state as a whole. In addition, as part of its own evaluation process, Missouri assesses the quality and impact of the demonstration on:

- Reductions in the practice of psychiatric boarding and improved access for Medicaid eligible patients;
- Rapidity of stabilization of the emergency medical conditions and overall length of stay;
- Improvement in continuity of care; and
- Overall changes in service utilization and cost under the demonstration.

Initial outcomes information on the demonstration project will be available in spring 2013 and annually thereafter.

¹² A Medicaid State Plan is an official document that describes the nature and scope of a state's Medicaid program. Any change to the State Plan is referred to as a State Plan Amendment or SPA change.

Participating Hospitals

The three hospitals included in the demonstration are Royal Oaks in Windsor, Two Rivers Behavioral Health System in Kansas City, and the Psychiatric Stabilization Center in St. Louis. Admission data estimated that in calendar year 2012 as many as 7,615 Medicaid eligible adults will present for inpatient care with an emergency medical condition, of which the three participating hospitals are likely to admit an average of 2,379 across the three years of the demonstration. The state anticipates a total of 11,097 inpatient days and the receipt of \$3,794,400 of the apportioned three-year Federal Share limit.

Medicaid Health Homes

Background

Section 2703 of the ACA provides states an opportunity to receive federal funding for coverage of “coordinated care through a health home for individuals with chronic conditions,” also referred to as health home services. The optional health home benefit was officially available in January 2011, allowing approved states to receive enhanced federal funding for health home services at a 90 percent Federal Medical Assistance Percentage (FMAP) rate¹³ for eight consecutive quarters.

A core purpose of Medicaid health homes is coverage of care coordination for individuals with chronic health conditions. The care coordination services are intended to be provided through well-defined services supporting whole-person care. Covered health home services provided as appropriate based on beneficiaries’ changing needs are:

- Comprehensive care management;
- Care coordination;
- Health promotion;
- Comprehensive transitional care;
- Individual and family support services; and
- Referral to community and social support services.

CMS encourages, but does not require, that health home services are supported through use of health information technology. Health home services complement traditional medical, behavioral, and other services but are not to supplant health care treatment services.

States may implement health home services statewide or on a sub-state geographic basis (e.g., regional or by county) for beneficiaries with:

- At least two chronic conditions¹⁴ (e.g., mental health condition, substance use disorder, asthma, diabetes, heart disease, a body mass index (BMI) greater than 25); or

¹³ Federal Medical Assistance Percentages (FMAP) are the percentage rates used to determine the matching federal funds allocated annually to states for Medicaid.

¹⁴ Chronic conditions listed in Section 2703 of the ACA include cardiovascular disease, asthma, diabetes, hypertension, serious and persistent mental health condition, substance use disorder and obesity. However, states may propose additional chronic conditions subject to CMS approval.

- One chronic condition and the risk of having a second chronic condition; or
- One serious and persistent mental health condition.

The statute permits health homes to be established among designated providers, which may include physicians, clinics, community health centers (such as federally qualified health centers), community mental health centers, providers of substance abuse services, or home health agencies, as examples. Teams of health care professionals (e.g., physicians, nurses, social workers, nutritionists, etc.) may be organized to deliver health home services through freestanding designated health home providers.

Missouri Medicaid Health Homes for Individuals with Behavioral Health Conditions
Community mental health centers (CMHCs) are the designated providers for the behavioral health population (i.e., those requiring treatment of a serious and persistent mental health condition, other mental illness, or substance use disorders), while primary care centers—specifically, federally qualified health centers (FQHCs), rural health clinics (RHCs), and hospital-operated primary care clinics—are the designated providers for the population with multiple chronic conditions, including mild-to-moderate mental illness and substance use disorder.

Goals of Missouri’s CMHC health home services are to:

- Improve care coordination;
- Improve receipt of primary and preventive services;
- Reduce preventable hospitalizations and emergency room use;
- Improve disease-related care for chronic conditions;
- Improve outcomes for persons with mental illness and/or substance use disorders;
- Improve transition to mental health, primary care, or long-term care services;
- Reduce substance abuse; and
- Increase patient empowerment and self-management.

Use of Health Information Technology is Critical for Service Delivery

Missouri CMHCs utilize health information supplied by the state to support their delivery and monitoring of health home services. For example, the Missouri Department of Mental Health provides monthly electronic monitoring reports to each health home provider via a contracted data analytics vendor. The report enables health homes to know whether a patient’s care complies with the state’s expectations on clinical standards. By accessing electronic reports, providers are able, for example, to identify the percentage of patients in need of laboratory and diagnostic service who also require follow-up by the nurse care manager. Reports currently made available to CMHC health homes on a monthly basis relate to: (a) prescription drug adherence, (b) behavioral health pharmacy management, and (c) disease management.

Missouri's Six Month Review of CMHC Health Home Services

Enrollment

In January 2012, CMHC health homes began providing services to 15,051 enrollees. The individuals were selected for initial enrollment because they were already receiving services from the CMHCs, met the diagnostic criteria for enrollment, and were significant users of Medicaid services as evidenced by an annual cost to Medicaid in the previous year of over \$10,000. The actual average annual cost to Medicaid for each of these individuals was more than \$24,000 in the previous year. As of June 2012, five CMHCs health homes had fewer than 250 enrollees, while three had more than 1,000 enrollees. Ten CMHCs had between 250 and 500 enrollees, and ten CMHCs had between 500 and 1,000 enrollees.

Mental Health Diagnoses

Beneficiaries receiving health home services have diagnoses including: major depression, schizophrenia, bipolar disorder, post-traumatic stress disorder, anxiety disorder, or personality disorder. Individuals may, of course, have more than one diagnosis.

All of the children and youth enrolled in a CMHC health home have a serious emotional disturbance as evidenced by an Axis I diagnosis (exclusive of conduct disorder, mental retardation, developmental disorder, substance abuse, or V code) resulting in substantial impairment in their ability to function at a developmentally appropriate level in two of the following: self-care, social relationships, self-direction, family life, learning ability, and/or self-expression.

Co-Occurring Physical Health Conditions among CMHC Health Home Enrollees

In addition to a serious mental illness or serious emotional disturbance, CMHC health home enrollees also struggle with other chronic conditions and risk factors at much higher rates than the general population and as indicated in patients' electronic clinical records:

- More than 25% of enrollees have been diagnosed with COPD or asthma.
- More than 25% of enrollees have been diagnosed with diabetes.
- About 3% of enrollees have been diagnosed with congestive heart failure.
- About 6% of enrollees have been diagnosed with coronary artery disease.
- One third of enrollees have been diagnosed with hypertension.
- The majority of enrollees are at risk of developing cardiovascular disease due to the fact that they have diabetes, have a body mass index greater than twenty-five, or are smokers.
- About 80% of enrollees have a BMI greater than 25.
- About 50% of enrollees report that they are smokers.
- More than 50% of the adults and about 8% of the children and youth enrolled in CMHC health homes have a history of substance abuse.
- About 28% of children and youth, and 14% of adults enrolled in CMHC health homes have received services through the Division of Developmental Disabilities.

Cost Savings Through Health Homes

Since Missouri's CMHCs have been engaged in care coordination and disease management for general medical conditions in persons with severe mental illness since 2004, the state forecasted cost savings associated with CMHC health home services with solid baseline data. The state has estimated general "off-trend" savings of approximately 17 percent of total Medicaid spending for eligible CMHC health home users. Savings are expected due to anticipated reductions in hospital readmissions and emergency department visits and more appropriate prescription medication usage (i.e., increased adherence and decreased prescriptions for the same/multiple conditions across numerous medical practitioners).

Conclusion

Missouri has made use of several areas of the ACA to address the disease burden of behavioral health. This brief only describes those most directly associated with beneficiaries who have mental illness or substance use disorders. By improving Medicaid emergency psychiatry services and solidifying coverage for care coordination through health homes, Missouri intends to bridge a gap in two critical areas of mental health treatment access: crisis stabilization in emergency psychiatry settings and the delivery of whole-person care in community settings. Evaluation results will be useful in understanding the overall effectiveness of both programs.

Section 9

Basic Pharmacy Reimbursement Principles in MO HealthNet

Issue Statement

In federal fiscal year (FFY) 2011, the Medicaid pharmacy expenditures in the United States equaled approximately \$30 billion. This spending level was offset by nearly 50 percent (just over \$14 billion) by manufacturer drug rebates, resulting in state and federal expenditures of over \$15 billion.¹ Missouri's pharmacy program accounted for less than eight percent (\$625 million)² of the \$8 billion total in Medicaid expenditures in FFY 2011. Almost all state Medicaid programs employ a number of pharmacy management tools to help contain costs. These tools include preferred drug lists (PDL), supplemental rebate programs, prior authorization programs, state maximum allowable cost (MAC) programs, generic incentives, and other utilization management controls.

A national survey of state Medicaid programs (including the District of Columbia) indicates that in FY 2012:³

- 46 states adopted a PDL and obtained supplemental rebates; three of the five states that did not adopt a PDL or supplemental rebates (Arizona, Hawaii, and New Jersey) rely heavily or completely on capitated managed care organizations (MCOs) to administer the Medicaid pharmacy benefit.
- 16 states place limitations on the number of prescriptions that Medicaid will pay for each month.
- 33 states implemented some type of pharmacy cost-containment.

Though containing the cost of Medicaid is a fiscal imperative for state budgets, states remain aware that drug therapies play an essential role in care plans for their beneficiaries and that the use of prescription drugs for chronic illness can reduce Medicaid costs by avoiding expensive emergency room visits, costly complications, and surgeries. How states address the pressure of drug cost increases and the demand for the latest product innovations has a significant impact on the efficacy of medical treatment. As noted from a 2007 study:⁴

“Lichtenberg found that longevity increased the most in those states where access to newer drugs—measured by mean “vintage” (FDA approval year)—in Medicaid and Medicare programs has increased the most. In fact, about two-thirds of the potential increase in longevity—the longevity increase that would have occurred if obesity, income, and other factors had not changed—is attributable to the use of newer drugs. According to his calculations, for every year increase in drug vintage there is about a two-month gain in life expectancy. These represent important findings given the fact that the costs of prescription drugs continue to receive a

1 Data from Medicaid Financial Management Report (CMS-64), 2002-2011. Form CMS-64 is a statement of expenditures for which states are entitled to Federal reimbursement under Title XIX. The amounts reported on the CMS-64 are a summary of expenditures and revenues derived from source documents such as invoices, cost reports, and eligibility records.

2 Ibid. After rebate amount; combined federal and state funds expenditures of \$974 million minus \$349 million in drug rebates.

3 Kaiser Commission on Medicaid and the Uninsured: Medicaid Today; Preparing for Tomorrow A Look at State Medicaid Program Spending, Enrollment and Policy Trends, Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2012 and 2013.

4 Lichtenberg, FR; Why Has Longevity Increased More in Some States than in Others? The Role of Medical Innovation and Other Factors; Manhattan Institute for Policy Research, Medical Progress Report Number 4; July 2007 http://www.manhattan-institute.org/html/mp_r_04.htm

great deal of attention in the ongoing debate over health care policy, while their benefits are often overlooked.”

This issue brief is written for individuals who are less familiar with the basics of Medicaid prescription drug pricing, and provides a basis for reviewing future policy issues facing state Medicaid programs, including MO HealthNet. See Appendix A for definitions of some common pharmacy reimbursement terms.

Background

This section describes Medicaid pharmacy program basics, key programs, and recent changes impacting Missouri's prescription drug pricing and expenditures.

Medicaid Drug Rebate Program

Created by the Omnibus Budget Reconciliation Act of 1990 (OBRA '90)⁵, the Medicaid drug rebate program requires drug manufacturers⁶ to have, in effect, a national rebate agreement with the Secretary of the United States Department of Health and Human Services (HHS)⁷ that allows states to receive federal funding for that manufacturer's outpatient drugs dispensed to Medicaid patients. If a state Medicaid program has a prescription drug benefit, the state is required to cover the drugs of a manufacturer that has executed the national drug rebate agreement. Conversely, the drugs of a manufacturer that does not sign a federal rebate agreement can be excluded by a state from their Medicaid program. Missouri Medicaid collected about \$350 million in drug rebates from manufacturers in FFY 2011.⁸

Under federal law (i.e. OBRA '90), federal drug rebates were required for all covered outpatient drugs with the exception of organized health care settings. Federal statute⁹ exempted covered outpatient drugs dispensed by health maintenance organizations, including Medicaid managed care organizations and by hospitals using drug formulary systems and billing the Medicaid program no more than the hospital's purchasing costs for covered outpatient drugs.

As of January 1, 1996, the basic federal rebate for single source and innovator multiple source drugs (brand name drugs) was the larger of 15.1 percent of the Average Manufacturer Price (AMP) per unit or the difference between the AMP and the best price per unit given to other purchasers. This rebate can also be increased by an inflation penalty. Known as the CPI-U additional rebate,¹⁰ this additional rebate is equal to the difference between the base AMP¹¹ and what the AMP should be based on the increase in CPI-U. The rebate for non-innovator multiple source drugs (generic drugs) was 11 percent of the AMP per unit.

5 The Omnibus Budget Reconciliation Act of 1990 added Section 1927 and authorized the Medicaid drug rebate program starting in 1991.

6 Approximately 500-600 pharmaceutical companies currently participate in the federal Medicaid drug rebate program.

7 The drug rebate program is administered by the Centers for Medicare & Medicaid Services' Center for Medicaid and State Operations (CMSO).

8 Data from Medicaid Financial Management Report (CMS-64), 2002-2011.

9 Social Security Act section 1927(j)

10 This penalty is based on the change in the Consumer Price Index, All Urban Users from the base AMP quarter to the quarter for which the rebate is being calculated.

11 Base AMP is the quarterly AMP from the first quarter a drug was sold.

The Patient Protection and Affordable Care Act (ACA)¹² made numerous changes to the Medicaid rebate program. These changes are expected to provide \$24 billion in federal savings over a ten year period (federal fiscal years 2010 through 2019).¹³ Effective, January 1, 2010, the basic federal rebate levels are:

- For brand name drugs, the rebate is the larger of 23.1% of AMP per unit or the difference between the AMP and the best price.
- For brand name drugs identified by the Centers for Medicare and Medicaid Services (CMS) as clotting factors or as being approved by the federal Food and Drug Administration exclusively for pediatric indications, the rebate is the larger of 17.1% of AMP per unit or the difference between the AMP and the best price.
- For brand name drugs that CMS identifies as a “line extension” of an already existing drug, the rebate is equal to the basic federal rebate plus an additional rebate “equal to the highest additional rebate (calculated as a percentage of average manufacturer price)” for any strength of the original brand name drug.
- The CPI-U additional rebate continues to apply to all brand name drugs.
- The rebate for a brand name drug cannot exceed 100% of the AMP.
- For generic drugs, the rebate is equal to 13% of the AMP per unit.

Rebate Recapture

The ACA also enacted provision requiring the savings from select rebate changes are “recaptured” 100 percent by the federal government – instead of the current practice of sharing rebate revenue based on a state’s Federal Medical Assistance Percentage (FMAP).

The rebate recapture provisions initially created significant concern with state Medicaid programs. The recapture provides that the federal government will retain 100 percent of the increases in basic rebates and rebate penalties created by the ACA. In a State Medicaid Director letter¹⁴ dated April 22, 2010, CMS indicated that it was planning to recapture the non-Federal share of the entire difference between the minimum rebate percentages in effect on December 31, 2009, and the new minimum rebate percentages in effect under the ACA, regardless of whether states received a rebate amount based on the difference between the average manufacturer price (AMP) and best price (BP). States were concerned that this change would mean the loss of rebates they already collected. However, after further consideration, CMS decided to change the recapture to include the lesser of the difference between the increased minimum rebate percentage and the AMP minus BP. This change insured that states would not lose rebates they were collecting prior to implementation of ACA rebate changes.

12 The Patient Protection and Affordable Care Act (P.L. 111-148) and the Health and Education Reconciliation Act (P.L. 111-152) are collectively known as the Affordable Care Act or ACA.

13 Statement by Richard S. Foster, CMS, FSA, Chief Actuary before Health Subcommittee to the US House of Representatives Committee on Energy and Commerce ; <http://www.hhs.gov/asl/testify/2011/03/t20110330e.html>

14 SMD letter #10-006

Drug Rebate Equalization between Medicaid Fee-For-Service and Managed Care Settings

As previously noted, before enactment of the ACA, manufacturer rebates were not available for drugs paid under “capitation” arrangements with Medicaid managed care organizations (MCOs). Because of the lack of rebates for MCOs, fourteen of the 38 states with risk-based MCOs, including Missouri, excluded or carved out prescription drugs from their contracts and paid pharmacy benefits for MCO enrollees under their fee-for-service program to obtain rebate revenue.¹⁵ The cost effectiveness of pharmacy carve-outs has been a long-standing debate among state Medicaid officials, federal policymakers, and providers. Those who argue that carve-outs undermine MCO care management, resulting in increased utilization and spending,¹⁶ advocated that Medicaid rebates be applied to capitated Medicaid drug payments.

The ACA authorized such “drug rebate equalization” and stipulated that states must administer the rebates for both fee-for-service and MCO drug claims. CMS indicated this change was effective March 23, 2010. Of the fourteen states with a full pharmacy carve-out, four states (New Jersey, New York, Ohio and Texas) have carved the prescription drug benefit back into their MCO capitated payments. Connecticut has eliminated its managed care program and the state is taking responsibility for managing care for parents and children directly, using an administrative services organization model. Additionally, Utah has indicated it will carve the benefit into its new Accountable Care Organizations (ACOs) beginning in 2013.

