

Missouri Health Improvement Act of 2007

Senate Bill 577

Senate Bill 577 (SB 577) would reshape the Medicaid program in Missouri by moving recipients into some form of managed care, by providing these individuals with a health care home, and by creating incentives for developing healthy lifestyles. Also, the bill would minimize Medicaid enrollment by providing incentives for low-income workers to purchase private insurance and for older adults to purchase private long-term care coverage. The following summarizes the essential elements of this bill.

Health Improvement Plans

Summary

The bill would expand managed care to new areas of the state and new populations. The Department of Social Services would implement three types of health improvement plans in areas with similar demographics and populations. The health improvement plans are described as:

- risk-bearing care coordination programs (HMO model);¹
- administrative services organizations (non-risk, contracted management entity);² and
- care management point of service programs (state operated).

The legislation specifically states that its intent is not to limit the department to pilot projects in the implementation of the health improvement plans requirements.

Implementation Timeline

- By July 1, 2008, programs operational, with all parents and children enrolled by July 1, 2009.
- By July 1, 2009, enrollment of the aged, blind and disabled populations begins. (There is an exemption for Medicaid enrollees if their current treating physician is not participating in the HMO or administrative services organizations).
- By July 1, 2013, all Missouri Medicaid participants are to be enrolled.

Other States' Experience

Texas operates multiple service delivery models for its Medicaid populations. Most urban populations are served in risk-bearing HMOs. In the case of the aged, blind and disabled populations in urban areas, the model is partially capitated – inpatient hospital is not part of the capitation – with the exception of the Dallas/Fort Worth metroplex where a new non-capitated care management model is being implemented. In rural areas, Medicaid enrollees are served through an enhanced primary care case management model. Much of the motivation for this configuration was financial. An actuarial assessment of Texas Medicaid managed care expansion options showed different savings opportunities, depending on the service area and the type of program.

Considerations

- The health improvement plan(s) serving the most vulnerable MO HealthNet enrollees would need to develop a specialized infrastructure, including tailored provider networks, customer service capacity geared to the needs of the aged, blind, and disabled population, a behavioral

health component appropriate to the frequency with which chronic conditions are accompanied by mental health issues, and quality improvement strategies specifically designed for the aged, blind, and disabled population.

- The state would need to conduct an analysis by specific population and geographic area prior to determining which proposed managed care plans are both available and cost-effective. The bill indicates that all statewide participants would be offered a choice among three plans. An examination of Missouri's Medicaid managed care experience suggests that offering three models of care in rural and semi-rural areas could be problematic.
- Moving the aged, blind, and disabled population into any service delivery model involving intensive care management requires substantial advance work at the community level to engage all provider and consumer stakeholders in the development of the model.

Healthy Behaviors

Summary

The bill would require risk-bearing and administrative services organizations to issue electronic access cards that could be used to allow participants to “earn enhanced health improvement points” by:

- signing a health improvement participant agreement;
- participating in healthy practices (which include developing and following a plan of care); and
- making responsible lifestyle choices consistent with a participant's unique health care needs and goals.

The earned points could then be used to pay for “approved health care expenditures.” The Missouri HealthNet Division (Division) would create a list of approved point earning activities or behaviors. The Division would also create a list of approved health care expenditures, including but not limited to: Medicaid eligible services, co-pays, spend-downs, over the counter drugs, and vitamins. The health care advocate (discussed below) would function as a gatekeeper for accessing additional services.

Other States' Experiences

Several other states have recently received approval from federal regulators to initiate healthy behavior incentive programs similar to proposals in SB577. These states include West Virginia, Florida, Kentucky, and Idaho. The incentives offered vary from state to state.³

Considerations

- The Act does not define the potential services to be included in the “approved health care expenditures.” Other states allow participants to use their credits for a sizable variety of approved health care expenditures including over-the-counter drugs, medical equipment, smoking cessation classes, and membership in a health club.
- The Act is not clear if the point earning activities must be outlined in the health improvement plan for the individual enrollee to earn credits or if there would be a standard list of activities available to all enrollees.
- While providing incentives to promote healthy lifestyles may encourage some people to improve their behavior, research indicates that patients do not comply with medical recommendations because of other factors. These factors include cost of care, poor physician-patient communication, side effects of medication, lack of transportation or child care, sick children, psychiatric illness, the complexity of the recommendations, and language or cultural barriers.⁴ These factors challenge the potential efficacy of healthy behaviors incentives.

