

Issues in Missouri Health Care 2011

Executive Summaries

Acknowledgement

This is one in a series of issue papers on critical health care issues facing Missouri and the nation prepared by Health Management Associates, Inc., a national health care policy research and consulting firm, and made possible by funding from the Missouri Foundation for Health and the Healthcare Foundation of Greater Kansas City. The papers are intended to provide nonpartisan expert analysis in an accessible format that will contribute to the public dialogue on the state of health care in Missouri. Questions should be directed to Thomas McAuliffe, Policy Analyst, Missouri Foundation for Health, 314.345.5574, tmcauliffe@mffh.org.

The State of Missourians' Health

According to the 20th annual report, *America's Health Rankings: A Call to Action for Individuals and Their Communities, 2009 Edition*, Missouri ranked 38th overall on a wide range of public and environmental health issues, clinical indicators and health outcomes from a variety of national sources.¹ From The Commonwealth Fund's *State Scorecard on Health System Performance, 2009*, Missouri ranked 36th in the country on measures of coverage, access, quality, and equity.² The Kaiser Family Foundation also provides the most up-to-date measures of state health indicators through its interactive website, www.statehealthfacts.org, for which Missouri ranks worse than the national average on a variety of health status measures.

Insurance coverage typically increases (but does not guarantee) access to needed health care. Rates of insurance coverage in Missouri are only slightly higher than those of the U.S. as a whole. The rate of employer-based coverage is slightly higher in Missouri than the U.S. rate (57.1% v. 55.8%), and this likely contributes to Missouri's lower uninsured rate compared to the U.S. (15.3% v. 16.7%).³ With 914,000 of Missouri's 5.97 million residents uninsured—15.3 percent of the state's population—Missouri ranks 24th in the percentage of total population uninsured, one of the few measures examined that ranks it in the top half of states.⁴

Missouri residents have a much higher incidence of smoking among adults, as well higher rates of obesity, and a higher rate of 'poor mental health days' when compared to the nation. As a result, Missouri lags behind the rest of the nation in premature mortality, though it has made some improvement in this area in recent years.

The Patient Protection and Affordability Care Act (ACA) provides many opportunities for the state to consider as it prepares to address the multiple of issues affecting Missourians' health. The prospects to change health outcomes through expanded coverage, smoking cessation programs, incentives to change member behavior, health homes for people with chronic illness and other provider payment incentives are real. The issue brief on *The State of Missourians' Health* covers these opportunities in more detail.

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 of 2010, Missouri has a number of unprecedented opportunities for policy

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- 1 United Health Foundation. 2009. The report draws on data from a variety of federal agencies, including but not limited to the Centers for Disease Control and Prevention (CDC) and the Census Bureau, as well as the American Medical Association. See <http://www.americashealthrankings.org/>.
 - 2 The Commonwealth Fund. 2009. The scorecard includes measures of health care access, quality, avoidable use of services, and healthy lives. See <http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2009/Oct/2009-State-Scorecard.aspx>.
 - 3 U.S. Census Bureau, Current Population Survey. 2010, Health Insurance Coverage Status and Type of Coverage by State and Age for All People, 2009. Available at http://www.census.gov/hhes/www/cpstables/032010/health/h05_000.htm.
 - 4 Kaiser Family Foundation (KFF). Retrieved October 10, 2010, from <http://www.statehealthfacts.org/profileind.jsp?cat=3&sub=39&rgn=27>. Rate is based on average for 2007-2008.

reforms, as well as mandates, related to providing health coverage to its state residents who are uninsured. These reforms and mandates range from incremental steps designed to shore up and expand access to the private insurance market, to 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), to the establishment of state-based Health Insurance Exchanges and requirements for individuals and employers to participate in the health insurance system.

Based on CHIPRA, Missouri could try new approaches to enrolling the 123,000 children who are eligible for but not participating in Medicaid and the Children's Health Insurance Program (CHIP). 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 also gives states increased flexibility to provide premium assistance to Medicaid and CHIP-eligible children with access to employment-sponsored coverage.

Finally, CHIPRA makes available increased federal funding and financial incentives to support the cost of enrolling more children in Medicaid and CHIP. Missouri's federal CHIP allotment increased 58 percent, to \$129.3 million from \$81.9 million in fiscal year 2009.

ACA goes much further in terms of covering Missouri's uninsured. Beginning in 2010, a number of changes shored up and expanded access 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 covers adult children through 25 years of age).

Also available beginning in 2010 is a Temporary Reinsurance Program to reimburse employers whose group health plans cover retired individuals who do not qualify for Medicare. As of November 1, 2010, more than 30 Missouri employers have received assistance from this program. In addition, beginning in July 2010, Missouri received \$81 million in ACA funds to operate a temporary federal high-risk pool to make coverage more affordable for the medically uninsurable. This pool is in addition to Missouri's state-operated high-risk pool, which covers a limited segment of the medically uninsurable.