Texas has taken a “hybrid” approach with its carve-out of prescription drug services. In order to maximize rebate return while allowing the MCOs to “manage” the prescription benefits of their enrollees, the Texas Vendor Drug Program¹⁷ controls the Preferred Drug List (PDL) and supplemental drug rebate negotiations and MCOs must follow the PDL as set by the state. Any utilization controls implemented by the MCOs must first be approved by the state.

Medicaid Pharmacy Reimbursement Background

In general, prescription drug reimbursement recognizes a pharmacy’s costs for procuring drug products and for dispensing prescriptions. Each State has the flexibility to determine the amount it will reimburse for each component of the formula based on their best estimate of the price currently paid by providers for a particular manufacturer’s drug. These reimbursement formulas are subject to review and approval by CMS through the State plan amendment (SPA) process. In general, states reimburse single source (brand name) drugs based on an estimated acquisition cost (EAC), defined in regulations as the state Medicaid agency’s best estimate of the price generally and currently paid by providers for a drug marketed or sold by a particular manufacturer or labeler in the package size of drug most frequently purchased by providers.¹⁸ This formula is also used for multiple source drugs (generic drugs) that do not have a federal upper limit (FUL) or state maximum allowable cost (MAC) established (as discussed below).

15 States with full pharmacy carve-outs included CT, DE, DC, IL, IN, MO, NE, NJ, NY, OH, TN, TX, WI, and WV. Other states may have partial pharmacy carve-outs for select drugs, e.g., psychotropics, HIV/AIDS drugs, and antihemophilia drugs. Utah previously converted most of its insurer- and provider-led health plans from full-risk to partial- and no-risk arrangements and was excluded from the full carve-out list.

16 Medicare Advantage News, “President Obama’s Budget Would Extend Drug Rebates to Medicaid Health Plans,” Mar 2009, available at <http://aishealth.com/node/3376>

17 <http://www.txvendordrug.com/>

18 Code of Federal Regulations § 447.502

States, as well as MCOs, have traditionally used average wholesale price (AWP) and wholesaler acquisition cost (WAC) as the benchmarks to establish EAC. Originating in the California Medicaid program in the late 1960's as a price derived from surveys of major drug wholesalers, AWP evolved into a calculated value based on the WAC supplied solely by drug manufacturers. In reaction to the numerous issues related to the accuracy regarding AWP and at the urging of state Medicaid Directors, CMS issued proposed final rules¹⁹ that would change how Medicaid programs establish pharmacy reimbursement.

The new regulations replace EAC with “actual acquisition cost” (AAC). CMS believes AAC will be more reflective of actual prices paid, as opposed to estimates based on unreliable published compendia pricing. CMS also noted that states likely would not be able to determine the actual price of each individual drug. Therefore they acknowledged that payment based on an average of the actual acquisition costs based on the CMS survey described below would be sufficient to meet new regulatory definitions.

CMS Survey of Prescription Drug Prices

The Deficit Reduction Act of 2005, which was enacted in February 2006, requires CMS to establish a survey of retail pharmacy prices. CMS entered into a contract with Myers & Stauffer, LC to perform a survey entitled “Survey of Retail Prices: Payment and Utilization Rates and Performance Rankings.” The purpose was to perform a monthly nationwide survey of retail community pharmacy prescription drug prices and to provide states with on-going pricing files. CMS believes the pricing information will provide state Medicaid agencies with an array of covered outpatient drug prices so state agencies can use the information to compare their own pricing methodologies and payments to those derived from these surveys.

In addition to the retail price survey, Myers & Stauffer, LC will also perform a National Average Drug Acquisition Cost (NADAC) survey of the drug acquisition costs of all covered outpatient drugs purchased by retail community pharmacies – both independent community pharmacies and chain pharmacies. The NADAC takes into consideration any regional and pharmacy purchasing differences to obtain an acquisition price for covered outpatient drugs. CMS anticipates some states may consider the NADAC as a reference price when setting their reimbursement methodology.

Pharmacy representatives have expressed concern about the accuracy and validity of the NADAC. In a letter to CMS,²⁰ the National Community Pharmacists Association (NCPA) indicated they do not believe that CMS has the authority to publish NADAC data or acquisition cost data and that it creates an unfunded mandate on small businesses. NCPA also questions the methodology and applicability of NADAC prices to individual state's Medicaid program reimbursement formulas.

Current State Reimbursement Methods

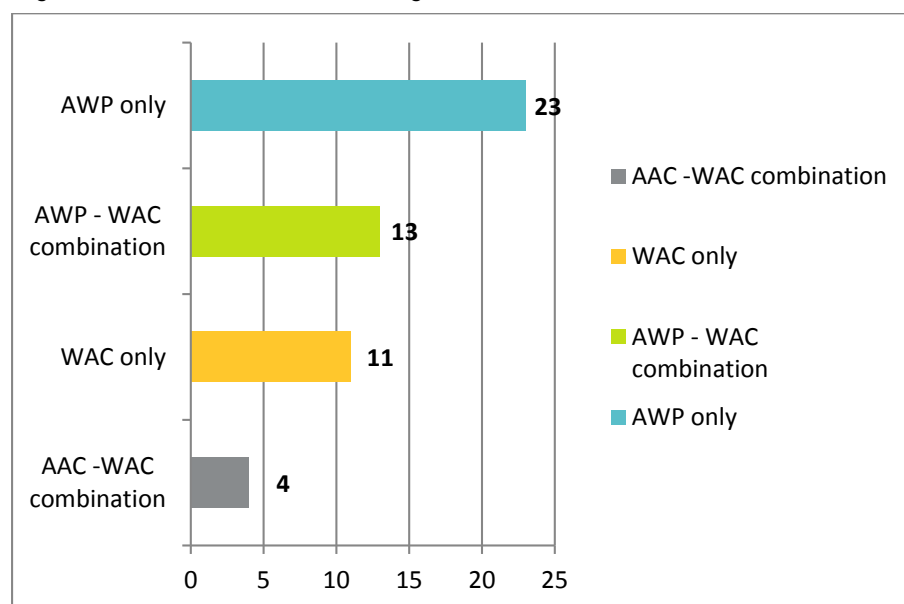
Single Source Drugs: Though the use of AWP or WAC has been identified as not being the best pricing information and new federal rules refer to AAC, many states continue to use AWP, WAC, or a combination of the two for their reimbursement formula. For example, Missouri pays single source drugs based on the lower of AWP less 10.43 percent or WAC plus 10 percent. Figure 1

¹⁹ Federal Register, Vol. 77, No. 22, Thursday, February 2, 2012, pp 5318-5366.

²⁰ Letter to Barbara Edwards Director, Disabled and Elderly Health Programs Group, June 21, 2012.

shows that as of September 2012, all but four states (Alabama, Colorado, Idaho and Oregon), continue to use AWP and/or WAC in their pharmacy reimbursement formula.

Figure 1. Number of States Using Various Medicaid Product Cost Reimbursement Methodologies



Source: Medicaid Prescription Reimbursement Information by State – Quarter Ending September 2012

Multiple Source Drugs, with FULs or State MAC Rates: Multiple source drugs include noninnovator (i.e., generics) and innovator drugs (brands with no patent protection). For decades, CMS has issued FULs on these drugs. The calculation of the FUL has also changed. Pursuant to changes established by the ACA, effective October 1, 2010, the calculation of FULs became 175 percent of the weighted average (determined on the basis of utilization) of the most recently reported monthly average manufacturer prices (AMP) for pharmaceutically and therapeutically equivalent multiple source drug products that are available for purchase by retail community pharmacies on a nationwide basis. The calculation of FULs has also become an issue with pharmacy representatives. In a letter to Cindy Mann dated June 18, 2012,²¹ NCPA expressed their concern regarding the accuracy of draft FULs published by CMS under the new rules. NCPA points out in their letter that “FULs for hundreds of products remain below our acquisition costs, and the FULs fluctuate from month to month.” Until the new FULs are final, the FULs established prior to October 1, 2010 are still active.

States may opt to use the FULs or their own state MAC rates—as long as payments do not exceed, in aggregate, the amount that would have been paid if the FULs were used. Payment exceptions above the FULs or state MAC rates are allowed when a brand is medically necessary for a beneficiary, confirmed usually through prior authorization.

Multiple Source Drugs, with no FUL or State MAC: When a multiple source drug does not have a FUL or MAC rate, most states use pricing the same as a single source drug. However, eleven states (Arkansas, Connecticut, Illinois, Indiana, Kansas, Kentucky, Mississippi, New York,

²¹ Director of the Center for Medicaid and CHIP Services

Pennsylvania, Washington, and Wisconsin) have implemented separate AWP or WAC based reimbursement formulas for multiple source drugs falling into this category.

Professional Fee for Dispensing

Traditionally referenced as a “dispensing fee,” the federal regulations now refer to the fee as a “professional dispensing fee.” CMS has made this change from “dispensing fee” to “professional dispensing fee” to reinforce their position that “once the reimbursement for the drug is properly determined, the dispensing fee should reflect the pharmacist’s professional services and costs associated with ensuring that possession of the appropriate covered outpatient drug is transferred to a Medicaid beneficiary.” CMS wants states to reconsider their dispensing fee methodology so that it is consistent with new AAC reimbursement requirements. The revised regulation identifies professional dispensing fee as one which:

1. Is incurred at the point of sale or service and pays for costs in excess of the ingredient cost of a covered outpatient drug each time a covered outpatient drug is dispensed;
2. Includes only pharmacy costs associated with ensuring that possession of the appropriate covered outpatient drug is transferred to a Medicaid beneficiary. Pharmacy costs include, but are not limited to, reasonable costs associated with a pharmacist’s time in checking the computer for information about an individual’s coverage, performing drug utilization review and PDL review activities, measurement or mixing of the covered outpatient drug, filling the container, beneficiary counseling, physically providing the completed prescription to the Medicaid beneficiary, delivery, special packaging, and overhead associated with maintaining the facility and equipment necessary to operate the pharmacy; and
3. Does not include administrative costs incurred by the State in the operation of the covered outpatient drug benefit including systems costs for interfacing with pharmacies.

Currently state Medicaid dispensing fees for brand drugs vary from a low of \$1.75 (New Hampshire) to a high of \$15.11 (Idaho).²² Most states have dispensing fees between \$3 and \$6. Pharmacy representatives indicate dispensing fees used by state Medicaid programs and other insurers are often below their actual dispensing costs, but this deficit has been cross-subsidized by product cost payment over a pharmacy’s actual acquisition costs.²³ Pharmacy representatives believe CMS should “make it clear to states that, in order to reimburse pharmacies fairly and preserve patient access, they must increase their dispensing fees to pharmacies if they use NADAC or FULs.”²⁴

MO HealthNet Pharmacy Reimbursement

MO HealthNet pharmacy reimbursement is based on a combination of AWP discounted, WAC markups, FULs, and state MAC prices, as listed in Table 1. The next sections describe key MO HealthNet payment approaches and strategies.

²² Medicaid Prescription Reimbursement Information by State – Quarter Ending September 2012; Idaho fee is tiered based on pharmacy volume: Less than 39,999 claims a year = \$15.11; between 40,000 and 69,999 claims per year = \$12.35; 70,000 or more claims per year = \$11.51

²³ Expert Report of Zachary Dyckman, Ph.D. for the National Association of Chain Drug Stores (NACDS) and the National Community Pharmacists Association (NCPA) Regarding Cross-Subsidization of Pharmacy Reimbursement Rates in the State of California, October 19, 2009

²⁴ June 18, 2012 letter to Cindy Mann

Table 1. MO HealthNet Pharmacy Reimbursement Methodology²⁵

Fee-for-service (FFS) pharmacy reimbursement is the lowest of:
1. Applicable Wholesaler Acquisition Cost (WAC), plus 10%, plus professional dispensing fee;
2. Applicable Missouri Maximum Allowable Cost (MAC) plus professional dispensing fee;
3. Applicable Federal Upper Limit plus professional dispensing fee; or
4. Usual and customary charge.

MO HealthNet Dispensing Fees

In addition to product cost payment, MO HealthNet pays pharmacies a standard and an enhanced dispensing fee. Combined, these fees currently total \$9.66; for generics, an additional preferred incentive fee is applied.

Table 2. MO HealthNet Dispensing Fee Rates

Fee	Rate	Comments
Standard Fee	\$4.84	Base fee paid to pharmacies.
Enhanced Fee	\$4.82	Fee funded from revenue collected from pharmacy provider taxes.
Generic Product Preferred Incentive	\$4.00	This fee started January 1, 2010, and is paid in addition to other existing dispensing fees.

These fees are supported by a pharmacy “provider tax” that is used to leverage additional federal matching funds. Related federal requirements generally stipulate that the taxes must be broad-based, applying to all pharmacies uniformly, and must avoid hold harmless arrangements. The Missouri Pharmacy Association supports the state’s provider tax, and created the Pharmacy Agency Corporation to perform administrative activities related to the tax on behalf of pharmacies.

Preferred Drug List and Supplemental Manufacturer Drug Rebates

MO HealthNet negotiates state supplemental manufacturer rebates leveraged on a PDL. This approach identifies preferred products in higher cost drug classes that are based on clinical effectiveness and cost effectiveness. A drug not identified as preferred is reimbursed only with prior authorization and documentation of medical need. Some non-preferred agents are transparently approved through the SmartPASM program after a trial of preferred agents paid for by MO HealthNet.

During the preferred drug process, MO HealthNet offers manufacturers an opportunity to provide supplemental rebates in addition to federal rebates. The supplemental rebates, if given, may allow a manufacturer’s products to become competitively priced and avoid prior authorization requirements. Resulting revenue from federal and state supplemental rebates is shared between the state and federal governments based on the state’s FMAP (Table 3). An exception is the new federal “recapture,” previously described.

²⁵ MO HealthNet Pharmacy Manual Section 12; Missouri has not used AWP since July of 2001 (AWP – 10.86% may be used if no WAC exists or it cannot be calculated).

Table 3. MO HealthNet Drug Expenditures and Rebate Revenue²⁶

Gross Expenditure	2011	%
Federal Share	\$681,720,173	70.0%
State Share	\$292,016,403	30.0%
Total	\$973,736,576	
Rebates ²⁷	2011	%
Federal Share	\$243,411,256	69.7%
State Share	\$105,583,781	30.3%
Total	\$348,995,037	

Missouri statutes²⁸ prohibit MO HealthNet from implementing preferred drug approaches for psychotropic medications for persons with mental illness diagnoses or other illnesses for which treatment with psychotropic medications is indicated. Select exceptions are allowed for dose optimization, new drug combinations consisting of one of more existing drug entities, or preference algorithms for serotonin-specific reuptake inhibitor (SSRI) antidepressants. No restrictions to access can be imposed that would preclude availability of any individual atypical antipsychotic monotherapy for treatment of schizophrenia, bipolar disorder, or psychosis associated with severe depression.

Medicare Part D and the Phased-Down State Contribution for Dual Eligibles

The Medicare Modernization Act added Medicare Part D prescription drug coverage and required that individuals enrolled in both Medicare and Medicaid (“dual eligibles”) transition from Medicaid pharmacy coverage to Medicare Part D beginning in January 2006. As part of this transition, states were required to help finance the prescription costs of the dual eligibles through a phased-down state contribution, commonly referred to as the “clawback.” The initial clawback was based on a state’s 2003 per capita pharmacy spending for its dual eligibles and has been trended forward each year for inflation. The resulting amount was discounted 10 percent in 2006 (i.e. states paid a clawback equal to 90% of expenditures); the discount gradually increases to 25 percent by 2015 and remains constant thereafter. Monthly, each state pays the adjusted per capita amount for its dual eligibles based on its current share of FMAP²⁹. As MO HealthNet dual eligibles transitioned to Part D, the state’s fee-for-service prescriptions dropped about 50 percent, from 19.1 million (2005) to 9.6 million (2007). This change was counterbalanced by general revenue liabilities for the clawback, which in state fiscal year 2008 accounted for \$169 million for about 129,000 dual eligibles.

²⁶ Data from Medicaid Financial Management Report (CMS-64), 2002-2011.

²⁷ The CMS-64 report did not show any supplemental rebates. This may be due to a reporting error (e.g. supplemental rebates were not reported separately, but aggregated under the mandatory federal rebate amount).

²⁸ Missouri Revised Statutes, Title XII, Ch. 208, § 208.227

²⁹ The Medicaid program is jointly funded by states and the federal government with the federal share of costs determined by a formula set forth in the Social Security Act. The federal matching percentage (FMAP) is calculated based on a state’s average per capita income, relative to the national average. States with lower average per capita incomes have higher FMAPs.

In February 2010, HHS Secretary Kathleen Sebelius announced that due to the increase in federal share of Medicaid costs (FMAP), clawback payments would be reduced. For MO HealthNet, that decrease was projected to save \$107.8 million from first quarter 2009 through first quarter 2011 based on a projected clawback of \$407.3 million over the same time period. The MO HealthNet budget provides for a \$187.1 million clawback for Missouri in FY 2012.

