

Issues in Missouri Health Care 2011

Coverage Issues for Missourians with
Chronic Health Care Conditions

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Issue Statement

Adults with chronic or disabling conditions have typically faced special problems in trying to get health insurance coverage. Commercial insurers are wary about offering coverage to people at high risk of needing expensive health care, such as the chronically ill, because they are likely to incur disproportionately high medical expenses. As permitted by law, insurers have often denied coverage to such individuals or charged a higher rate to individuals or small groups that include such 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 any access to employer-sponsored coverage.

Implementation of the Patient Protection and Affordable Care Act (ACA) of 2010—in particular, the provisions that change the rules regarding sale of insurance to individuals and small groups—will go far toward making coverage available and affordable to uninsured people in general and to the chronically ill in particular. Most notably, when the Act takes full effect in 2014, people seeking coverage as individuals, rather than through an employer, cannot be denied coverage because of their medical conditions, and neither individuals nor small groups can be charged more because of the health status of individuals being insured. ACA also includes provisions for additional consumer protections, and establishes demonstration programs and incentives to improve the coordination of care for higher-cost or at-risk individuals, including those with chronic health conditions.

There is also increased recognition, 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.

Background

Chronic conditions are common, even among the non-elderly population. In 2000, there were more than 33 million working age people (ages 16 to 64) with disabilities in the United States.¹ Six million of these were covered by Medicare, and another 1.2 million were estimated to be in the 29-month waiting period between establishing disability and having Medicare coverage begin. Forty percent of those in the Medicare waiting period had Medicaid coverage, but another third was uninsured.² In all, 2.3 million adults under age 65 with a disabling condition reported being uninsured.³

1 U.S. Census Bureau. (March 2003). *Disability Status: 2000*. Accessed October 18, 2010. Retrieved from <http://www.census.gov/prod/2003pubs/c2kbr-17.pdf>.

2 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

There were an estimated 526,000 adults in Missouri with a disability in 2005, or 14.9 percent of all adults age 18 to 65. Only 28 percent of Missourians with a disability in this age group were part of the labor force, with 7.9 percent of those with a disability being employed.⁴

Historically, there has been a strong relationship between being uninsured and having a chronic condition. An analysis of the 2003 National Health Interview Survey found that, of the 15.6 million nonelderly adults who are uninsured in the United States, at least 45 percent report one or more chronic health conditions (e.g., diabetes, asthma, chronic heart failure). Uninsured adults with chronic conditions are less likely than those who are insured to receive needed medical care. Thirty-eight percent are without a usual source of care, compared with 5 percent of insured adults with chronic conditions, and almost half of uninsured adults with chronic conditions reported forgoing needed medical care because of cost. Despite having fewer contacts with the health system, many uninsured adults with chronic conditions report spending 5 to 10 percent or more of their family incomes on out-of-pocket medical care.⁵

Commercial Insurance: Historical Barriers and Reforms

To understand why the new federal health reform will have such a major impact on improving coverage rates for the chronically ill and all people at higher-than-average risk, it is useful to understand how the insurance market has operated in the past.

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, creates major access and affordability problems for individuals with disabilities and people who are not disabled but have chronic health conditions.

Without specific state regulations to the contrary, commercial insurers in the individual market, which serves people buying as individuals rather than through their employers, have been able to:

- Deny a policy to someone with what they consider high medical risk;
- Grant coverage but with an exclusionary rider that temporarily or permanently denies coverage for a specific condition;

Paralysis Foundation. Accessed on October 18, 2010. Retrieved from http://www.commonwealthfund.org/usr_doc/786_Williams_waiting_for_Medicare.pdf.

3 Ibid.

4 Estimates for 2005, Centre for Personal Assistance Services. (2007). *Missouri Disability Data Table from the 2005 American Community Survey*. Accessed on October 18, 2010. Retrieved from http://www.pascenter.org/state_based_stats/state_statistics_acs.php?state=missouri&year=2005.

5 The Robert Wood Johnson. (May 2005). *Uninsured Americans With Chronic Health Conditions: Key Findings from the National Health Interview Survey*. Accessed on October 18, 2010. Retrieved from http://www.urban.org/uploadedpdf/411161_uninsured_americans.pdf.

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

In the small-group market (2 to 50 employees), federal law has prohibited insurers from denying coverage to a group or excluding an individual with high risk. But federal law has not prohibited insurers from varying the premium for the entire group based on the risk of the individuals in the group. The limitations on insurers' ability to rate risk groups have been determined by state regulation.⁶

Other strategies employed by commercial insurers have also discouraged health coverage for people with chronic or disabling conditions. Specifically, insurers could design a benefit package that did not include sufficient coverage of treatment needed for certain conditions, that applied higher cost-sharing requirements for certain treatments or services, or that limited access to providers with specialties in certain diseases. Such policies might be attractive to healthy people, but they would be unattractive to less healthy people or, if purchased, would leave them "underinsured" for needed services.