By 2014, ACA's provisions go much further to cover the uninsured by 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; and establishing state-based Health Insurance Exchanges ("Exchanges") with tax credits available to low-income individuals and families. 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-based information on private health insurance plans.

While CHIPRA and ACA have great potential for reducing the number of uninsured, there are also a number of hurdles to their actual implementation. First is cost. State governments, despite generous federal funding, will experience increased cost with the Medicaid expansion, and the implementation of the Exchanges could pose a serious financial burden depending on the strength and timing of an economic recovery. However, federal grant funding has been awarded to support the planning process for Exchanges, and additional federal funds will be available to support their development and implementation. Second, the individual mandate provision of ACA is highly controversial. In August 2010, 71 percent of Missouri voters approved a ballot initiative banning the government from requiring individuals to purchase health insurance. In the meantime, ACA is the law of the land and Missouri must move forward with carrying out ACA's provisions. This issue brief explores the various options and opportunities for the State of Missouri.

When Basic Benefits Aren't Enough: Caring for Missourians with Chronic Conditions

Adults with chronic or disabling conditions typically have faced special problems in trying to obtain health insurance coverage. Commercial insurers are wary about offering coverage to these populations because they are likely to incur disproportionately high medical expenses. When the law permits, insurers often deny coverage to such individuals or charge a higher rate to individuals or small groups that include such individuals to reflect the increased risk, sometimes making coverage unavailable or unaffordable. These problems are exacerbated by chronic health conditions that may result in disability that prevents employment and access to employer-sponsored coverage.

ACA, particularly the provisions changing the rules regarding sale of insurance to individuals and small groups, raises the possibility of making coverage available and affordable to uninsured people in general and to the chronically ill in particular. Most notably, when the ACA takes full effect in 2014, people seeking coverage as individuals cannot be denied coverage because of their medical conditions, and neither individuals nor small groups can be charged more because of health status.

ACA 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. 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 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 several constructive steps to create an infrastructure that both supports and promotes adoption and use of EHRs. The creation of the Missouri Health Information Technology (MO-HITECH) governance structure, establishment of several public and private collaboratives, and anticipated grants and payment incentives resulting from the ACA will result in a robust HIT program in the state. This issue brief describes the HIT requirements and funding opportunities for the state.

Addressing Medicaid Fraud and Abuse: Facts and Policy Options

The National Health Care Anti-Fraud Association estimates that at least 3 percent of spending for health services—more than \$60 billion each year—is lost to health care fraud in the private and public sectors,⁵ including Medicaid. The Missouri Medicaid program, known as MO HealthNet, covers almost one in every seven Missourians (about 830,000 beneficiaries). The MO HealthNet budget for fiscal year 2008 was appropriated at \$5.8 billion, with about \$1.2 billion coming from state general revenue⁶ representing about 26 percent of the total state general revenues.⁷ Applying the 3 percent national fraud estimate, the cost to Missouri resulting from fraud is at least \$36 million per year. Given continued budget constraints, initiatives to deter, detect, and prosecute Medicaid health care provider fraud are increasingly important to pursue.

The issue brief on Addressing Medicaid Fraud and Abuse defines health care fraud, summarizes some of the attempts at both the federal and state level to address fraud, and then discusses further policy options that Missouri might consider to cope with this problem.

Meeting the Needs of Missourians Who Are Elderly or Have Disabilities: Long-Term Care

Long-term care services refer to health and social services, and supports to individuals who have lost some capacity for self-care. These services consist predominantly of assistance with

5 Daniel R. Levinson, Inspector General, Office of the Inspector General, before the Senate Special Committee on Aging, U.S. Senate, May 6, 2009, available at <http://www.hhs.gov/asl/testify/2009/05/t20090506d.html>.

6 \$3 billion from federal funds, and the remainder from other funds. Missouri received a Federal Medical Assistance Percentage (FMAP) of 75.16 percent in September 2010 under American Recovery and Reinvestment Act. Without the ARRA adjustment, its FMAP would be 64.51 percent. Source: MO Health Net Medicaid Pharmacy Report, November 16, 2009.

7 *Missouri Medicaid Basics, Winter 2009* and *Missouri Medicaid Basics, Winter 2007*, Missouri Foundation for Health (MFH) available at <http://www.mfh.org/medicaidbasics07.pdf>

essential, routine tasks of life. Those in need of long-term care services include the elderly and persons with physical, mental, and developmental disabilities.