An additional change in Medicare Part D will occur in 2013. Under the original statute, drugs that are considered optional or excludable from the Medicaid program were considered non-benefits of the Medicare Part D program. The Medicare Improvements for Patients and Providers Act (MIPPA)³⁰ of 2008 allows barbiturates “used in the treatment of epilepsy, cancer, or a chronic mental health disorder” and benzodiazepines to be considered a benefit under Medicare Part D. MIPPA further specified that these amendments apply to prescriptions dispensed on or after January 1, 2013. The ACA removes smoking cessation drugs, benzodiazepines and barbiturates from the list Medicaid excludable drugs effective January 1, 2014.

Medication Therapy Management

MO HealthNet recognizes additional reimbursement for Medication Therapy Management (MTM) services. Implementation began in 2008, focusing on diabetes and asthma education. Through MTM programs, pharmacists provide patient education and monitoring “to optimize the benefits of prescribed drugs, improve medication use, reduce the risk of adverse drug events and drug interactions, and increase patient adherence to prescribed regimens.”³¹ MO HealthNet pharmacies providing MTM services must use a web-based computer system, DirectCare Pro. This system allows a pharmacist to reserve intervention opportunities for specific patients, document completed activities, and generate a bill to MO HealthNet. MTM reimbursement is available in addition to any fee paid when a prescription is dispensed (Table 4).

Table 4. MO HealthNet Reimbursement for MTM

Reimbursement	Description of Pharmacist Service
\$20	MTM service(s) provided by a pharmacist, individual, face-to-face with patient, with assessment and intervention if provided; initial 15 minutes, new patient (Limit: 1-time per participant per lifetime intervention)
\$10	MTM service(s) provided by a pharmacist, individual, face-to-face with patient, with assessment and intervention if provided; initial 15 minutes, established patient. (Limit: 1-time per calendar month per participant per intervention)
\$15	For each additional 15 minutes

Key Pharmacy Issues Facing MO HealthNet

The following are key pharmacy issues that MO HealthNet will be facing during the next several years.

³⁰ Section 175 of MIPPA amended section 1860D-2(e)(2)(A) of the Social Security Act

³¹ The Pharmacist’s Role in Medicare Medication Therapy Management Services, Alliance for Pharmaceutical Care, available at <http://www.pswi.org/professional/patient/mtm.pdf>

Product Cost Reimbursement

The change in federal regulations to set maximum Medicaid drug reimbursement based on actual acquisition cost will have a profound affect on pharmacy providers. MO HealthNet would no longer be able to utilize WAC to set pharmacy reimbursement (most states have traditionally based EAC on a discount off the published AWP or a markup on the published WAC).

To implement an AAC reimbursement policy, MO HealthNet may either have to conduct regular costly surveys or rely on the NADAC survey that CMS is developing. If MO HealthNet does not believe the NADAC represents the costs to pharmacies in Missouri, it may be forced to do its own AAC survey. In addition to implementing an AAC, MO HealthNet may have to increase their base dispensing fee. As it has done with states that have already moved to AAC (e.g., Alabama and Oregon), CMS may require MO HealthNet to increase dispensing fees to more accurately reflect pharmacies' costs to dispense.³² For example, after it moved to AAC-based reimbursement, Oregon increased its dispensing fee to \$10.65, while Alabama went to \$10.64. A national survey of costs to dispense in 2007 noted the mean overall cost to dispense for pharmacies in Alabama was \$9.68, in Oregon \$11.61 and in Missouri \$9.36. Missouri could be forced to increase its base dispensing fee an additional \$6.00 with the implementation of AAC.

Pharmacy Provider Tax

Missouri has implemented an innovative pharmacy provider tax to leverage additional federal matching funds. This tax provides needed revenue to help the state sustain current product cost and dispensing fee rates, and to recognize reimbursement for MTM services. This additional revenue has allowed MO HealthNet to provide relatively generous pharmacy reimbursement in comparison to other states. The implementation of AAC and a revised dispensing fee could have an affect on CMS's view of the pharmacy provider tax.

Managed Care Pharmacy Carve-Out

Now that states can collect drug rebates for both fee-for-service and capitated managed care prescriptions, the carve-out decision may be revisited. There are, however, many factors to consider when reviewing this issue, including: How will changes in provider tax and supplemental rebate revenue affect savings if drugs are carved back into managed care plans, or if managed care enrollment increases? Will carve-out and carve-in changes increase or decrease capitation rates paid? Will a state uniform PDL maximize rebate income?

The actions in Texas will be a factor in this consideration as Texas has carved the drug benefit back into managed care plans while retaining control over a uniform PDL.

Medicaid drug reimbursement strategies are complex, involving not only payments to pharmacies, but also net effects of manufacturer rebates and coverages under PDLs. Missouri, like other states, must be poised to face challenging policy issues resulting from changes in federal requirements and available funding. At the same time, the state must balance expectations for continued levels of pharmacy reimbursement, access to pharmacy services, and quality of care.

32 Centers for Medicare and Medicaid Services (CMS). Medicaid program; covered outpatient drugs. 42 CFR Part 447. Federal Register. 2012;77(22):5318-5367

Appendix A

Definitions Relating to Pharmacy Reimbursement

Term	Meaning	Legal Reference
Single Source Drug	Means a drug that is produced or distributed under an original new drug application approved by the Food and Drug Administration (FDA), including a drug product marketed by any cross-licensed producers or distributors operating under the new drug application. One product is approved on the market for the active ingredient, strength, and dosage form (e.g., tablet, capsule, vial, etc.).	Sec 1927(k) of the Social Security Act (SSA) and 42 CFR §447.502
Multiple Source Drug	Means a drug multiple manufacturers distribute, each providing a pharmaceutical equivalent having the same active ingredient(s), strength, and dosage form. These drugs include non-innovator products, often called generics, and the innovator drug that was originally marketed under an original new drug application approved by the FDA.	Sec 1927(k)(7) of the SSA provides requirements relating to multiple source drugs as used in the FUL process
Innovator Multiple Source Drug	Means a multiple source drug that was originally marketed under an original new drug application (NDA) approved by the FDA. A Single Source Drug becomes an Innovator Multiple Source Drug as it loses its patent protection.	42 CFR §447.502
Non-innovator Multiple Source Drug	Means a multiple source drug that is not an innovator multiple source drug or a single source drug. Non-innovator Multiple Source Drugs are often referred to as generics.	42 CFR §447.502
Brand Drug	Means a Single Source Drug or Innovator Multiple Source Drug.	42 CFR §447.502
Dispensing Fee	Means a fee for costs in excess of the ingredient cost of a covered outpatient drug each time a covered outpatient drug is dispensed. It includes pharmacy costs associated with ensuring that possession of the appropriate covered outpatient drug is transferred to a Medicaid recipient. Pharmacy costs include, but are not limited to, reasonable costs associated with a pharmacist's time in checking the computer for information about an individual's coverage, performing drug utilization review and preferred drug list review activities, measurement or mixing of the covered outpatient drug, filling the container, beneficiary counseling, physically providing the completed prescription to the Medicaid beneficiary, delivery, special packaging, and overhead associated with maintaining the facility and equipment necessary to operate the pharmacy.	42 CFR §447.502

Term	Meaning	Legal Reference
Average Wholesale Price (AWP)	Means the list price from a wholesaler to a pharmacy. AWP is not the price paid, as pharmacies negotiate discounts. Payers typically discount AWP to estimate a pharmacy's acquisition costs.	Not defined in federal Medicaid law or regulation
Wholesale Acquisition Cost (WAC)	Means the manufacturer's list price to wholesalers or direct purchasers. WAC is not the price paid, as manufacturers offer discounts. Payers typically markup WAC to estimate a pharmacy's acquisition costs.	Defined in Medicare law at Sec 1847A (c)(6)(B) of the SSA, but not Medicaid law
Average Manufacturer Price (AMP)	Means the average price paid to the manufacturer for the drug in the United States by wholesalers, for drugs distributed to retail community pharmacies; and retail community pharmacies that purchase drugs direct from the manufacturer.	Sec 1927(k) of the SSA
Federal Upper Limit (FUL)	Means a federal upper reimbursement limit set for a multiple source drug for which the FDA has rated three or more products therapeutically and pharmaceutically equivalent, regardless of whether all such additional formulations are rated as such and shall use only such formulations when determining any such upper limit. FULs are set as no less than 175 percent of the weighted average (determined on the basis of utilization) of the most recently reported monthly Average Manufacturer Price (AMP) for pharmaceutically and therapeutically equivalent multiple source drug products that are available for purchase by retail community pharmacies on a nationwide basis.	Sec 1927(e) of the SSA
Maximum Allowable Cost (MAC)	Payment ceilings on multiple-source drugs and select other drugs set by states and other payers. A state may implement its own MAC rates - as long as its payments do not exceed FULs in aggregate.	Not defined in federal Medicaid law or regulation

Section

10

Buying Value: Improving the Quality of Missourians' Health Care

Issue Statement

Missouri spends \$41.6 billion on health care each year, or \$6,967 per person,¹ slightly higher than the U.S. average of \$5,283. However, higher expenditures do not equate with better outcomes. Missouri ranks in the bottom third of states on key indicators of quality and health outcomes.² The residents of Missouri could get better value for their health care dollars with improvements in the quality of care and patient safety. State health policy plays a vital role in making this happen.

Background

Quality care is providing the right care at the right time in the right place. Far too often, patient care fails to meet this standard. Poor quality generally takes the form of overuse, underuse, misuse, or some combination. Some ineffective services are vastly overused, while other types of care that could prevent illness are seriously underused. Medical errors occur in all parts of the health care system, from prescribing contradictory medications to operating on the wrong limb. One third of health care that is delivered in the U.S. is estimated to be of questionable value; nearly half of all Americans do not receive recommended preventive or primary care (45%);³ and about 98,000 deaths a year are attributed to preventable medical errors.⁴

Opportunities to Improve Quality of Care in Missouri

Missouri ranks 36th among the 50 states in quality of care, according to the Commonwealth Fund, a national health care foundation.⁵ Just 42 percent of adults age 50 or older receive recommended screening and preventive care in Missouri. Among adults with diabetes, 44 percent receive recommended preventive care. Children fare somewhat better; 64.6 percent of Missourians aged 19 months to 35 months get all recommended immunizations.⁶ In 2009, there were just over 20,000 preventable hospitalizations and readmissions among Missouri's elderly.⁷ On the positive side, Missouri ranked alongside the top 10 in the nation for pregnant women receiving adequate prenatal care (85.8%, rank – 10th) in 2011.⁸

Greater use of preventive care

Improving the quality of care can improve health care outcomes and reduce health care spending. The Commonwealth Fund estimated the benefits to Missouri residents if the state's

1 Kaiser State Health Facts. www.statehealthfacts.org. Accessed January 8, 2013. Expenditure data include all privately and publicly funded personal health services. Health insurance administration, research, and construction are excluded.

2 Cantor, J.C. et al. October 2009. Aiming Higher: Results from a State Scorecard on Health System Performance, 2009. The Commonwealth Fund. <http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2009/Oct/2009-State-Scorecard.aspx?page=all>. Accessed January 8, 2013.

3 McGlynn, E.A., et al. 2003. The quality of health care delivered to adults in the United States. *The New England Journal of Medicine*, 348(26): 2635-2645.

4 Institute of Medicine. *To Err is Human: Building a Safer Health System*. National Academies of Science Press, Washington, D.C., 1999.

5 Cantor, et al. 2009. Accessed January 8, 2013.

6 Sabrina K.H. How, et al. *Securing a Healthy Future: The Commonwealth Fund State Scorecard on Child Health System Performance, 2011* <http://www.commonwealthfund.org/Publications/Fund-Reports/2011/Feb/State-Scorecard-Child-Health.aspx> Accessed January 8, 2013.

7 Cantor, et al. 2009. Accessed January 8, 2013.

8 United Health Foundation, *America's Health Rankings: Missouri*, 2011.

performance on nationally recognized quality indicators matched that of the highest ranked states in the nation:

- 183,281 more adults aged 50 and older would receive recommended preventive care such as colon cancer screenings, mammograms, Pap smears, and flu shots at appropriate ages;
- 81,116 more adults aged 18 and older with diabetes would receive three recommended services (eye exam, foot exam, and hemoglobin A1c test) to help prevent or delay disease complications; and
- 18,056 more children aged 19 months to 35 months would be up-to-date on all recommended doses of five key vaccines.

Reduction in avoidable hospitalizations

Improving the quality of health care services in Missouri has the potential to reduce hospital admissions by tens of thousands each year, lowering costs by hundreds of millions of dollars. Improving the state's quality of care to levels similar to that of the highest ranked states could lead each year to:

- 20,911 fewer preventable hospitalizations for ambulatory care sensitive conditions among Medicare beneficiaries aged 65 and older, at a savings of \$121 million;
- 5,150 fewer hospital readmissions among Medicare beneficiaries aged 65 and older, at a savings of \$60 million; and
- 3,829 fewer long-stay nursing home residents hospitalized, at a savings of \$25 million.

Patient Protection and Affordable Care Act: Quality Improvement Initiatives

The Patient Protection and Affordable Care Act (ACA) includes numerous provisions to address quality improvement in the nation's health care system. The ACA supports health care quality by funding research and innovations in patient care, collecting and reporting quality measures, coordinating administrative processes, and piloting payment reforms.

Research and Innovations to Improve Quality

- *Private, nonprofit Patient Centered Outcomes Research Institute*: The Patient Centered Outcomes Research Institute is charged with establishing and carrying out a research agenda that serves to advance and improve the quality of health care outcomes research. The Institute will conduct primary research such as clinical trials and systematic reviews and assessment of existing and future research.⁹
- *Center for Medicare and Medicaid Innovation (CMS Innovation Center)*: The purpose of the CMS Innovation Center is to "test innovative payment and service delivery models" to reduce program expenditures under Medicaid and Medicare while "preserving or enhancing the quality of care."¹⁰ Among other functions, the ACA directs CMI to develop and test patient-centered medical home models and other approaches that improve care management and coordination between providers.

⁹ Section 6301(b) of Patient Protection and Affordable Care Act (ACA).

¹⁰ Section 3021 of the ACA.

- *National Strategy for Quality Improvement in Health Care:* The Secretary of the Department of Health and Human Services (HHS) is charged with developing a national strategy for quality improvement with the following requirements included:
 - Have the greatest potential for improving the health outcomes, efficiency, and patient- centeredness of health care for all populations, including children and vulnerable populations.
 - Identify areas in the delivery of health care services that have the potential for rapid improvement in the quality and efficiency of patient care.
 - Address gaps in quality, efficiency, comparative effectiveness information, health outcomes measures, and data aggregation techniques.
 - Improve federal payment policy to emphasize quality and efficiency.
 - Enhance the use of health care data to improve quality, efficiency, transparency, and outcomes.
 - Address the health care provided to patients with high-cost chronic diseases.
 - Improve research and dissemination of strategies and best practices to improve patient safety and reduce medical errors, preventable admissions and readmissions, and health care-associated infections.
 - Reduce health disparities across populations and geographic areas.¹¹

Collecting and Reporting Quality Measurement

- *Medicaid Quality Measurement Program:* The ACA directed HHS to develop, test, and disseminate quality measures for adults in Medicaid¹² through a process similar to the child health quality measure development process included in the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). The child health quality measures were published in January 2010 and can be used by states to improve pediatric health care quality in the Children's Health Insurance Program (CHIP) and Medicaid programs.¹³ The Adult measures were published in December 2011 and can be found the Agency for Health Research and Quality (AHRQ) website.¹⁴
- *Quality Measurement Identification for all public programs:* The Secretary of HHS, in coordination with AHRQ, is responsible for, on a triennial basis, identifying gaps in quality measures across all public programs and making recommendations for eliminating these gaps.¹⁵

Coordination of Administrative Functions

- *Federal Coordinated Health Care Office:* The ACA requires that the Centers for Medicare and Medicaid Services (CMS) establish a Federal Coordinated Office of Health Care to

¹¹ Section 3011, ACA.

¹² Section 2701(b)(5).

¹³ A list of the Core set of Pediatric Health Care Quality Measures can be found at <http://www.ahrq.gov/chipra/listtable.htm>. Accessed January 9, 2013.

¹⁴ <http://www.ahrq.gov/about/nacqm11/>

¹⁵ Section 3013, ACA.

address care coordination problems associated with dually-eligible Medicare and Medicaid beneficiaries. The goals are to more effectively integrate benefits and improve coordination between the federal and state governments.¹⁶

- *Interagency Working Group on Streamlining Federal Quality Activities:* The ACA provides for the establishment of an interagency workgroup, headed by the Secretary of HHS, to collaborate on quality, avoid duplication of effort, streamline quality reporting and compliance requirements, and assess alignment of quality efforts in the public and private sector.¹⁷

Payment Reform

- *Accountable Care Organization (ACO) Incentives Pilots:* The ACA establishes ACO pilot programs for pediatric providers and Medicare, with the goal of improving care coordination and efficiencies of health care services. The ACO pilot includes payment incentives for providers who meet or exceed established quality standards and cost savings goals.^{18,19}
- *Other Medicare-specific payment reforms:* The potential exists that payment reforms established by the ACA for Medicare may be transferable to the Medicaid program, such as a provision to develop a value-based purchasing pilot in traditional Medicare (October 2012), a national pilot on payment bundling and care coordination (January 2013), and a provision to pay physicians based on quality standards (January 2015).

States Have Influential Role to Play in Advancing Quality Improvement

States have considerable influence over health care quality through their roles as purchasers of health services, regulators of providers, and supporters of innovation. They can use these levers to improve quality and patient safety, and safeguard the public.