- This program would hold Medicaid beneficiaries to a standard higher than that required of other patients.⁵ Because they are typically lower-income than the average Missourian, the Medicaid population faces many challenges to living a healthy lifestyle. Poverty often leads to reduced access to transportation, to child care, to grocery stores with healthy foods, to exercise facilities, to lower literacy, and to higher rates of untreated psychiatric illness. All of these factors could challenge Medicaid beneficiaries to practice healthy lifestyles.⁶

Healthcare Advocate

Summary

The bill would require all plans to provide an “option” for a health care advocate to all Medicaid-eligible people. The legislation requires that the health care advocate be a health care professional trained and certified by the Missouri Department of Social Services. The health care advocate would create a comprehensive physical and behavioral health plan of care for individuals enrolled in one of the state’s “Health Improvement Plans.” The plan would be created by the health care advocate in conjunction with a multi-disciplinary team of health care professionals and would utilize the information from the health risk assessment. The health care advocate would coordinate educational interventions, in- and out-of-home care, and family support services offered in both the public and private sectors.

Other States’ Experiences

Historically, many states implementing care coordination within a Medicaid managed care delivery system have targeted either specific chronic illnesses (such as diabetes or asthma) or specific high or special needs populations (such as the aged, blind or disabled). Examples include Oregon, with its *Exceptional Needs Care Coordination (ENCC)* program for its aged and disabled Medicaid population, and Colorado and Delaware, which have care coordination programs for children with special health needs. Other states have used a primary care case management approach. A primary care case management model is an alternative care delivery system which retains the fee-for-service payment system but addresses the utilization problems by providing the beneficiaries a “medical home” through a primary care physician. Texas and Florida operate primary care case management programs.

Considerations

- The success of this provision will hinge on the health improvement plans providing the health care advocates with the resources (i.e. caseload, number of advocates, salary, etc.) needed to serve as health care homes to their enrollees. In Missouri over 800,000 Medicaid enrollees would need health care advocates.
- The bill would require that the health care advocate be a licensed and/or certified health care professional. Currently Missouri licenses and/or certifies more than twenty types “health practioners” (physicians, dentists, nurses, pharmacists, acupuncturists, dietitians, perfusionists, etc.), some of whom may not have the requisite skills to be effective health care advocates.
- In order for the proposed system to work, the health care advocate would represent the interests of the participant while simultaneously being employed by a health care plan vendor. Dependent on the vendor for evaluation and compensation, the possibility exists for health care advocates to put the vendor’s interests before the participant’s when making decisions about the allocation of resources. To be effective, health advocates would need to be evaluated by precise performance measures related to delivery of care and health outcomes, not vendor profits.

Premium Offset Program

Summary

The bill proposes a premium offset program where uninsured, low-income families could apply for premium assistance for employer-sponsored health insurance on a first-come first-served basis. To be eligible, individuals must have been uninsured for a period of one year and either the employer or employee or both would have to pay their respective shares of the required premium. Participation in the program is also open to individuals with employers who do not contribute to the purchase of insurance. The plan would be administered by the Missouri HealthNet Division, which is instructed to apply for state plan amendments or waivers as required to obtain federal funding assistance.

Other States' Experiences

Premium assistance programs have been implemented in several states to encourage Medicaid beneficiaries and their families to participate in available employer sponsored health insurance coverage when it is cost effective to do so. The 2001 Health Insurance Flexibility and Accountability (HIFA) section 1115 waiver initiative relaxed some of the requirements previously associated with premium assistance programs, including cost-sharing rules, and removed the requirement that states provide wrap-around coverage for enrollees.⁷ This has caused a number of states to initiate premium assistance programs for Medicaid beneficiaries. The majority of these programs subsidizes employer sponsored health insurance. Though many states have initiated premium assistance programs, the participation in the programs has been minimal. One study found that enrollment in premium assistance programs constituted less than one percent of the relevant eligibility groups in Medicaid and SCHIP.⁸

Considerations

- In recent years, the per capita costs of private health insurance have been increasing faster than the per capita cost of Medicaid coverage.⁹ Over time, the increasing costs of private health insurance may make the premium offset program less cost-effective than Medicaid coverage.
- In order for premium assistance programs to be cost effective, the program must be able to achieve significant enrollment and adequate employer contributions to offset the additional administrative costs of establishing the program.¹⁰ Without further clarification on these issues, the likelihood of the proposed premium assistance program's success is unclear.
- The degree to which this premium assistance program increases coverage depends on the premiums charged for private insurance. Premium assistance could provide more Missourians with private health insurance, while potentially limiting Medicaid enrollment and reducing the uninsured. However, Medicaid-eligible Missourians choosing to enroll in the program may face increased cost sharing and a smaller set of benefits than provided through the general Medicaid program.

Long-Term Care Partnership Program

Summary

The bill provides greater incentives for Missourians to buy long-term care insurance with the intent of easing the growing financial burdens on the Medicaid program. The 2005 federal Deficit Reduction Act aimed to encourage individuals – particularly middle-class individuals with relatively modest savings – to buy long-term care insurance. The Deficit Reduction Act allowed individuals to protect assets provided they exhausted their insurance benefits before applying for Medicaid coverage. Federal law enacted in February 2006 allows states to amend their Medicaid programs and to disregard individual assets equal to the amount of benefits paid by a person's long-term care policy. SB 577 would disqualify persons from long-term care eligibility if they had equity of \$500,000 or more in a home.