The demand for long-term care services is projected to increase over the next 20 years, due primarily to the aging of Baby Boomers.⁸ By 2010, an estimated 15 percent of Missouri's population was 65 years of age or older. By the year 2020, Missourians aged 65 and older are projected to comprise 18 percent of the population.⁹

A survey conducted for AARP indicated that most individuals prefer to receive long-term care services in their own homes or community-based residential settings.¹⁰ Missouri's 2007 State Plan on Aging establishes that "services such as personal care, homemaker, chore, nursing, respite, adult day health care, counseling, and consumer-directed services should be made available to the elderly and persons with disabilities in their homes."¹¹ This brief explores the steps Missouri has taken toward building a system of care that begins shifting from an institutional to a home- and community-based care model, and toward other improvements in long term care delivery.

Treating the Whole Missourian: Mental Health and Substance Abuse

While reports of the Surgeon General and numerous academic studies have supported the notion that mental health is fundamental to overall health, behavioral health issues are often ignored or marginalized in health care policy discussions.¹² As Missouri addresses the issue of how best to care for individuals, including the uninsured whose needs include behavioral health services, a number of questions need to be addressed, including:

- What are behavioral health disorders?
- How large is this problem?
- What are the options for change?

The issue brief on Mental Health and Substance Abuse summarizes policy options relevant to these three key questions, with specific attention focused on opportunities newly available in ACA. These opportunities – expanded coverage, grants, payment incentives, and Medicaid benefit improvements – offer Missouri the chance to greatly improve its care delivery system and outcomes for people with mental illness, substance use disorders and developmental disabilities.

8 Baby boomer describes a person born between 1946 and 1964.

9 "Missouri State Plan on Aging" *Division of Senior and Disability Services*. 27 September 2007 , pg 4.

10 Gibson, M., Fox-Grage, W., and Houser, A. (2009). *Across the States 2009: Profiles of Long-Term care and Independent Living*. Access October 4, 2010. Retrieved from http://assets.aarp.org/rgcenter/il/d19105_2008_at.pdf.

11 Ibid, pg 14.

12 U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General—Executive Summary*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999. <http://www.surgeongeneral.gov/library/mentalhealth/summary.html> Retrieved 10/21/10.

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

Medicaid pharmacy spending across the United States was \$25.2 billion in fiscal year 2009. This spending was offset 38 percent by manufacturer drug rebates paid to states, resulting in net expenditures of \$15.5 billion.¹³ To address continued budget constraints, 33 states implemented pharmacy controls such as prior authorization, use of preferred lists, and pricing controls during fiscal year 2010.¹⁴ At the same time, states remain aware that drug therapies play an essential role in care plans for their beneficiaries, especially for those who are elderly or have disabilities or chronic conditions. How states address the pressure of continued drug cost increases and the demand for the latest product innovations has a significant impact on the efficacy of medical treatment. The issue brief on the Medication Marketplace is written for individuals who are unfamiliar with the basics of Medicaid prescription drug pricing, and provides a basis for reviewing future policy implications facing state Medicaid programs, including MO HealthNet, the Medicaid program in Missouri.

Buying Value: Improving the Quality of Missourians' Health Care

Missouri spends \$31 billion on health care each year, or \$5,444 per person, slightly more than the U.S. average of \$5,283. Despite a sizable expenditure, Missouri ranks in the bottom third of states on quality of care and health outcomes. By leveraging its role as health care purchaser and regulator more fully, Missouri could improve the quality of care and the health outcomes of its citizens to get more value for 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 Act, an Oversight Committee was created to develop initiatives to improve care and its outcomes. Some of the efforts growing from the Committee's recommendations, such as the Chronic Care Improvement Program, however, had to be discontinued due to budget constraints.

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 ACA are discussed in this issue brief.

13 Financial Management Reports, FY 2007 through FY 2009 (federal fiscal year October 1 through September 30), obtained from CMS upon HMA request.

14 Medicaid Cost Containment Actions Taken by States, FY 2010 (federal fiscal year), available at statehealthfacts.org.

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

Tobacco use is the leading preventable cause of death in Missouri. More than 400,000¹⁵ persons die annually from tobacco-related causes in the U.S., and 9,362 of them are from Missouri. Tobacco use, including smoking, causes cancer, including 90 percent of lung cancers in men and almost 80 percent in women.^{16,17} Cigarette smokers also suffer at much higher rates than the general population from coronary heart disease, stroke, and peripheral vascular disease.^{18,19} Cigarette smoking is the major cause of chronic obstructive pulmonary disease (COPD), causing 90 percent of the deaths from this disease.²⁰ Smoking causes infertility problems, early births and stillbirths, low birth weight babies, and sudden infant death syndrome (SIDS).²¹ The death toll does not take into account the suffering caused by tobacco-related diseases and the potentially productive years that afflicted persons would have lived had they not used tobacco.