Key strategies states are pursuing to improve quality include:

- Leveraging the purchasing power and opportunities to coordinate quality standards through Medicaid, state employee health programs, and other state agency purchasers.
- Engaging providers and consumers by collecting and publicly reporting data on medical errors and adverse events.
- Promoting adoption of Health Information Technology (HIT) and Health InformationExchange (HIE) so that providers and consumers have safe, reliable systems underlying their decision making.
- Adopting payment reform approaches in Medicaid such as payment bundling and ACO pilot programs.

This brief summarizes policy options relevant to these key strategies and provides examples in other states along with a summary of Missouri's progress on these fronts.

¹⁶ Section 2602, ACA.

¹⁷ Section 3012, ACA.

¹⁸ Section 3022, ACA.

¹⁹ Section 2706, ACA.

Leverage Coordinated Approach to Quality

As a major purchaser of health care—for state employees, Medicaid beneficiaries, wards of the state, and residents who receive public health services—Missouri has the purchasing power to demand high quality from providers. The state pays for poor quality care when it is the result of overuse, underuse, or misuse of health care services.²⁰ Missouri can use its purchasing leverage to improve quality and patient safety by rewarding high quality and safe performance, and encouraging correction of poor performance.

Standardize Performance Measures Used for Purchasing High Quality Care

States are leveraging their purchasing power for quality in a variety of ways. Medicaid, state employee health programs, and other state agencies that purchase health services are:

- Building quality and safety standards into their contracts with health plans and providers that include requirements for reporting on quality and safety measures.
- Using standard contracting language, performance measures, reporting requirements, and quality incentives (i.e., pay-for-performance or P4P) to create more value per state health care dollar and create greater efficiencies for providers.
- Issuing joint requests for proposals (RFPs) for health services, which may include managed care, behavioral health, prescription drug benefit management, quality and patient safety data collection and reporting.
- Forming multi-payer purchasing coalitions with private purchasers to make measurement, reporting, and incentive programs uniform for providers and to establish common benchmarks for improvements in quality and safety.

Align Quality Improvement and Health Outcomes Goals across State Agencies

A state's leverage to drive quality improvements and efficiencies in the health care system is enhanced when an agency has a contract or grant requirement specifically designed to support the goals of another state agency or program. For example, a Medicaid program could require health plans to work with local public health departments on strategies to improve immunization rates. Sister agencies can also share data and the costs of data collection and reporting related to mutual health care goals, such as improving immunization and lead screening rates.

As mentioned above, the ACA and CHIPRA both provide states with additional structure regarding standardization of quality measurement across populations, with the establishment of a core set of adult and child health quality measures for states to use in their Medicaid and CHIP programs.

Reward High Quality

As the largest purchasers of nursing home care services in their states, Medicaid programs have considerable purchasing power to promote improvements in quality of care provided by their

²⁰ Hess, C. et al. 2008. State Health Policies Aimed at Promoting Excellent Systems: A Report on States' Roles in Health Systems Performance, National Academy for State Health Policy. <http://nashp.org/publication/state-health-policies-aimed-promoting-excellent-systems-report-states%E2%80%99-roles-health>. Accessed on January 9, 2013.

state's skilled nursing facilities. Missouri spends \$2.9 billion annually on nursing home care.²¹ On average, state Medicaid programs pay 46 percent of the total bill for nursing home care.²² Ten states²³ have used their purchasing power to implement nursing home quality improvement P4P initiatives. The initiatives typically include financial incentives that target improvements in resident outcomes using the Minimum Data Set, staffing-level measures, certification survey deficiencies, and resident/family quality of life surveys.

While not a new idea, value-based purchasing efforts are gaining more attention, given the provisions included in the ACA. In compliance with the law, in October 2012, CMS initiated Medicare value-based purchasing in hospitals,²⁴ skilled nursing facilities, home health agencies,²⁵ and ambulatory surgical centers.²⁶ These initiatives require standardization of quality measures as well as public reporting. Importantly, these initiatives, along with the ACO, CMS Innovation Center patient care models, and other payment reform pilots, may be directly transferable to Medicaid and have the potential to drive quality improvements for the program's highest expenditure service categories (i.e., aged, disabled, and dual-eligibles).

Building on its efforts to date, Missouri should consider examining other states' multi-purchaser P4P initiatives to gain valuable insights. These include the states of Minnesota, Maine, Washington, and Virginia.

- *Example:* Minnesota seeks to realize savings to the public by insisting on stringent quality and safety standards in state health contracts. The state is working to align standards and payment incentives across state agencies, including Medicaid and the state employee health plan, to meet benchmarks of improved patient safety and quality of care.
 - Study feasibility of requiring state health programs, particularly MO HealthNet and state employee health benefit plans, to issue RFPs with uniform requirements regarding the collection and reporting of quality and patient safety measures.
- *Example:* The Maine state employee plan participates in an ad hoc group that includes five large purchasers from both the public and private sectors. This group has agreed to a set of purchasing principles and RFP language related to patient safety and quality performance.
 - Align goals and requirements of MO HealthNet and other health-related service agencies with state public health priorities.
- *Example:* The Washington Medicaid program jointly supports the state Department of Health's Child Profile health promotional materials and immunization registry.
 - Convene a stakeholders' group to research the cost, benefits, and feasibility of implementing a state P4P initiative that targets skilled nursing homes in Missouri.

21 Kaiser State Health Facts www.statehealthfacts.org Accessed on January 9, 2013.

22 Ellen O'Brien. 2005. Medicaid's coverage of nursing home costs: Asset shelter for the wealthy or essential safety net? <http://lrc.georgetown.edu/pdfs/nursinghomecosts.pdf> Accessed January 9, 2013

23 Colorado, Georgia, Iowa, Kansas, Maryland, Minnesota, Ohio, Oklahoma, Utah and Vermont

24 Section 3001, ACA.

25 Section 3006, ACA.

26 Section 10301, ACA.

Missouri's Progress in Leveraging Purchasing Power for Quality Improvement

The Missouri Health Improvement Act of 2007 was designed to be a blueprint for health care reform in the state. The legislation created a Professional Services Payment committee to develop P4P guidelines. The Missouri Health Improvement Act also created the MO HealthNet Oversight Committee to develop health improvement plans for all managed care participants. Missouri started the Chronic Care Improvement Program (CCIP) in November 2006. CCIP paid physicians to complete an initial assessment and manage a care plan for patients with chronic health conditions. The program also provided incentive payments for physicians who achieved certain quality gains. However, despite the program's potential and recognition as a trend-setter among state P4P programs, the CCIP vendor agreement was discontinued in 2009 because of the Medicaid program's severe budget shortfall.

- *MO HealthNet Managed Care Quality Improvement Efforts:* Missouri's Medicaid program includes several quality improvement strategies through its MO HealthNet managed care organization (MCO) contracts. As of October 2011, the state requires all MCOs to be accredited by the National Committee for Quality Assurance (NCQA).²⁷ As an incentive for improving quality, MCO's with higher quality scores are guaranteed a higher rate of auto assigned enrollees.
- *Health Homes Initiative:* In 2011, the MO HealthNet Division within the Department of Social Services implemented a primary care health home program to provide case management services for participants with chronic behavioral or medical conditions. At the same time, the Department of Mental Health implemented a behavioral Health Home program. These Health Home programs are possible with a State Plan Amendment, per ACA Section 2703. The Health Home programs intensify care coordination and care management with the aim of improving patient health and outcomes, reducing emergency department utilization and hospital admissions, and reducing health care costs.²⁸ The programs focus on the highest risk and highest cost patients. Eligible patients have two chronic conditions, have a chronic condition and be at risk for a second chronic condition, and/or have a serious and persistent mental health condition. Qualifying chronic conditions include:
 - Asthma
 - Cardiovascular disease
 - Diabetes
 - Developmental disabilities
 - Overweight (BMI > 25) or
 - One of the above and tobacco use
 - Diabetes

²⁷ State of Missouri Quality Improvement Strategy (QIS) Medicaid Managed Care Program 2010. Missouri Department of Social Services. MO HealthNet Division. Attachment 16 to MO HealthNet Request for Proposal B3Z12055.

²⁸ "Health Care Transparency in Quality, Price, Interoperability in Health Systems and Incentives to Reward Outcomes" Missouri Department of Social Services. June 2012. <http://www.dss.mo.gov/mhd/oversight/pdf/2012-transparency-report.pdf> Accessed on January 9, 2013.

– Serious mental health condition

There are 24 organizations participating in the Primary Care Health Home Initiative with a total of 71 sites. There are 29 organizations participating in the Community Mental Health Center Health Home Initiative with a total of 101 sites. MO HealthNet is currently in discussions with CMS to explore the possibility of implementing shared savings initiatives with the participating health home organizations.²⁹

- *Avoidable Hospitalizations Among Nursing Facility Residents:* The CMS Innovations Center has made grant funding available to develop models of care that will reduce avoidable hospitalizations among nursing facility residents. MO HealthNet is supporting agencies or organizations as they apply for participation as enhanced care and coordination providers in the Avoidable Hospitalizations Initiative.

Engage Consumers and Providers by Collecting and Publicly Reporting Data on Medical Errors and Adverse Events

More than 10 years ago, the Institute of Medicine (IOM) published its landmark report *To Err is Human: Building a Safer Health System*. The 1999 report revealed that medical errors were the fourth leading cause of death in the United States.³⁰ Since then, the federal government's response has taken three primary paths:

- Increasing consumers' awareness and involvement in their own safety.
- Denying Medicare payment for certain medical errors, called "never events."
- Funding systems of measuring and reporting medical errors.

A variety of private organizations also began to address professional training, process improvement, and safety standards.³¹

States have undertaken a variety of strategies to protect the public's health and safety. These include launching patient safety reporting systems, creating patient safety centers, making patient safety part of facility licensure requirements, joining purchaser groups devoted to patient safety, and providing patient safety educational materials to consumers and providers.³²

Some states also choose to publicly release data to improve accountability by informing consumers and payers about the quality of health care facilities.

Data Collection Mandates for Providers and Public Reporting

The IOM called on every state government to create a mandatory reporting system to collect information about adverse events that result in death or serious harm. Twenty- six states have a

29 "Health Home Update, Shared Savings" Presented to MO HealthNet Oversight Committee. April 10, 2012. <http://dss.mo.gov/mhd/oversight/pdf/120410-health-home-shared-savings-update.pdf>

30 Institute of Medicine. *To Err is Human: Building a Safer Health System*. National Academies of Science Press, Washington, D.C., 1999.

31 For example, the National Quality Forum, The National Committee on Quality Assurance, the Institute for Health Care Improvement, and the Hospital Research and Education Trust.

32 Buxbaum, Jason "Opportunities and Recommendations for State-Federal Coordination to Improve Health System Performance: A Focus on Patient Safety. State Health Policy Briefing. January 2010. National Academy for State Health Policy. http://www.nashp.org/sites/default/files/Patient_Safety_1-12-10.pdf Accessed January 10, 2013.

mandate to publicly report data on hospital-based infections.³³ The purpose of public reporting is to stimulate providers to focus on improving care processes to reduce errors that may cause bad health outcomes.

New provisions included in the ACA require physicians and nursing homes to report on Medicare quality measures that are now posted on an HHS website for public comparison. Also, the Secretary of HHS is required to develop a list of quality metrics that must be reported by long-term care hospitals, inpatient rehabilitation hospitals, and hospice programs. The data will be made publicly available by HHS.^{34, 35, 36} Additionally, the law mandates data collection on various metrics to track progress toward the elimination of health disparities.³⁷

Not Paying for Poor Quality

The National Quality Forum reached a consensus on 28 “never events”— occurrences that should never happen in a hospital and can be prevented.³⁸ At least 20 states, including Missouri, have passed legislation or are considering policies denying Medicaid payment to hospitals for never events.³⁹

Missouri's Progress in Reducing Medical Errors and Adverse Events

Missouri's approach to patient safety has been mostly private and voluntary. The Missouri Hospital Association (MHA), the Missouri State Medical Association (MSMA) and Primaris established the Missouri Center for Patient Safety (MOCPS) in response to recommendations from the Governor's Commission for Patient Safety in 2004. The primary goal of MOCPS is to serve as a central resource of patient safety information for providers, physicians, consumers, and others by:

- Creating and maintaining a voluntary, confidential reporting system that is consistent with national patient safety organization criteria.
- Establishing a focus for improvement activities.
- Identifying best practices for sharing.⁴⁰

Reporting Hospital-Acquired Infections

The “Missouri Nosocomial Infection Reporting Act of 2004” was passed to decrease the incidence of infections in health care facilities in Missouri. It requires hospitals and ambulatory surgical centers to report specific health care-associated infections to the Missouri Department of Health and Senior Services (DHSS).⁴¹ The Department releases annual public reports based on the information, which identifies individual health care providers.

33 “Variability of States Reporting of Adverse Events” National Quality Forum.

http://www.qualityforum.org/Topics/SREs/Serious_Reportable_Events.aspx Accessed on January 9, 2013.

34 Section 10331, ACA.

35 Section 6103, ACA.

36 Section 3004, ACA.

37 Section 4301, ACA.

38 National Quality Forum. www.qualityforum.org . Accessed January 11, 2013.

39 #08-004 State Medicaid Director Letter <http://www.cms.gov/SMDL/downloads/SMD073108.pdf>. Accessed January 11, 2013.

40 Center for Patient Safety. <http://www.centerforpatientsafety.org/> Accessed January 11, 2013.

41 Missouri Department of Health and Human Services. <http://health.mo.gov/data/hai/> Accessed January 11, 2013.

Reporting Hospital Adverse Events

The Missouri Health Transformation Act of 2008 requires hospitals to report to MOCPS each serious reportable event in health care as defined by the National Quality Forum. MOCPS is required to publish an annual report to the public on reportable incidents. By 2010, hospitals were not allowed to charge for, or bill any entity for, all services related to the reportable incident. In July 2012, MO HealthNet implemented 13 CSR 70-3.230 Payment Policy for Provider Preventable Conditions.⁴² This regulation applies Medicare prohibitions for health care acquired conditions (HCACs) in inpatient hospitals and ambulatory surgical centers to Medicaid. States are required by 42 CFR Parts 434, 438, and 447 to develop regulations that identify and outline process for HCACs. Under this regulation, CMS prohibits payment to states for any amount expended for providing medical assistance to specified HCACs.

Potential Strategies for Missouri to Improve the Safety and Quality of Patient Care Building on its efforts to date, Missouri should consider:

- Continuing to move from voluntary to mandatory reporting so that providers and payers can gain a better understanding of quality and safety problems in the system.
- Requiring that errors of a certain type of frequency trigger corrective action plans, and providing DHHS with resources to oversee the appropriateness and effectiveness of corrective actions.
- Providing DHHS adequate resources to evaluate trends in reporting and outcomes including changes in utilization, readmission rates, and costs over time.

Support Health Information Technology and Exchange

Electronic health information systems have the capacity to improve the delivery and coordination of care, reduce medical errors, and provide a mechanism for tracking and assessing performance. The federal government, private sector, and many states are active— although not always well coordinated—in advancing new information systems and technologies in the health field.

The American Recovery and Reinvestment Act of 2009 (ARRA) provided funding for Medicaid Health Information Technology (HIT) and Health Information Exchange (HIE) plan development to encourage providers to be “meaningful users” of health information technology. The ACA also provides significant funding for various HIT initiatives and establishes the CMS Innovation Center to test various models of patient care that leverage HIT and HIE to promote coordination.

States' Involvement in Supporting Health Information Exchange and Health Information Technology

Most states have public health information systems that integrate data from multiple sources. Immunization and vital statistic data are most common. Other data systems may include

⁴² “Health Care Transparency in Quality, Price, Interoperability in Health Systems and Incentives to Reward Outcomes” Missouri Department of Social Services. June 2012. <http://www.dss.mo.gov/mhd/oversight/pdf/2012-transparency-report.pdf> Accessed on January 9, 2013.

newborn screenings, laboratory, hospital discharges, hospital emergency services, and cancer registry. States can leverage financing of HIE and HIT through:⁴³

- Demonstration or pilot initiatives.
- Encouraging or requiring use of health information exchange and technology in their purchasing roles.
- Accounting for HIT-related costs in their payment policies. ARRA specifically provided for incentive funding to providers as they adopt electronic health records that meet certain meaningful use criteria, including improved quality, safety, efficacy, and care coordination.⁴⁴

More than 200 electronic HIE initiatives are functioning across all 50 states. Of these, 88 HIEs reported operating “advanced” initiatives in 2012. Others are developing and revising legal structure through laws and regulations. The most significant challenge for all state efforts is addressing sustainability issues and an ever-growing competitive HIE market.⁴⁵

Progress in Missouri to Support HIT and HIE

The Missouri Health Improvement Act of 2007 established a Healthcare Technology Fund to support technological approaches to improving patient care and administrative efficiencies.