Impact Nationwide

Experience in other states and from the federal government demonstrates the potential shortcomings of this approach:

- The Congressional Budget Office estimated that the partnership provisions in the 2005 Deficit Reduction Act would add – rather than reduce – costs by \$26 million to the federal Medicaid program in the first five years and \$86 million over 10 years.¹¹
- The General Accounting Office reported that through 2003, in the four states currently in the partnership program (California, New York, Connecticut and Indiana), 172,000 partnership policies had been sold in the four states, but only 251 individuals had exhausted their insurance benefits. Of those, 119 had enrolled in Medicaid. The data indicates that the partnership programs appeal to middle-class Americans who were already more likely to buy long-term care insurance and unlikely to ever qualify for Medicaid.
- A 2004 Brookings Institution-George Washington University study found that the functioning partnership policies only reached 1.5 to 5.7 percent of the elderly populations.

Consideration

- In Missouri, Medicaid expenditures for nursing-home care in Missouri grew from \$633.9 million in 1997 to \$785.4 million in 2006, while the number of enrollees declined by 6 percent. Community- and home-based Medicaid programs almost tripled from \$122 million to \$344 million from 1997 to 2006, compared to enrollee growth of 65 percent. SB 577 is designed to curb state long-term care spending by providing incentives for consumers to purchase private long-term care policies. Theoretically, providing incentives to purchase private long-term care insurance has the potential to delay enrollment in Medicaid for the elderly. However, experience from other states and national research shows that for government-private partnership programs, enrollment tends to be low, with minimal savings to the state.

Healthcare Technology Fund

Summary

The bill would establish a Healthcare Technology Fund (Fund) in the state treasury as the repository for gifts, donations, transfers, general appropriations, and bequests. The fund is to be administered by the Department of Social Services. Monies in the fund are to be used to promote improvement of patient care, reduction in administrative burden, and increases in patient and provider satisfaction through technology. The bill lists the following examples of areas of technology improvement that would improve safety, quality and costs of healthcare: electronic medical records, community and personal health records, e-prescribing, telemedicine, and telemonitoring. Unexpended monies in the fund at the end of the two year period would revert to the general fund.

Considerations

- The bill language does not express any intent for prioritizing the use of Fund resources among the many opportunities to achieve improvements with the help of technology.
- Because the federal government strictly regulates the matching of non-state general revenue funds, the state should examine whether it would be preferable to have outside contributions come directly to the general revenue fund and then be appropriated to the Fund.
- Reversion of unexpended monies from the Fund to the general fund at the end of the two

- year period is likely to inhibit non-legislative sources of monies from giving to the Fund.
- Healthcare technology initiatives are likely to be broad in scope. Planning and implementing the initiatives may need to be shared by the Department of Social Services as well as the departments and affected programs.

END NOTES

¹ A traditional HMO model including utilization management, claims adjudication, participant education, primary care case management and pharmacy management.

² Administrative services organizations (ASOs) provide care coordination, utilization management, participant education and primary care case management. The state retains responsibility for provider reimbursement, pharmacy management, eligibility determination and provider network management

³ D Vock, Patients Key to Latest Medicaid Reforms, Stateline.org, 2006. Available at <http://www.stateline.org/live/details/story?contentId=146088>

⁴ R Steinbrook, "Imposing Personal Responsibility for Health," New England Journal of Medicine 355.8 (2006):753-756.

⁵ In general, patients are notoriously non-compliant with medical advice. One study found that in the case of clinical trials, which is the ideal situation for patient compliance, only 43 to 78 percent of the patients took their medication as prescribed. G Bishop and A Brodkey, "Personal Responsibility and Physician Responsibility – West Virginia's Medicaid Plan," New England Journal of 355.8 (2006):756-758.

⁶ G Bishop and A Brodkey, 2006.

⁷ J Alker, Premium Assistance Programs: How are They Financed and Do States Save Money? (Issue Paper), Kaiser Family Foundation Commission on Medicaid and the Uninsured, 2005. Available at <http://www.kff.org/medicaid/upload/Premium-Assistance-Programs-How-are-they-Financed-and-do-States-Save-Money-Issue-Brief.pdf>

⁸ J Alker, Premium Assistance: A Look at Recent State Activity (Issue Paper), Kaiser Commission on Medicaid and the Uninsured, 2003.

⁹ J Holahan and A Ghosh, "Understanding The Recent Growth in Medicaid Spending," Health Affairs- Web Exclusive (26 January 2005) W5-53.

¹⁰ J Alker, 2005.

¹¹ J Crowley, "Medicaid Long-Term Services Reforms in the Deficit Reduction Act" (Issue Paper), Kaiser Commission on Medicaid and the Uninsured, April 2006.

About this Analysis

Much of the research for this fact sheet was directed by the Washington University Center for Health Policy for the Missouri Foundation for Health. Any questions please contact the MFH Health Policy staff at info@mffh.org or toll-free at 1-800-655-5560.

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