Nearly 90,000 of Missouri smokers are youth, and their smoking rates exceed the national average. Twenty-two percent of Missouri sixth graders have tried smoking, a percentage that rises to 45 percent by high school.²² In addition, 16.6 percent of youth currently use smokeless tobacco products such as chew and snuff.²³ These youth are susceptible to cigarette advertising. In 2009, 36 percent of middle school tobacco users bought or received items featuring a tobacco brand name or picture.²⁴ Furthermore, almost half of Missouri children are exposed to second hand smoke.²⁵

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- 15 Campaign for Tobacco-free Kids, "Toll of Tobacco in the United States of America", October 2010 <http://www.tobaccofreekids.org/research/factsheets/pdf/0072.pdf> .
 - 16 Missouri Department of Health and Senior Services, "Tobacco State" <http://www.dhss.mo.gov/SmokingAndTobacco/TobaccoState.pdf>.
 - 17 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.
 - 18 Ockene IS, Miller NH. Cigarette Smoking, Cardiovascular Disease and Stroke: A Statement for Healthcare Professionals from the American Health Association." *Journal of American Health Association*. 1997;96;3242-3247.
 - 19 Fielding, JE, Husten CG, Erikson MP. Tobacco: Health Effects and Control. In: Maxcy KF, Rosenau MJ, Last JM, Wallace, RB, Doebbling BN (eds). *Public Health and Preventive Medicine*. New York:McGraw-Hill;1998;817-845.
 - 20 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.
 - 21 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.
 - 22 "Reducing Tobacco Use in Missouri: Progress against all odds" Missouri Department of Health and Senior Services. http://www.dhss.mo.gov/YTS/tobacco_use_among_mo_youth.pdf
 - 23 Ibid.
 - 24 Ibid.
 - 25 Carter, M. Tobacco Use Among Middle School Students, 1999. Missouri Department of Health, Division of Chronic Disease and Health Promotion, p.12.

Real opportunities exist for change in Missouri. First, ACA provides for immediate coverage of smoking cessation products and programs for pregnant women. Furthermore, ACA will require coverage of smoking cessation related drugs for all Medicaid members by 2014. The state could reduce the number of locations exempted from the State's Clean Air Act. Finally, raising Missouri's cigarette tax could reduce smoking by making the habit more expensive, and raise revenue to finance additional tobacco cessation efforts. These topics are explored in this issue brief.

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 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. While MO HealthNet already operates elements of the Medicaid program in Missouri pursuant to a number of waivers, the ongoing transformation of the program and efforts to cover the uninsured may benefit from further flexibility attained through additional waivers.

The issue brief on Federal Waiver Options and Processes explores the types of waivers and related requirements. Missouri uses seven 1915(c) waivers to provide Home and Community Based Services to a variety of aged, blind and disabled populations. Also, since 1998, Missouri's Medicaid program (MO HealthNet) has been using an 1115 waiver to provide expanded coverage to children up to 300 percent of the FPL. The state can continue to use waivers to explore additional innovations and program improvements. However, ACA will potentially play a significant role in reducing the need for waivers to provide expanded coverage. Starting in 2014, the ACA expands Medicaid up to 133 percent of the FPL for all non-Medicare individuals under age 65. Many waivers that originally were used to expand coverage to these previously uninsured populations will now be unnecessary.

This issue brief addresses Missouri's opportunities to review its current programs and waivers, new legislation and opportunities, and consider how programs and delivery models should be shaped in the future.

Who Will Care for the Sick: Ensuring an Adequate Health Care Workforce in Missouri

Like other states, Missouri faces the ongoing challenge of training, recruiting, and retaining a health care workforce to meet the changing needs of the state's growing population. That challenge is particularly acute for rural areas, which have difficulty attracting and keeping specialists and primary care providers. How the state addresses this challenge is critical for

ensuring access to quality medical care not only for the uninsured and recipients of publicly financed health care services, but those with commercial insurance coverage as well.

While Missouri produces more medical school graduates per capita than the national average (second in the nation), the state has several designated physician shortage areas, and has fewer practicing physicians and primary care physicians per capita than the national average. Missouri's and its local communities' numerous efforts to attract and retain health care professionals in rural and other underserved areas to date have had varying degrees of success. One such program operated by the University of Missouri's School of Medicine is only experiencing a 33 percent success rate.

Addressing rural Missouri's needs for health care professionals requires a multi-dimensional approach. With the passage of ACA, Missouri has a number of opportunities to leverage federal resources to expand the availability of providers to work in medically underserved areas.

This brief addresses two issues: first, the challenges Missouri faces in establishing and maintaining an adequate health care workforce to meet the needs of rural and other medically underserved areas; and second, the opportunities federal health care reform offers Missouri to expand the availability of appropriately qualified health care providers in medically underserved areas of the state.