The Missouri Office of Health Information Technology (MO HITECH) and Missouri Health Connection promote the use of certified electronic health records (EHRs) by doctors, hospitals, clinics and other health care providers as a path to support a secure, statewide health information network (HIN). MO HITECH was awarded \$13,765,040 in federal stimulus money, made available ARRA, to design and implement a statewide HIN. The goal is to develop the infrastructure to enable statewide health information exchange in the 2010 to 2015 period and to achieve statewide adoption of electronic health records by 2015.⁴⁶ Missouri developed a plan for implementing HIE in two phases. Each phase will have alpha and beta groups of providers willing to pilot the establishment of the HIN. The alpha and beta pilots for the first phase are scheduled for completion by December 2012. The alpha and beta pilots for the second phase are planned for 2013. Missouri Medicaid plans to participate in the alpha pilots for both phases.⁴⁷

MO HealthNet also implemented the Medicaid Electronic Health Record Incentive Program in May 2011. In the first year, applications for the incentive payment were received from over 1,200 hospitals and professionals. To date, Medicaid has paid out over \$70 million in incentive payments.⁴⁸

43 Hess, C et al. 2008.

44 ARRA, Section 4201, 2009.

45 e-Health Initiative. 2012 HIE Survey. <http://www.ehealthinitiative.org/resources/viewdownload/54-annual-surveys/613-2012-report-on-health-information-exchange-supporting-healthcare-reform.html> Accessed January 11, 2013.

46 HMO-HITECH <http://www.assistancecenter.missouri.edu/?q=node/36> Accessed January 11, 2013.

47 “Health Care Transparency in Quality, Price, Interoperability in Health Systems and Incentives to Reward Outcomes” Missouri Department of Social Services. June 2012. <http://www.dss.mo.gov/mhd/oversight/pdf/2012-transparency-report.pdf> Accessed on January 11, 2013.

48 Missouri Department of Social Services, <http://www.dss.mo.gov/mhd/oversight/pdf/2012-transparency-report.pdf> Accessed on January 11, 2013.

Potential Strategies for Missouri to Use HIT/HIE to Improve the Safety and Quality of Patient Care

Building on its efforts to date, Missouri should consider:

- Coordinating HIT and HIE investments in the state (e.g., Healthcare Technology Fund, MO HealthNet, and private sector) to align quality measures for public reporting and performance-based contracting; and
- Using upcoming ACA provisions, such as the physician quality-based payment policies⁴⁹ (January 2015), as an opportunity to support providers in adopting HIT in health care practice.

⁴⁹ Section 3007, ACA.

Section

11

Real Opportunities for Ending the Addiction: Tobacco Use Prevention and Cessation

Issue Statement

Tobacco use is the single most preventable cause of death and disease in the United States. Lung cancer ranks as the leading cause of cancer death in the United States for both men and women, and more than 80 percent of lung cancer cases are caused by smoking.¹ An estimated 45 million American adults currently smoke cigarettes.² Smoking causes cancer, heart disease, stroke, and lung diseases (including emphysema, bronchitis, and chronic airway obstruction). Half of the adults who continue to smoke will die from smoking related causes.³ All tobacco products, including smokeless tobacco and cigars, cause cancer, and all forms of tobacco are addictive.^{4,5} Secondhand smoke causes premature death and disease in children and adults who do not smoke. Approximately 88 million nonsmokers (40% of the nonsmoking U.S. public) continue to be exposed to secondhand smoke. On average, smokers die 13 to 14 years earlier than nonsmokers.⁶ Smoking causes infertility problems, early births and stillbirths, low-birth-weight, and sudden infant death syndrome (SIDS).⁷

Tobacco use is also the leading preventable cause of death in Missouri. Smoking kills an estimated 443,000 Americans each year (50,000 from exposure to secondhand smoke).⁸ From 2005 to 2007, more than nine thousand (9,362) Missourians died from tobacco related diseases, including 29 infants due to maternal smoking during pregnancy and 1,180 deaths attributable to secondhand smoke.⁹ When surveyed, two out of three Missouri adult smokers indicated they wanted to quit smoking within the next six months. However, only 14.3 percent reported trying nicotine replacement therapy or other smoking cessation medication and only 2.8 percent utilized counseling the last time they tried to quit.¹⁰

Given this information on the death, disability, and costs that result from tobacco use, policymakers are faced with the challenge of designing effective tobacco-control policies. States with lower smoking prevalence rates have substantially reduced their tobacco use rates by strengthening their tobacco control policies through cessation programs, smoke-free indoor air legislation, tobacco tax, and regulatory policies.

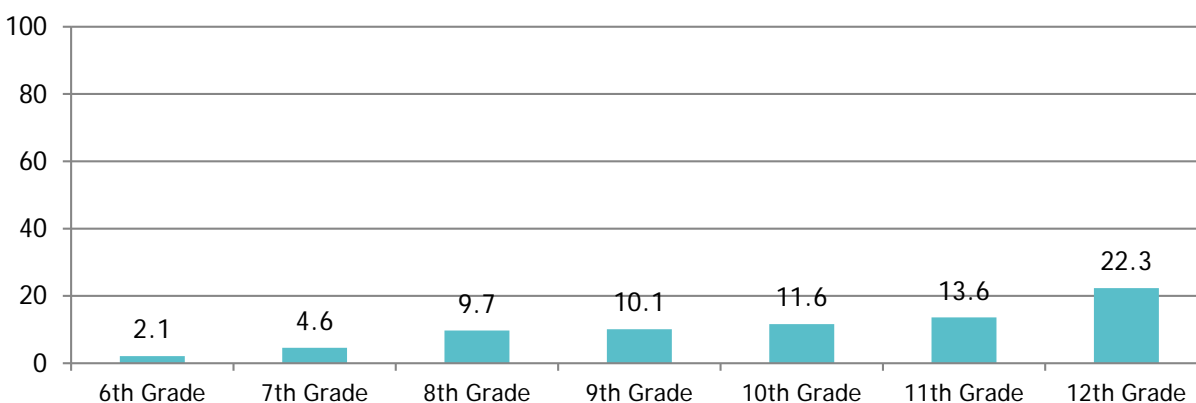
- 1 Centers for Disease Control and Prevention (CDC). (2008). Smoking-attributable mortality, years of potential life lost, and productivity losses—United States, 2000–2004. *MMWR: Morbidity and Mortality Weekly Report*, 57(45), 1226-1228.
- 2 U.S. Department of Health and Human Services (HHS). (2012). Preventing tobacco use among youth and young adults: A report of the Surgeon General. Atlanta, GA: U.S. Department of Health and Human Services.
- 3 CDC. (2008). Smoking-attributable mortality, years of potential life lost, and productivity losses—United States, 2000–2004. *MMWR: Morbidity and Mortality Weekly Report*, 57(45), 1226-1228.
- 4 Institute of Medicine. *Clearing the Smoke: Assessing the Science Base for Tobacco Harm Reduction*. Washington, DC: National Academies Press; 2001.
- 5 HHS. *The Health Consequences of Smoking: Nicotine Addiction. A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control, Center for Health Promotion and Education, Office on Smoking and Health; 1988.
- 6 CDC. Annual Smoking-Attributable Mortality, Years of Potential Life Lost, and Productivity Losses—United States, 1995–1999. *Morbidity and Mortality Weekly Report* 2002;51(14):300–3
- 7 HHS. *The Health Consequences of Smoking: A Report of the Surgeon General*. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2004.
- 8 CDC. (2008). Smoking-attributable mortality, years of potential life lost, and productivity losses—United States, 2000–2004. *MMWR: Morbidity and Mortality Weekly Report*, 57(45), 1226-1228.
- 9 Missouri Department of Health and Senior Services (DHSS) Fact Sheet, Tobacco State, July 2010; <http://health.mo.gov/living/wellness/tobacco/smokingandtobacco/pdf/TobaccoState.pdf>
- 10 DHSS. (2007). Missouri 2007 County-level Study. State Cessation Report.

Background

Beginning with the U.S. Surgeon General's 1964 report regarding the effects of smoking, federal, state, and local governments have taken multiple actions to decrease smoking prevalence, including requiring health warning labels on tobacco products, banning advertising of tobacco products in broadcast media, banning smoking on airline flights, conducting education campaigns, and sponsoring research on the impacts of tobacco use. As a result of these efforts and strengthened by the Tobacco Master Settlement Agreement (MSA) in 1998, smoking rates have significantly declined nationally. However, Missouri has the second highest percentage of smokers in the United States at 26 percent (tied with Oklahoma, Louisiana, Mississippi, Arkansas, and Ohio).¹¹

Nearly 90,000 Missouri smokers are under age 18. According to the Centers for Disease Control and Prevention (CDC), 18.1 percent of Missouri high school students smoke, which is higher than the 15.8 percent national average.¹² The 2011 Missouri Youth Tobacco Survey found a similar percentage, with current cigarette smoking increased from 2.1 percent among 6th grade students to 22.3 percent of 12th grade students.¹³

Missouri Youth Tobacco Survey 2011
Middle and High School:
Percentage of students who smoked cigarettes on one or
more of the past 30 days, by grade (Current Smoking)



Source: 2011 Missouri Youth Tobacco Survey

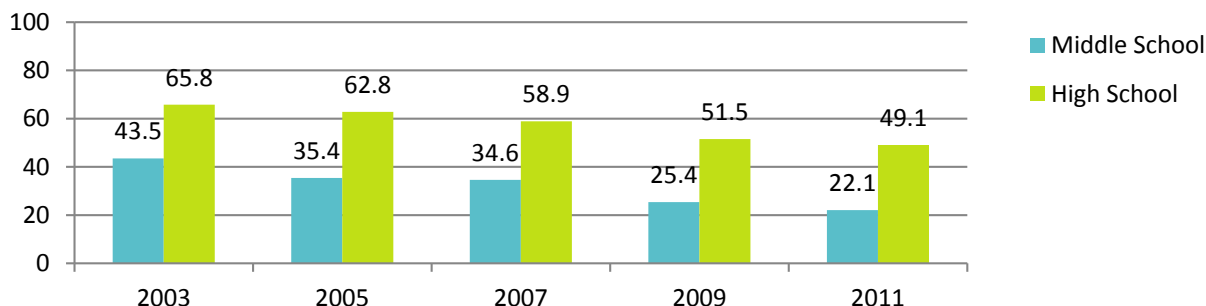
The rates of youth that have tried tobacco on at least one occasion is significantly higher, with 49.1 percent of high school and 22.1 percent of middle school students having ever used any form of tobacco. These rates are a decrease from 2009 rates of 51.5 percent and 25.4 percent respectively and a significant decrease from 2003 rates of 65.8 percent and 43.5 percent respectively.

¹¹ Gallup-Healthways Well-Being Index data for the first half of 2011; <http://www.gallup.com/poll/150779/Smoking-Rates-Remain-Highest-Kentucky-Lowest-Utah.aspx>

¹² State Tobacco Activities Tracking and Evaluation (STATE) System; <http://apps.nccd.cdc.gov/statesystem/HighLightReport/highlightReport.aspx>

¹³ DHSS. (2011). Results from the 2011 Missouri Youth Tobacco Survey; <http://health.mo.gov/living/wellness/tobacco/smokingandtobacco/pdf/2011YouthTobaccoSurvey.pdf>

Missouri Youth Tobacco Survey 2003 - 2011: Percentage of students who had ever used any form of tobacco



Source: 2011 Missouri Youth Tobacco Survey

According to the 2011 survey, the number of non-smoking Missouri youths exposed to secondhand smoke also has declined significantly. The percentage of middle school youths declined from 53.7 percent in 2003 to 39.8 percent in 2011. The percentage of high school youths declined from 52.6 percent in 2003 to 43.4 percent in 2011.

Cost of Tobacco

Missouri spends \$2.24 billion (including \$532 million through Medicaid) annually to treat smoking-related illnesses and \$10.1 million for care of newborns due to their mothers smoking during pregnancy. Each Missouri household is burdened by \$585 in state and federal tax dollars that pay for smoking-caused expenditures. An estimated 144,501 years of potential life are lost annually from smokers' early deaths, and annual lost productivity due to tobacco-related disease is estimated to be \$2.6 billion in Missouri.¹⁴

Missouri is often identified as a tobacco-growing state in national surveys, which raises a question about whether policies that curb smoking trends threaten the state's economic base. However, according to the state Department of Agriculture, Missouri's tobacco harvest of 3.5 million pounds accounted for less than one-half percent of the total U.S. production of 778 million pounds of tobacco (\$5 million out of \$1.3 billion in market value).¹⁵

In 1998, state Medicaid programs and the four largest U.S. tobacco companies entered into the MSA. The states had sued the tobacco companies for recovery of their tobacco-related health care costs. When the MSA was finalized, many states dedicated a large share, if not all, of the proceeds to efforts to reduce the incidence of smoking.

Missouri received \$228 million annually in tobacco-related revenue from the MSA (\$135.2 million for 2012) and tobacco taxes (\$92.7 million for 2011).¹⁶ In 2012, Missouri voters rejected

¹⁴ DHSS. Fact Sheet, Tobacco State, July 2010;

<http://health.mo.gov/living/wellness/tobacco/smokingandtobacco/pdf/TobaccoState.pdf>

¹⁵ U.S. Department of Agriculture. 2007 Census of Agriculture

¹⁶ State Tobacco Activities Tracking and Evaluation (STATE) System;

<http://apps.nccd.cdc.gov/statesystem/HighLightReport/highlightReport.aspx>

a ballot initiative to increase the cigarette tax by 73 cents per pack.¹⁷ Twenty percent of the revenue raised by the tax would have been allocated to tobacco prevention and cessation programs. Missouri remains among the bottom states in funding tobacco prevention and cessation, ranking 45th in the nation in 2012. Missouri commits \$67,785 in state funds for tobacco prevention and cessation programs which equals 0.1 percent of the \$73.2 million recommended by the CDC. Missouri is receiving \$2.3 million in federal funds dedicated to tobacco prevention and control. These funds include:¹⁸

- \$1.2 million from the CDC in a 12-month grant for the period beginning April 2012 (from annual appropriations).
- \$503,513 from the Prevention and Public Health Fund in the new health care reform law for the period beginning August 1, 2012.
- \$614,828 from the Food and Drug Administration (FDA) for enforcement of the Family Smoking Prevention and Tobacco Control Act, including the provision regarding tobacco sales to minors.

Federal Initiatives to Reduce Tobacco Use

In 2009 and 2010, President Obama signed into law five new programs. These new laws give federal agencies more authority and funding to: restrict the sale, distribution, and promotion of cigarettes and smokeless tobacco; make them less accessible and attractive to youth; deter people from smoking; help people quit; reduce exposure to secondhand smoke; and promote an overall culture of health and prevention.

1. **The American Recovery and Reinvestment Act (ARRA).** ARRA invested \$200 million to support local, state, and national tobacco prevention and control efforts, thus mitigating decreases in state tobacco control budgets. With this funding, the U.S. Department of Health and Human Services (HHS) and CDC launched the Communities Putting Prevention to Work (CPPW) program, which provided grants to help states, cities, counties, and tribes address ongoing public health challenges; 22 grants addressed tobacco use specifically.
2. **The Children's Health Insurance Program Reauthorization Act (CHIPRA).** CHIPRA included a 62 cent increase in the federal excise tax on cigarettes to \$1.01 per pack. For every 10 percent increase in the price of tobacco products, consumption falls by approximately 4 percent overall, with a greater reduction among youth. Increasing the price of cigarettes is projected to prevent more than 2 million youths from initiating smoking, cause more than one million adult smokers to quit, avert nearly 900,000 smoking-attributed deaths, and avoid \$44.5 billion in long-term health care costs.¹⁹
3. **The Family Smoking Prevention and Tobacco Control Act** (referred to as the Tobacco Control Act). The Tobacco Control Act grants the FDA the authority to comprehensively regulate thousands of tobacco products. This law facilitated the

¹⁷ Missouri's cigarette tax of 17 cents per pack is lower than the \$1.48 per pack U.S. average

¹⁸ http://www.tobaccofreekids.org/what_we_do/state_local/tobacco_settlement/missouri

¹⁹ Public health benefits and healthcare cost savings from the federal cigarette tax increase [Fact sheet]. <http://staging.tobaccofreekids.org/research/factsheets/pdf/0314.pdf>

creation of the Center for Tobacco Products (CTP) to regulate the manufacture, distribution, and marketing of tobacco products to protect public health.

The Tobacco Control Act also required that as of September 2012, cigarette packages have larger and bolder health warnings, including graphic images. Additionally, the Tobacco Control Act mandates that tobacco companies disclose harmful or potentially harmful constituents in their products. It prohibits false or misleading labeling and advertising for tobacco products and requires the tobacco industry to submit an application to CTP for new products or products with modified risk claims. This law also gives CTP the authority to set standards for tobacco products that are appropriate for the protection of public health.

4. **The Prevent All Cigarette Trafficking (PACT) Act.** PACT was enacted to limit the illegal sale and transport of cigarettes and other tobacco products. The intent is to reduce and prevent smoking by blocking access to underpriced and untaxed cigarettes and smokeless tobacco products. PACT is also intends to curtail online and mail order sales to underage youth by requiring sellers to verify a customer's age prior to sale by checking databases. The delivery service must also check the age and identification of the person accepting a package containing cigarettes or smokeless tobacco products. PACT is expected to help the government collect more than \$5 billion a year in lost revenue from online and mail order cigarette sales.²⁰
5. **The Patient Protection and Affordable Care Act (ACA).** The ACA requires private insurance plans to cover tobacco cessation treatments, including medications that help people quit smoking. The ACA expands smoking cessation coverage for pregnant women who receive Medicaid and provides Medicare beneficiaries with an annual wellness visit that includes personalized prevention plan services which may include referrals for tobacco cessation services. The ACA also established the Prevention and Public Health Fund; money from this fund will support prevention efforts every year.²¹ HHS distributed \$500 million from the fund in fiscal year (FY) 2010, \$750 million in FY 2011, and \$1 billion in FY 2012.²²

The money was used to target four priorities: community prevention, clinical prevention, public health infrastructure, and research and tracking. In addition, the ACA created the National Prevention, Health Promotion, and Public Health Council and called for the development of the National Prevention Strategy to enhance the benefits of prevention for all Americans' health. The National Prevention Council has identified specific areas in which prevention can be accelerated through the combined efforts of all 17 National Prevention Council departments. One of these areas is a commitment to increase tobacco-free environments within National Prevention Council departments and encourage partners to do so voluntarily, as appropriate.²³

20 Quick, B. (2011). Bans of the Cigarette Trafficking Act. http://www.ehow.com/info_8424012_bans-cigarette-trafficking-act.html

21 HHS. Fact sheet; <http://www.healthcare.gov/news/factsheets/2011/02/prevention02092011a.html>

22 Ending the Tobacco Epidemic: Progress Toward a Healthier Nation. Washington: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Health, August 2012.

23 Ibid

State Initiatives to Reduce Tobacco Use

Common initiatives implemented by states for curbing tobacco use have included:²⁴

- Implementation of comprehensive tobacco control programs;
- Passage of smoke-free indoor air legislation; and
- Increases in excise taxes on cigarettes.

Components of state tobacco-control programs have included:²⁵

State and community interventions:

Statewide efforts to develop a state strategic plan, support coalition development, offer training and technical support, monitor tobacco company influences, implement evidence-based interventions, and support demonstration or research projects.

Community programs that change community knowledge, attitudes, and practices about tobacco use, tobacco promotion, tobacco sales, and exposure to secondhand smoke.

Tobacco-related disparities efforts to identify and eliminate differences in prevention, use, treatment, risk, illness, death, burden, access to resources, and exposure to secondhand smoke.

Youth programs that reshape the environment to support tobacco-free living as normal are implemented across community and school environments, along with increasing the price of tobacco products, making environments smoke-free, restricting youth access, enforcing retailer sales laws, and conducting mass media campaigns.

Collaboration with chronic disease programs for early detection, prevention, and management of chronic diseases related to tobacco use, and for the promotion of tobacco use treatment.

Health Communication Interventions:

Sustained media campaigns combined with other interventions and strategies that educate about health risks of tobacco use, motivate smokers to quit, and create a supportive climate for community efforts in tobacco control.

Cessation Interventions:

Cessation efforts include individual, group, and telephone cessation counseling; medications; and eliminate cost and other barriers to tobacco use treatment.

Surveillance and Evaluation:

Establish surveillance and evaluation systems to monitor and document implementation, effectiveness, and outcomes to inform program and policy direction and to ensure accountability.

Administration and Management:

²⁴ State Tobacco Activities Tracking and Evaluation (STATE) System
²⁵ DHSS. Fact Sheet, Tobacco State, July 2010.

Establish administration and management with sufficient capacity to plan strategic efforts; provide strong leadership; foster collaboration among partners; provide program oversight, technical assistance, and training; and ensure accountability.

The CDC notes that a comprehensive tobacco control program should have four basic goals:

1. Prevent youth and adults from starting to use tobacco (initiation).
2. Eliminate exposure to secondhand smoke.
3. Promote cessation among youth and adults.
4. Identify and eliminate tobacco-related health disparities.

Missouri's strategic plan²⁶ identifies five goals:

1. Prevent tobacco use initiation among young people.
2. Promote quitting among youth and adults.
3. Decrease exposure to secondhand (environmental) tobacco smoke.
4. Identify and eliminate tobacco-related disparities.
5. Build and sustain an effective tobacco control program.

Tobacco Excise Taxes

Raising excise taxes on tobacco has a direct effect on tobacco initiation by youth, and adults' continued tobacco use. Currently all states²⁷ have an excise tax on cigarettes, all but one tax smokeless tobacco and all but three tax cigars. As of the fourth quarter 2012, Missouri has the lowest excise tax on cigarettes at 17 cents per pack and New York has the highest at \$4.35. The median state tax is \$1.36 per pack. Increased tobacco tax has a direct effect on consumption. According to the Congressional Budget Office, it anticipates that a 50 cent increase in the federal tax would, in the years just after the tax increase took effect, lead to a decline in smoking rates by about 5 percent among 12 to 17-year-olds, by 4.5 percent among 18 year olds, by slightly less than 4 percent among 19 to 39 year olds, and by about 1.5 percent among people age 40 or older.²⁸

Smoke-Free Indoor Air Legislation

Forty-eight states have enacted smoke-free indoor air legislation, creating smoke-free indoor environments that include workplaces, restaurants, and bars. In addition to state laws, more than 430 municipalities and local jurisdictions have enacted comprehensive smoke-free policies. Missouri state law requires all public places to prohibit smoking unless designated smoking areas are provided. More comprehensive ordinances for smoke free workplaces, including restaurants and bars have been enacted in 21 communities. Twenty-two percent of Missourians reside in communities with comprehensive smoke free ordinances covering restaurants, bars, and workplaces compared to 49 percent of United States citizens.²⁹

²⁶ <http://health.mo.gov/living/wellness/tobacco/smokingandtobacco/pdf/StrategicPlan.pdf>

²⁷ Including the District of Columbia

²⁸ Congressional Budget Office; Raising the Excise Tax on Cigarettes: Effects on Health and the Federal Budget, June 2012

²⁹ Tobacco Free Missouri, Missouri Communities Indoor Air Quality in Public Places, January 10, 2013

Missouri's Clean Indoor Air Act of 1992 contains a number of exemptions that significantly reduce the intended impact of the law. The consequence of exemptions to the Missouri law is that smoking is permitted in many more workplaces than in other states. A revised Clean Indoor Air Act that expands restricted smoking areas was introduced in the Missouri House and Senate during the 2010 session, but it did not receive a floor vote in either chamber. As shown below, the State Tobacco Activities Tracking and Evaluation (STATE) System reflects that some states, like New York, have a 100 percent ban on smoking in specific locations.³⁰

Missouri Legislation - Smokefree Indoor Air, 2012, 4th Quarter

	Indoor Air Restrictions on Smoking				Penalties	
	Banned (100% Smokefree)	Separated Ventilated Areas	Designated Areas	None	To Business	To Smoker
Government Worksites			X		X	X
Private Worksites			X		X	X
Restaurants			X		X	X
Commercial Day Care Centers	X				X	X
Home-based Day Care Centers	X				X	X

New York Legislation - Smokefree Indoor Air, 2012, 4th Quarter

	Indoor Air Restrictions on Smoking				Penalties	
	Banned (100% Smokefree)	Separated Ventilated Areas	Designated Areas	None	To Business	To Smoker
Government Worksites	X				X	X
Private Worksites	X				X	X
Restaurants	X				X	X
Commercial Day Care Centers	X				X	X
Home-based Day Care Centers	X				X	X

Source: CDC State Tobacco Activities Tracking and Evaluation (STATE) System

Policy Options for Missouri

There are several key strategies that other states with lower smoking prevalence rates have used to substantially reduce their tobacco use rates, tobacco-related health problems and deaths, and the cost associated therewith. Below are options for reducing the toll that tobacco use takes on the lives of Missourians.

Increase State Investment in a Comprehensive Tobacco Control Program

The CDC publishes a "Best Practices Guide" that identifies effective state strategies to reduce tobacco use. This guide has identified the most effective ways to influence tobacco use initiation

³⁰ CDC. State Tobacco Activities Tracking and Evaluation (STATE) System;
<http://apps.nccd.cdc.gov/statesystem/HighLightReport/highlightReport.aspx>

and cessation. These methods include anti-tobacco media campaigns, negative social acceptability of smoking, and limitations on where tobacco use is permitted and how it is accessed.³¹

States that have made larger investments in comprehensive tobacco control programs have seen cigarette sales drop more than twice as much as in the United States as a whole, and smoking prevalence among adults and youth has declined faster as spending for tobacco control programs increased. In Florida, between 1998 and 2002, a comprehensive prevention program anchored by an aggressive youth-oriented health communications campaign reduced smoking rates among middle school students by 50 percent and among high school students by 35 percent.

Between 2000 and 2006, the New York State Tobacco Control Program reported that the prevalence of both adult and youth smoking declined faster in New York than in the United States as a whole. Adult smoking prevalence declined 16 percent, and smoking among high school students declined by 40 percent, resulting in more than 600,000 fewer smokers in the state over the seven-year intervention period.³²

To effectively address tobacco use, the Institute of Medicine (IOM) recommends that each state should fund state tobacco control activities at the level recommended by the CDC. If all states were to fully fund their tobacco control programs at the CDC-recommended level of investment, in five years, an estimated 5 million fewer people would smoke, and hundreds of thousands of premature tobacco-related deaths would be prevented each year. Longer investments will have even greater effects. With fully funded and sustained state tobacco control programs and policies (e.g., increases in the unit price of tobacco products), the IOM's best-case scenario of reducing tobacco prevalence to 10 percent by 2025 would be attainable.³³

Strengthen Missouri's Clean Indoor Air Law

Altogether, there are 22,465 municipalities covered by either local or state 100 percent smoke free laws in at least one of the three main categories (non-hospitality workplaces, restaurants, and bars). Overall, 49 percent of Americans are fully protected by a local or state law requiring workplaces, restaurants, and bars to be smoke-free; only 16 percent of Missourians are covered by similar smoke free local laws.³⁴ The Missouri State Clear Indoor Air law could be strengthened to include comprehensive provisions that protect more workers from exposure to secondhand smoke by prohibiting smoking indoors in all workplaces, restaurants, bars, and casinos.

Increase the State Tobacco Taxes

Missouri has not raised its tobacco tax since 1999. If Missouri significantly raised its tobacco tax to the national median and experience in other states translated to Missouri, the state would see significant declines in tobacco use and generate more resources to implement a statewide comprehensive tobacco control program. While it is true that more people would stop smoking in response to the increased tax, the total revenue would significantly exceed current levels. Missouri's tax is currently 17 cents per pack. Raising the cigarette tax to \$1.45 per pack would

31 Butterfoss FD, Goodman RM, Wandersman A. Community coalitions for prevention and health promotion. *Health Education Research*. 1993;8(3):315- 330.

32 CDC. Best Practices for Comprehensive Tobacco Control Programs—2007. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health; October 2007.

33 Ibid

34 Americans for Nonsmokers Rights Foundation: <http://www.no-smoke.org>

result in a 28 percent increase in the cost per pack of cigarettes. This would lead to approximately an 11 percent decrease in consumption, resulting in 63 million fewer packs of cigarettes sold. State revenues would total \$622 million.

It should be noted that the Hancock amendment limits the state's ability to raise taxes. In 1980, a Springfield businessman began an initiative petition drive in support of a constitutional amendment that would limit state and local government taxation and spending. That amendment was adopted by the voters on November 4, 1980. It is generally known as the Hancock amendment, after the principal advocate Mel Hancock, and can be found in Article X, Sections 18-24 of the Missouri Constitution. Section 18(e) prohibits the General Assembly from increasing taxes or fees in any fiscal year that would produce "new annual revenues" in excess of either \$50 million or 1 percent of total state revenue for the second fiscal year before the General Assembly's action, whichever is less.³⁵

Given this constitutional amendment, the Missouri legislature is limited to increasing the tobacco tax by no more than 17 cents per pack per year, which would generate \$92 million in revenue.

Other Options

The following options are additional policy considerations that could be implemented in Missouri:

1. Restrict advertising and promotion of tobacco products by banning outdoor advertising, prohibiting advertising in publications targeted to youth, and prohibiting point of sale advertising of tobacco products;
2. Prohibit tobacco brand name sponsorship of sporting or entertainment events;
3. Offer free tobacco cessation and nicotine replacement products through the Missouri Tobacco Quit-Line, a toll-free telephone line with counseling and nicotine replacement for persons wanting to quit smoking;
4. Increase education efforts about the dangers of chewing tobacco, loose leaf, and snuff tobacco; and
5. Assist the relatively small number of tobacco farmers in their transition to the growth of non-tobacco crops.

Implications

If Missouri were to reduce its smoking rates by 10 percent, there would be fewer deaths and less disability, lower health care costs, and a more productive workforce. Specifically:

- More than 1,000 lives could be saved per year;
- Missouri's Medicaid program would recoup \$23 million in five years;³⁶
- Private employers would stand to save millions, as 72 percent of Missourians are privately insured through their employers;
- Employers would spend an average of \$2,189 less per smoking employee for health-related workers' compensation costs;³⁷

35 Hembree, R. (2004). The Hancock Amendment: Missouri's Tax Limitation Measure, [Report 49-2004]. Retrieved from <http://ipp.missouri.edu/uploads/Publications/MLA%2049-2004.pdf>.

36 American Legacy Foundation Saving Lives, Saving Money II: Tobacco-free States Spend Less on Medicaid. p 12

- Employers would gain 18 days of productivity per year per employee for persons who no longer take smoking breaks;³⁸
- Absenteeism would also be reduced, as smokers have a 60 percent higher absenteeism rate than non-smokers.³⁹

37 Musich, S. Napier, D. Edington, D.W. The Association of Health Risks with Workers' Compensation Costs. *Journal of Occupational and Environmental Medicine*. 43(6): 534-541, June 2001.

38 Action on Smoking and Health, March 1994.

39 Halpern, MT. Shikar, R Rentz, A.M. : Khan, Z.M., Impact of Smoking Status on Workplace Absenteeism and Productivity. *Tobacco Control* 10 (3) : 233-238, September 2001.

Section **12**

**Transforming Missouri Medicaid:
Federal Waiver Options
and Processes**

Issue Statement

Medicaid and the Children's Health Insurance Program (CHIP) are important sources of financing for health care services for low-income Missouri adults and children. Both programs are financed jointly by the state and federal governments and are operated by states under federal guidelines set forth in law, regulation, and policy letters issued by the Centers for Medicare and Medicaid Services (CMS), the federal agency that oversees these programs.

Under waiver authority created by Congress, CMS can grant a state's request to deviate from statutory and/or regulatory requirements that may stand in the way of service expansion or innovation. While the Deficit Reduction Act of 2005 (DRA) and the Patient Protection and Affordable Care Act of 2010 (ACA) provided new state options that eliminate the need to seek waiver authority in certain circumstances, waivers continue to be an important tool for states seeking to implement other innovative service, payment, and delivery system reforms.

Background

All states, including Missouri, operate one or more Medicaid waiver programs that generally fall into three main categories authorized under various sections of the Social Security Act: 1) Section 1115 research and demonstration waivers; 2) Section 1915(b) "freedom of choice" waivers, and 3) Section 1915(c) home and community-based services (HCBS) waivers. Each of these waiver types is discussed below, including the provisions of law that can be waived under each type, how budget limits are calculated, the process for obtaining a waiver, and the timelines involved in seeking and renewing waivers.

All waivers must be designed to ensure that federal costs under the waiver will not be greater than the federal costs would have been in the absence of the waiver – referred to as "budget neutral," "cost neutral," or "cost-effective" depending upon the waiver type. Medicaid requirements that can be waived include (but are not limited to):

- *Statewideness*: Medicaid benefits must be available to all eligible individuals, regardless of where they live within the state.
- *Freedom of choice*: Medicaid beneficiaries may seek care from any provider who accepts Medicaid.
- *Comparability*: States must offer a consistent benefit package across all of the different eligibility groups that are covered in the Medicaid program.

There are some Medicaid program elements, however, that cannot be waived, such as the federal matching payment formula.

Section 1115 Research and Demonstration Waivers

Purpose

Section 1115 waiver authority is the broadest form of waiver authority and is used for experimental, pilot, or demonstration projects designed to test innovative approaches to delivering care in Medicaid or CHIP. When an approach has been tested and proven to be

effective under Section 1115 authority (such as managed care), Congress has sometimes acted to make it easier for states to adopt the approach in the future without a waiver. Section 1115 waivers have been used in both Medicaid and CHIP over the years to accomplish a number of public policy goals, such as:

- Expanding Medicaid or CHIP eligibility to additional low-income uninsured individuals;
- Lowering the Medicaid birth rate by providing free family planning services to women who would not otherwise be eligible;
- Testing new service delivery models, and
- Allowing for consumer-directed long-term care.

Following a slowdown in Section 1115 waiver activity in 2009 and 2010 when attention shifted to national health reform, state interest in Section 1115 waiver requests has rebounded reflecting both the new opportunities and priorities created by the ACA as well as a continued focus on efforts to limit Medicaid costs as state budgets continue to struggle with a weak economy.¹ Common themes found in many of these recent Section 1115 waiver requests include:

- Preparing for the ACA Medicaid coverage expansion in 2014² by expanding coverage early and simplifying enrollment processes;
- Expanding managed care delivery systems to high-need elderly and disabled individuals and adding services to managed care arrangements, including long term services and supports;
- Supporting safety-net delivery system improvements; and
- Restructuring payment and delivery systems.³

Missouri currently has two Section 1115 waivers in effect: 1) a family planning waiver, originally approved by CMS in 1998, that provides only family planning services to women losing Medicaid eligibility after the birth of a child, and 2) the “Gateway to Better Health” waiver designed to preserve St. Louis County and City safety net health care services available to the uninsured until new ACA-related coverage is available in 2014. The Gateway to Better Health waiver was approved in July 2010 and was scheduled to expire on December 31, 2013. The Missouri Department of Social Services (DSS) received a one-year extension of this waiver.⁴

What can be waived

Unlike the other waiver authorities, Section 1115 places few limits on the waiver discretion of the Secretary of the U.S. Department of Health and Human Services (HHS) which has allowed states to use Section 1115 waivers to pursue a wide variety of waiver initiatives. The Secretary may waive anything in Section 1902 of the Social Security Act (SSA), which describes how

1 S. Artiga, “An Overview of Recent Section 1115 Medicaid Demonstration Waiver Activity,” Kaiser Commission on Medicaid and the Uninsured, May 2012.

2 Effective in 2014, the ACA expands Medicaid eligibility up to 133 percent of the federal poverty level for all non-Medicare, under-65 individuals. As a result of the Supreme Court’s 2012 ruling in *National Federation of Independent Business v. Sebelius*, this expansion is now optional for states.

3 Ibid.

4 St. Louis Regional Health Commission. Gateway to Better Health Program Extended to 2015, September 28, 2013; at <http://www.stlrhc.org/work/gateway-better-health-demonstration-project/gateway-better-health-program-extended-2015/>.

states must run their Medicaid programs. Also, the Secretary can essentially “waive” Section 1903, which describes the items that can be reimbursed under Medicaid. This means costs that could not ordinarily be reimbursed by Medicaid can be covered using Section 1115 authority, including coverage for ineligible groups (e.g., non-disabled adults without dependent children prior to the implementation of the ACA Medicaid expansion in 2014). Some requirements cannot be waived including those described in a section of the statute not affected by Section 1115, or where the SSA explicitly states that the requirement cannot be waived. One example is coverage for certain immigrants.

Budget neutrality

Section 1115 budget neutrality requirements are not set forth in statute but have evolved, instead, in policy statements. In general, federal costs under the waiver may not exceed what federal costs would have been without the waiver. To enforce this requirement, the federal government places a cap on federal matching funds over the term of the waiver, placing the state at risk for all waiver costs above the cap. For groups covered under the waiver that could have been covered without a waiver (e.g., parents) a per capita cap is often applied so that the state is at-risk for higher than anticipated per person costs but not at-risk for higher than expected enrollment. However, for costs that could not be incurred under the standard Medicaid program (e.g., costs for non-disabled childless adults), the state must identify offsetting savings, such as funds that would otherwise be paid to hospitals under the Medicaid program for uncompensated care. Because the mechanics of measuring budget neutrality are not set forth in law, this is often an area of intense negotiation between the state and federal government.

The above discussion relates to budget neutrality in the Medicaid context. For the CHIP program, there is no budget neutrality requirement, since each state’s CHIP funds are limited to a statutory allotment. The only requirement for CHIP is that the waiver and the regular state CHIP program do not exceed the state’s allotment. If the state runs out of money in its CHIP allotment, the basic CHIP program has to be funded before the waiver program.

Process

Unlike the other waiver authorities, there is no required time frame for federal review and decision making on Section 1115 waiver proposals. Because of the amount of negotiation that is often required on budget neutrality and on programmatic issues (e.g., benefit package or cost sharing), years have passed between a state’s waiver application and CMS’s decision. Effective April 2012, however, new regulations⁵ mandated by the ACA have established a process for ensuring public input into the development and approval of new Section 1115 waivers (and waiver extensions) attempting to address a historic concern regarding the lack of public transparency in the waiver process. The new regulations set forth a series of steps that states will need to complete during the application process as well as the steps CMS will take once an application has been submitted. These steps include public notice and hearing requirements for the state prior to application and a requirement for a post-award implementation forum that the state must convene at least six months after CMS approval to solicit public comments on implementation. CMS is also required to post state applications on its website for a 30-day comment period. To facilitate meaningful public input, demonstration application requirements

5 See 42 CFR Part 431, Subpart G.

are standardized and CMS has also developed an interim application template. If a state chooses not to follow the template, the state remains responsible for ensuring that its application is complete and contains all required elements.⁶ In 2013, CMS implemented a web-based system that states can use to submit Section 1115 waiver applications electronically that is intended to streamline the application process and CMS review of pending applications.

Timing

Section 1115 waivers are approved for a five-year period. The waivers can typically be extended for three years at a time. Some Section 1115 waivers have been repeatedly extended allowing them to remain in place for many years.⁷ Many ACA-related waivers were scheduled to expire prior to January 1, 2014.

Section 1115A waivers for dual eligible demonstrations

The ACA created a new Center for Medicare and Medicaid Innovation (CMS Innovation Center) within HHS and provided new waiver authority under Section 1115A to test innovative health care payment and service delivery models, including models that allow states to test and evaluate fully integrating Medicare and Medicaid-funded care for persons dually eligible for Medicare and Medicaid (“dual eligibles”). The ACA also created the Federal Coordinated Health Care Office (also known as the Medicare-Medicaid Coordination Office) which announced the “Financial Alignment” initiative in July 2011 to test two financial models – a capitated model and a managed fee-for-service model – to improve care for dual eligibles. Working with the CMS Innovation Center, the Medicare-Medicaid Coordination Office invited states to apply to test one or both of these models under Section 1115A waiver authority. As of January 2013, 22 states, including Missouri, are working with the Medicare-Medicaid Coordination Office on demonstrations that would begin in 2013 or 2014. Missouri’s proposal would test the managed fee-for-service model by allowing the state to share in Medicare savings that are expected to result from the state’s two Medicaid health home programs.⁸

Section 1915(b) Freedom of Choice Waivers

Purpose

Section 1915(b) freedom of choice waivers allow states to require Medicaid beneficiaries to receive services from a limited set of providers, usually in managed care arrangements. These managed care arrangements can include a comprehensive set of services or can be limited to particular service types such as behavioral health or dental services. Because managed care plans are required to provide their enrollees guaranteed access to an adequate network of doctors, hospitals, and other providers, managed care arrangements can be important tools to improve access to care. Outside managed care, access to care is not always assured as beneficiaries sometimes have difficulty locating a doctor or other provider who is willing to

6 See Section 1115 Demonstration Program Template, accessed on January 7, 2013 at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/Fillable-1115-Demo-10-12v2.pdf>.

7 S. Artiga, “An Overview of Recent Section 1115 Medicaid Demonstration Waiver Activity,” Kaiser Commission on Medicaid and the Uninsured, May 2012.

8 Financial Model to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees Managed Fee-For-Service, Demonstration Proposal, submitted by Missouri Department of Social Services, MO HealthNet Division on May 31, 2012, accessed on January 7, 2013 at <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MOPProposal.pdf>.

accept Medicaid patients. Medicaid managed care plans are also held to quality of care standards, such as requirements to identify individuals with chronic diseases and link them with needed care, and targets for preventive health screening. In addition, there are enrollee protections including the right for enrollees to change managed care plans if the care provided is not adequate. These rules cannot be waived under Section 1915(b).

In addition to managed care arrangements, states may also request waiver authority under Section 1915(b)(4) to “selectively contract” for certain services (for example, medical supplies or durable medical equipment) and require Medicaid beneficiaries to obtain those services only from contracted providers. A state would typically designate a service area and solicit bids from interested providers to promote competition and thereby obtain high quality services at the lowest possible price.

Missouri currently operates one 1915(b) waiver – the MO Healthnet Managed care waiver – that provides for capitated managed care contracts with health plans in certain Missouri counties.

What can be waived

There are three general Medicaid requirements that can be waived under Section 1915(b):

- *Statewideness:* Under Section 1915(b), a state can have a different managed care program design in different areas or limit the availability of managed care on a geographic basis. This flexibility recognizes that it may not be possible to have a managed care network, or a sufficient choice of plans, in all areas of a state.
- *Freedom of choice:* States may restrict beneficiaries’ freedom of choice of providers to those in the managed care network, with certain exceptions. Medicaid managed care regulations require, for example, that beneficiaries have access to family planning services from any in-network or out-of-network provider.
- *Comparability:* The comparability of service requirement may be waived for the express purpose of allowing managed care plans to offer benefit enhancements. Common examples of additional benefits include smoking cessation classes and weight loss programs.

Cost effectiveness

As mentioned above, every waiver authority has its own budget test. Under Section 1915(b), the underlying principle is that managed care should be “cost effective” when compared with standard fee-for-service (FFS) Medicaid. Previously, CMS required states to compare their costs under Section 1915(b) managed care programs with the FFS costs for the same benefits provided to an equivalent population. However, in states where there has been widespread use of managed care for a number of years and recent FFS data is limited, cost-effectiveness is calculated by demonstrating that cost growth in the Section 1915(b) waiver program is within reasonable projected levels.

Process

CMS has 90 days to approve or deny a Section 1915(b) waiver request, but may “stop the clock” with a request for additional information. Once the state formally responds to the request, a second 90-day clock begins. It is not unusual for states and CMS to have many informal

conversations before the clock restarts, in the interest of developing a response that renders the application approvable. Section 1915(b) waivers are submitted on an application template designed by CMS.

Timing

Section 1915(b) waivers must be renewed every two years.

Section 1915(c) Home and Community-Based Services Waivers

Purpose

Section 1915(c) waivers are used to offer home and community-based services (HCBS) as an alternative to institutional care. Services such as respite care, adult day care, home modifications, and Meals on Wheels are used to avoid or delay placement in a nursing home or other institution such as a hospital or intermediate care facility for individuals with intellectual disabilities (ICF-ID). Section 1915(c) has been an important tool in attacking the so-called “institutional bias” in Medicaid caused, in part, by the fact that in many states, a more generous income eligibility threshold is used for individuals who live in an institution than for those who live in the community. Examples of groups that states elect to serve under Section 1915(c) waivers are the elderly, the disabled, and individuals with intellectual disabilities, a traumatic brain injury, or severe mental illness.

To be eligible for Section 1915(c) waiver services, an applicant must meet the state’s institutional “level of care” criteria by demonstrating the need for help performing direct care tasks due to a functional, cognitive, or medical impairment. Unlike other Medicaid services, HCBS waivers can be limited to a set number of clients, and states can maintain waiting lists. A notice of proposed rulemaking published by CMS in April 2011,⁹ if adopted, would provide state flexibility to serve more than one target group in each 1915(c) waiver, but would also define HCBS service settings to require that they be integrated in the community and not located in a building that is also a facility that provides institutional or custodial care or located on the grounds of, or immediately adjacent to, a public institution. The notice contains other criteria for determining whether a proposed HCBS setting is institutional in nature.

Missouri currently operates ten Section 1915(c) waivers.

What can be waived

The Medicaid statewideness and comparability requirements can be waived as well as the rules surrounding income eligibility for individuals living in the community. This means states can use the same income standards for community-based individuals as they do for those in an institution such as a nursing home.

Cost neutrality

The budget test for Section 1915(c) waivers compares the cost of institutional care with HCBS services. In other words, the state must demonstrate that it costs no more to deliver care under the waiver than would be the case if the individuals were served in institutions. Based

⁹ “Medicaid Program; Home and Community-Based Services (HCBS) Waivers, Proposed Rule.” Federal Register 76 (April 15, 2011): 21311-21317.

on the population that is served under the waiver, the basis of comparison can be nursing home costs, hospital costs (such as for children with mental illness), or ICF-ID costs. States can choose whether to apply this test on a person-by-person basis or in the aggregate across the entire waiver.

Process

The process for review and approval of Section 1915(c) waivers is the same as for 1915(b). These waivers are submitted on a web-based template designed by CMS.

Timing

Initial approval of Section 1915(c) waivers is for three years; renewals are for five years. For waivers that will include dual eligibles, the ACA provided new authority for states to request an initial five-year waiver term. This provision can be an important tool for states wishing to simplify the operation of waivers that serve dual eligibles, especially if a state is combining waiver authorities that have different approval periods.

State Plan HCBS Services

The DRA provided a new option for states to provide HCBS services under their Medicaid State Plan without seeking a Section 1915(c) waiver – the Section 1915(i) HCBS state plan option. Thus far, however, Section 1915(i) has had limited impact. To make it more attractive to states, the ACA amended Section 1915(i) to allow states the option of providing services to individuals with incomes up to the higher institutional income level – i.e., 300 percent of the Supplemental Security Income (SSI) Federal benefit rate (FBR)¹⁰ – but removed the ability of states to cap enrollment (as is possible under Section 1915(c) waivers) making it less attractive to states from a fiscal perspective.

Combination 1915(b)/(c) Waivers

Waivers under Sections 1915(b) and 1915(c) can be used jointly. A state can use a combination waiver to provide home and community-based care in a managed care environment. However, states must apply for and operate two separate waivers resulting in separate reporting, renewal and other requirements that may complicate administration of the program. As noted above, however, the ACA provided new authority to seek initial five-year waiver terms (for all waiver types) if dual eligibles are included which addresses one area of conflict for 1915(b)/(c) combination waivers.

Implications

As noted above, waivers can allow states to pursue objectives that would not otherwise be permitted under federal law and regulation. Waivers have become commonplace, particularly those that allow for mandatory enrollment in managed care and those that allow HCBS services for individuals who would otherwise require institutional care. Even Section 1115 waivers have seen widespread use for both acute care and long-term care services and supports and have been, by far, the most powerful tool in a state's arsenal for covering the uninsured. The implementation of ACA health coverage expansions in 2014 through health insurance exchanges

¹⁰ \$2,130 monthly income per individual in 2013.

Section 13

**Assuring an Adequate Health Care
Workforce in Missouri's Medically
Underserved Areas**

Issue Statement

This issue brief addresses two issues:

- 1) Missouri's health care workforce and the challenges Missouri faces in maintaining an adequate health care workforce to meet the needs of rural and other medically underserved areas.
- 2) Provisions in the 2010 health reform law that are designed to expand the supply and distribution of appropriately trained health care professionals to eliminate health care workforce shortages in medically underserved areas.

Background

Many states with sizable rural populations, like Missouri, struggle to attract and maintain an adequate supply of medical providers, including nurses, primary care physicians, specialists, mental health professionals, and dentists. Missouri has made numerous efforts to attract and retain health care professionals in rural and other underserved areas, with varying degrees of success. With the passage of the Patient Protection and Affordable Care Act (ACA) in 2010 and the Supreme Court's validation of the constitutionality of the majority of the legislation in 2012, Missouri has additional opportunities to leverage federal resources to expand the availability of providers to work in medically underserved areas

Demographic shifts in the U.S. raise concerns about the future supply and distribution of adequately trained health care workers that are needed to meet the health care needs of aging and increasingly diverse populations, particularly in rural and medically underserved areas. There is widespread concern that the health care workforce shortage will continue to grow. The adverse effects of that shortage will be exacerbated as the aging population increases from 13 percent in 2010 to an estimated 19 percent in 2030.¹ Not only does an aging population require additional health care resources, but this also means that many health care professionals will be retiring. This double-edged sword has significant implications for health care throughout the U.S. and especially in states with large rural and medically underserved populations, like Missouri.

From 2000 to 2010, the U.S. population age 65 and older grew by 15.1 percent to over 40 million.² Similarly, in Missouri, the elderly population grew by almost 100,000 from 2000 to 2011; they make up 14.2 percent of Missouri's population. In rural areas of Missouri, 15.6 percent of the population is elderly, compared to 13.5 percent in urban areas.³ Nationally, 14.4 percent of rural residents are elderly, compared to 12.9 percent of urban residents, and that percentage is expected to grow as more Baby Boomers turn 65.⁴

The number of people of Hispanic descent who live in rural areas of the U.S. is also growing rapidly.⁵

1 Population Reference Bureau. June, 2010. Today's research on aging. Available: <http://www.prb.org/pdf10/TodaysResearchAging19.pdf>

2 United States Census Bureau. November, 2011. 2010 Census briefs, the older population: 2010. Available: <http://www.census.gov/prod/cen2010/briefs/c2010br-09.pdf>

3 United States Census Bureau. 2012. American Fact Finder. Available: <http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml>

4 Ibid.

5 Cromartie, J. December, 2011. Hispanics contribute to increasing diversity in rural America. Economic Research Service, Amber

These demographic changes present significant challenges for areas that already have health care professional shortages.

Missouri's Health Care Workforce

Health care plays a significant role in Missouri's economy. The fiscal year (FY) 2013 budget for the Missouri Department of Health and Senior Services (DHSS), including federal and state funds, is over \$1 billion.⁶ In 2011, 10 percent of Missouri's workforce—about 300,000 people⁷—was employed in the health care sector; the U.S. rate was 9.2 percent.⁸ In addition, Missouri is a national leader in annual medical school graduates. While the state comprises less than 2 percent of the nation's total population, it produces 2.8 percent of the medical school graduates in the U.S.⁹

Supply of Health Care Professionals

With an August 2012 estimated primary care underserved population of over 35 million,¹⁰ the U.S. currently has a significant shortage of health care practitioners. Missouri has a similar problem, with close to 1.5 million primary care underserved Missourians and an estimated 643 practitioners needed to achieve the target population-to-practitioner ratio of 2,000:1. Compared to the rest of the U.S., Missouri has lower per capita rates of physician assistants and dentists but is well above national rates for nursing professionals (registered nurses and nurse practitioners).¹¹

- *Physicians and Physician Assistants:* Missouri had 282 professionally active physicians per 100,000 in 2012 (based on 2011 total population estimates)¹² compared to 269 per 100,000 for the U.S. Missouri had 133 primary care physicians per 100,000, compared to a U.S. rate of 128 per 100,000. With only 13 physician assistants per 100,000 compared to the U.S. rate of 27, Missouri ranked 48th among all states in 2010. Like the U.S., Missouri has more specialist physicians than primary care physicians; 53 percent of all Missouri physicians are specialists.¹³
- *Dentists:* Based on population estimates for 2011, Missouri had 50 dentists per 100,000, while the U.S. had 64 dentists per 100,000 in 2012.¹⁴
- *Nursing Professionals:* Missouri's nursing workforce is stronger than the U.S. overall. In 2011, Missouri ranked 7th in the proportion of registered nurses, with a rate of 1,125 per 100,000 population. By comparison, the U.S. rate was 874 per 100,000. Missouri also

Waves. Available: <http://www.ers.usda.gov/amber-waves/2011-december/hispanics-contribute-to-increasing-diversity.aspx>

6 Missouri Office of Administration. 2012. FY 2013 Budget Information. Available: <http://oa.mo.gov/bp/facts2013.htm>

7 This number includes Allied Health, Dental, Health Administration, Mental Health, Nurses, Pharmacy, Physical Therapy, Physicians and Support, Public Health and Vision. Data is not inclusive of all Missourians who work in health care. Bureau of Labor Statistics. 2010. Occupational Employment Statistics Survey. HRSA. Available: <http://hws.hrsa.gov/default.aspx>

8 Kaiser Family Foundation (KFF). 2012. State Health Facts. Available: <http://statehealthfacts.org/index.jsp>

9 Ibid.

10 The Estimated Underserved Population is computed by multiplying the number of primary care physicians in the Health Professional Shortage Area (HPSA) by the target population-to-practitioner ratio (2,000:1), and subtracting this figure from the total HPSA population.

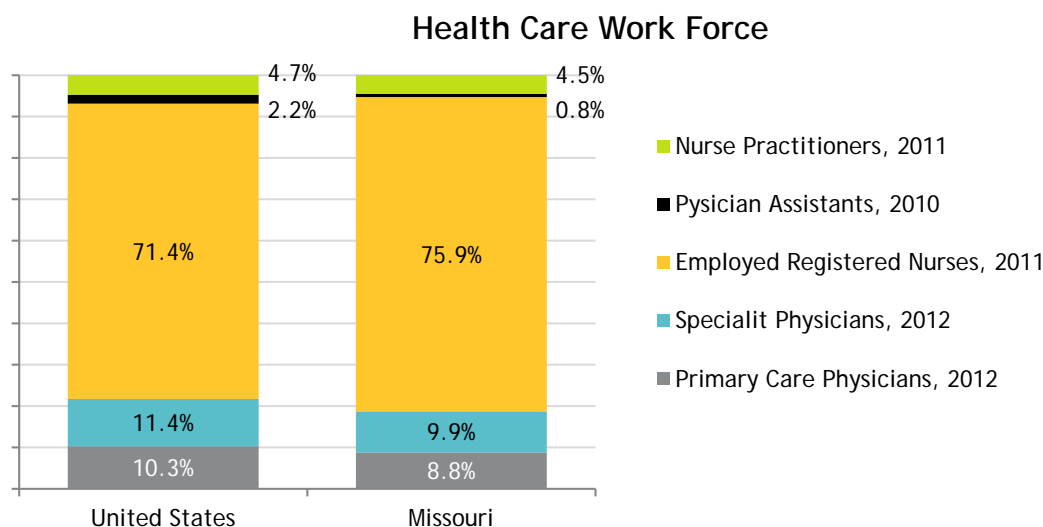
11 KFF, 2012.

12 For consistency, we have used KFF's 2011 population estimates for Missouri, 5,914,600; and the U.S., 307,891,500. The U.S. Census Bureau estimates Missouri's 2011 population to be 6,010,688 and the U.S. 2011 population to be 311,591,917.

13 Ibid.

14 Ibid.

ranked 16th in the proportion of nurse practitioners, with 67 per 100,000, compared to the U.S. rate of 58 per 100,000. While Missouri has a higher number of nurse practitioners relative to the nation, Missouri's nurse practitioners have a more limited scope of practice in diagnosing and treating patients than the majority of other states because of state scope-of-practice laws.¹⁵ In January 2012, HB 1371, a bill to remove many of the current restrictions on nurse practitioners, was introduced in the Missouri legislature; however, it did not pass.¹⁶



Source: Kaiser Family Foundation.¹⁷

To more completely understand the supply of health care workers in Missouri, DHSS has launched the Missouri Workforce Registry and Exchange.¹⁸ The Registry has been fully operational for less than one year, and data is collected on a voluntary basis. As the Registry grows, this information will help the state to better understand worker shortages and barriers to accessing services as a result of these shortages.¹⁹

Health Professional Shortage Areas

Health Professional Shortage Areas (HPSAs)²⁰ are areas designated as having a shortage of primary care, dental, or mental health providers based on federal criteria for population-to-practitioner ratios. Geographic areas designated as primary care HPSAs have a population-to-practitioner ratio (full time equivalent) greater than 3,500:1. A dental HPSA is designated by a population-to-practitioner ratio greater than 5,000:1. A mental health HPSA has a population-

¹⁵ Ibid.

¹⁶ Joiner, R. May 11, 2012. Missouri legislature refuses to loosen reigns on nurse practitioners. STL Beacon. Available: https://www.stlbeacon.org/#!/content/24975/nurse_practitioner_bill_mo_legis

¹⁷ KFF. 2012.

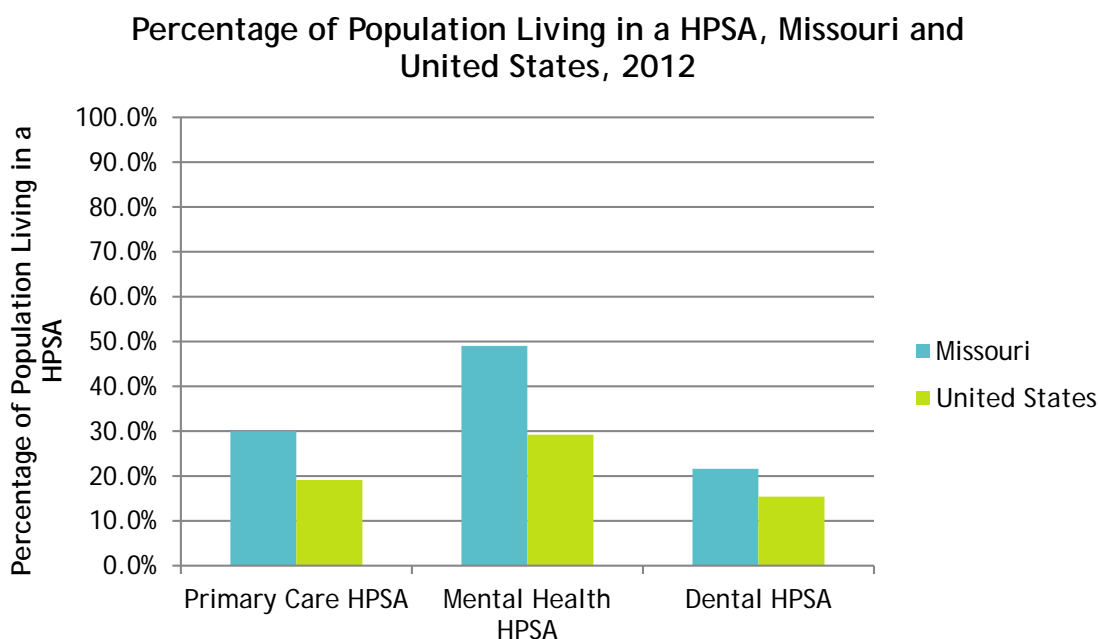
¹⁸ Missouri Department of Health and Senior Services (DHSS). 2012. Missouri healthcare workforce registry and exchange. Available: <http://www.health.mo.gov/professionals/>

¹⁹ E-mail correspondence with Lee Temmen, Office of Primary Care and Rural Health, Missouri Department of Health and Senior Services. December 18, 2012.

²⁰ HPSAs can be designated based on a geographic area, population group, or facility. Full definition available: <http://bhpr.hrsa.gov/shortage/hpsas/designationcriteria/primarycarehpsaoverview.html>

to-core-mental-health-professional ratio that is at least 6,000:1 and a population-to-psychiatrist ratio that exceeds 20,000:1.²¹

In 2012, 30 percent of Missourians were estimated to be living in a primary care HPSA. The estimate for the percentage living in a dental HPSA was much lower at 21.6 percent. U.S. rates are much lower: 19.1 percent and 15.4 percent, respectively. Almost 3 million people—about half of Missouri's population—lived in a mental health HPSA, compared to less than one third of the total U.S. population.²²



Source: Kaiser Family Foundation.²³

Health Care Workforce Shortages in Missouri's Rural Communities

According to the 2010 U.S. Census, 29.6 percent of Missourians live in a rural area,²⁴ but only 18 percent of primary care physicians in Missouri are located in rural areas. Additionally, 29 counties in Missouri, all rural, are designated as HPSAs.²⁵

Contributing Factors to Shortages of Health Professionals in Rural Communities

While many inner city areas also face health care provider shortages—often related to high density, poverty, and crime—rural areas face different challenges that contribute to the shortage of health professionals. They include:

21 Health Resources and Services Administration (HRSA). 2012. Shortage designation: professional shortage areas and medically underserved areas/populations. Available: <http://bhpr.hrsa.gov/shortage/index.html>

22 KFF. 2012.

23 KFF. 2012.

24 Definitions of rural and urban vary. For example, the Missouri Office of Primary Care uses a different definition of rurality which includes 37% of all Missourians. Here we use the U.S. Census definition: any population, housing, or territory that is not urban (urban is defined as at least 2,500 people, at least 1,500 of which reside outside institutional group quarters. U.S. Census Bureau. May 15, 2012. 2010 Census Urban and Rural Classification and Urban Area Criteria. Available: <http://www.census.gov/geo/www/ua/2010Urbanruralclass.html>

25 Office of Primary Care and Rural Health. 2010-2011. Missouri Rural Health Biennial Report 2010-2011. Available: <http://health.mo.gov/living/families/ruralhealth/pdf/biennial2011.pdf>

- An aging workforce;
- Lack of educational and training opportunities;
- Difficulty in recruiting and retaining health care providers;
- High turnover and vacancy rates;
- Lack of opportunities for career advancement;
- Increased work load demand;
- Lack of necessary health resources (e.g., specialty services); and
- Inability for rural towns to financially support full-time health care professionals.²⁶

Efforts to Expand Missouri's Rural Workforce

Several efforts have been under way in Missouri to increase the number of health care professionals practicing in rural areas. Major initiatives are described below.²⁷

- *Rural Track Pipeline Program*: The University of Missouri School of Medicine partnered with the local Area Health Education Center (AHEC) in 1994 to develop a comprehensive Rural Track Pipeline Program. The program is designed to attract future physicians to practice in rural areas. A key component of the program is the Rural Scholars Program (i.e., Bryant Rural Scholars Program), which recruits students from rural areas who are interested in practicing rural medicine. The Rural Scholars Program waives the MCAT admission requirement and also provides scholarship funding to students.²⁸

While data is somewhat limited, analysis of the Rural Track Pipeline Program has yielded promising results. Research shows that Rural Scholars were more than twice as likely to match into a Family Medicine program as their classmates, and over 57 percent of the students who participated in the Rural Scholars Program chose a rural location for their first practice.²⁹

- *Partnership with National Health Service Corps (NHSC)*: Missouri partners with the NHSC to award scholarships and loan repayment to primary care providers. According to the DHSS Office of Primary Care and Rural Health, Missouri is currently second in the nation in approved NHSC sites and loan repayment providers.³⁰ Missouri has 651 NHSC sites and 452 NHSC providers.³¹
- *Primary Care Resource Initiative for Missouri (PRIMO)*: PRIMO was created in response to 1993 legislation in Missouri to address health care issues in Missouri. The FY 2012

26 Office of Primary Care and Rural Health. 2010-2011.

27 Lee Temmen assisted in identifying initiatives in Missouri to increase the health care workforce. Op. cit.

28 University of Missouri School of Medicine. December 13, 2012. Area Health Education Center. Available: <http://medicine.missouri.edu/ahec/>

29 Quinn, K. et al. November, 2011. Influencing residency choice and practice location through a longitudinal rural pipeline program. *Academic Medicine*. 2011;86(11):1397-1406.

30 Lee Temmen. Op. cit.

31 NHSC. December 20, 2012. State-by-state guide. U.S. Department of Health and Human Services. Available: <http://nhsc.hrsa.gov/ambassadors/states/index.html>

budget for PRIMO included \$1.385 million to fund initiatives including health care delivery (e.g., funding to Federally Qualified Health Centers), student loan forgiveness, recruitment and placement, and state loan repayment. These initiatives are targeted towards rural and underserved areas, including HPSAs. In FY 2012, PRIMO successfully placed 15 health care professionals at sites located in HPSAs, including 3 family practice physicians, 2 internal medicine physicians, 3 advanced practice nurses, 1 dental hygienist, and 6 dentists.³² PRIMO also partners with the Missouri Primary Care Association to aid in recruiting and retaining health care professionals using the Association's MO Health Professional Placement Services (MHPPS).³³

Federal Health Care Reform

As a result of federal health care reform, states have more opportunities to pursue strategies to address the professional factors that may inhibit health professionals from practicing and permanently locating in rural or other underserved areas. The purpose of Title V of the ACA is to expand and retain a qualified health care workforce that can respond adequately to the health and medical needs of all Americans, with priority established for vulnerable populations including older adults, children, and the chronically ill and their families. Within these provisions, the ACA calls for tens of millions of dollars in federal grants and funding for improvements and demonstration projects.³⁴

Innovations in the Health Care Workforce

The ACA promotes health care workforce innovations through the establishment of a national health care workforce commission to coordinate efforts among federal agencies (Section 5101). The law establishes a grant program for states to plan and implement activities leading to health care workforce development strategies, with up to \$150,000 available per state partnership (Section 5102). Missouri was awarded the full grant amount in 2010, 2011, and 2012 to help recruit health care professionals, including mental health professionals, to HPSAs in Missouri.³⁵

Increasing the Supply of the Health Care Workforce

A major strategy for increasing the supply of health care professionals across the U.S. is an expansion of funding for the aforementioned NHSC in the amount of \$1.5 billion over five years, beginning in 2011 (Section 5207). This funding extended the Corps' student loan, loan repayment, and loan forgiveness programs. Eligibility for these benefits is based on serving a minimum number of years in HPSAs. As a result of the increased funding, the number of clinicians in the NHSC has almost tripled, from 3,600 in 2008, to almost 10,000 in 2012.³⁶

Enhancing Health Care Workforce Education and Training

The ACA provides an array of health workforce education and training opportunities. For example, grants are available to develop and operate training programs, provide financial

32 PRIMO. December 20, 2012. Missouri Department of Health and Senior Services. Available:

<http://www.health.mo.gov/living/families/primarycare/primo/index.php>

33 Missouri Primary Care Association. December 20, 2012. Available: <http://www.mo-pca.org/>

34 Unless otherwise referenced, descriptions of the provisions of the ACA in this brief have been summarized by HMA from the published legislation. Available: <http://housedocs.house.gov/energycommerce/ppacacon.pdf>

35 HRSA. December 17, 2012. Missouri grant awards. Available: <http://granteefind.hrsa.gov/Search.aspx>

36 HRSA. December 18, 2012. National Health Service Corps. Available: <http://www.hrsa.gov/about/organization/bureaus/bcrs/nhscoverview.html>

assistance to trainees and faculty, and enhance faculty development in family medicine, internal medicine, general pediatrics, and physician assistant programs (Section 5301). Federal grants also support geriatric, mental and behavioral health, and dentistry education and training (Sections 5305-5307). Embedded in each of these provisions are stipulations to increase the racial and ethnic diversity of the health care workforce.

Summary of HRSA Grants Awarded to Missouri Related to ACA Provisions for Health Care Workforce³⁷

Grant	Recipient	Award Year(s)	Award Amount
Affordable Care Act Teaching Health Center Graduate Medical Education Payment Program (T91)	Ozark Center	2013	\$225,000
		2012	\$75,000
Affordable Care Act: Primary Care Residency Expansion (T89)	University of Missouri System (2 separate awards)	2010	\$1.92 million (2 separate awards)
	Freeman Health System	2010	\$1.9 million

Reimbursement Provisions

Several provisions in the ACA strengthen the role of primary care in the health care delivery system. Beginning in 2011, primary care practitioners and general surgeons practicing in HPSAs will receive a 10 percent Medicare payment bonus for five years (Section 5501). The ACA is also expected to increase the participation of primary care physicians in Medicaid by requiring that Medicaid reimbursement rates for primary care services provided by primary care physicians be at least 100 percent of the Medicare payment rates in 2013 and 2014 (Section 1202). The federal government will finance 100 percent of the additional costs to states.

Conclusion

While Missouri has taken advantage of several provisions of the ACA that support health care workforce development, Missouri must look for other opportunities to address the shortage of health care professionals in the state. ACA initiatives like increasing Medicaid reimbursement for primary care services and loan forgiveness initiatives should stimulate growth of the health care workforce, particularly for underserved areas. However, uncertainty over the permanence of reimbursement increases and the relatively small grant awards for workforce development programs are a call to action for Missouri to address a growing shortage of health care professionals.³⁸ The health care workforce shortage is expected to increase, and that will have significant negative effects as the aging population increases. Not only does an aging population require additional health care resources, but this also means that many health care professionals

³⁷ HRSA. December 17, 2012.

³⁸ Carrier, E., Yee, T., Stark, L. December, 2011. Matching supply to demand: Addressing the U.S. primary care workforce shortage. National Institute for Health Care Reform. Available: http://www.nihcr.org/PCP_Workforce.html