These underwriting and benefit design practices might represent logical behavior from the perspective of a commercial health insurer that wishes to prevent adverse selection (attracting a disproportionate share of high-risk people), or one that seeks to hold down premiums to attract lower risk small groups to gain a competitive advantage. But such practices have made it difficult or impossible for those who have the greatest need for coverage to obtain it. Underwriting practices that result in high premiums may cause some employers with a relatively older or unhealthier workforce to not offer coverage, which denies affordable coverage not only to those with chronic conditions but to group members who are not at high risk. These underwriting practices may even reduce employment opportunities for those with chronic health care conditions because employers know that their premiums will rise if they hire them.

A survey of 11 non-group health insurers conducted by the industry group America's Health Insurance Plans (AHIP) found that in 30 percent of the cases in which people applied as individuals, coverage was denied, offered with exclusions, or offered with higher rates.⁷ 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 that people with mental health conditions of "generally moderate severity" were rejected

6 For very small businesses (2 to 25 employees), the state imposes limits on how premiums can be varied to reflect health-related risks, but there are no rating limits imposed for groups larger than 25.

7 Merlis, M., (April 13, 2005). *Fundamentals of Underwriting in the Nongroup Health Insurance Market: Access to Coverage and Options for Reform,* National Health Policy Forum. Accessed October 18, 2010. Retrieved from http://www.nhpf.org/library/background-papers/BP_Underwriting_04-13-05.pdf.

for coverage 52 percent of the time.⁸ As a result, public insurance programs like Medicaid and Medicare, and public health programs like those offered through community mental health centers, become the default payer for many people with chronic or disabling health problems.

Missouri, like other states, has adopted a range of small group and nongroup insurance reforms to address problems of access to affordable coverage. These provided some protections, but still left many high-risk individuals and groups without access to affordable coverage. The promise of the new federal reform law is that it will make many of these protections unnecessary because it will offer more encompassing protections that are beyond the ability of most states to provide.

Medicaid's Role in Covering Chronically Ill or Disabled Adults

In state fiscal year 2007, MO HealthNet provided coverage to approximately 77,000 elderly individuals and more than 141,000 nonelderly disabled individuals in Missouri, at a total state and federal cost of almost \$3.3 billion. The average monthly cost to cover the elderly population was \$1,156 per person, while the average monthly cost to cover a nonelderly disabled person was \$1,299. This compares to an average monthly cost of only \$342 to cover an adult with dependent children.⁹

In Missouri, the Aged, Blind or Disabled (ABD) population makes up 26 percent of total enrollment in MO HealthNet but accounts for 65 percent of total program spending.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. However, not everyone with chronic health conditions is disabled, and not everyone with a disability lives in a family whose income qualifies under basic Medicaid income standards.

Over time, federal Medicaid policy has evolved to allow states considerable flexibility to expand Medicaid coverage to additional optional groups with chronic or disabling conditions. For example, states can adopt Medically Needy programs that allow individuals who would qualify for Medicaid except for their income to "spend down" to Medicaid eligibility by subtracting incurred medical expenses from income to reach the Medicaid standard. In addition, Congress has enacted specific optional programs to allow states to reach targeted groups:

- *The Breast and Cervical Cancer Program* allows states to extend coverage to women with higher incomes who have been diagnosed with breast or cervical cancer through a federally funded screening program.

8 Ibid.

9 Medicaid Reform Commission. (2006). *Medicaid Reform Commission Report*. Accessed October 18, 2010. Retrieved from <http://www.senate.mo.gov/medicaidreform/medicaidreformcommfinal-122205.pdf>.

10 Missouri Foundation for Health. (2008). *Missouri Medicaid Basics*. Accessed October 18, 2010. Retrieved from <http://www.mffh.org/mm/files/medicaidbasics08.pdf>

- *The Ticket to Work Program* allows states to establish a subsidized premium program that enables people with disabling conditions to return to work and “buy into” Medicaid coverage.
- *The Family Opportunity Program* allows states to offer a subsidized premium program that enables higher income families to “buy into” Medicaid to obtain coverage for children with high-cost medical conditions.

Missouri offers coverage through MO HealthNet to optional groups of people with chronic or disabling conditions. For example, MO HealthNet allows individuals who meet the federal Supplemental Security Income (SSI) disability definition to qualify by spending down their incomes on medical expenses to meet the state’s income standard. Also, in 2007, the Missouri Health Improvement Act created the state Ticket to Work program, formerly known as Medicaid Assistance for the Working Disabled, to restore Medicaid eligibility to some persons who would otherwise exceed the state’s income standards.

Managing the Cost of Chronic Care

State Medicaid programs understand the impact that providing services to people with chronic and disabling conditions has on program costs, and are generally concerned that the growth in enrollment as the nation’s population ages will present significant challenges to the ability of states to sustain even current program commitments. States are actively engaged in efforts to adopt more cost effective strategies for managing care for people with chronic and disabling conditions.

Some states including Arizona, Pennsylvania, Ohio, and Washington now require some or all ABD consumers to enroll in managed care organizations or primary care case management arrangements to receive Medicaid services. Some states including Florida, Massachusetts, Wisconsin, and New Mexico have begun to provide 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. These states generally are contracting with Medicare Special Needs Plans (SNPs) to encourage integration between Medicaid- and Medicare-funded services for individuals who are dually eligible.

Many states have turned to disease management strategies to control costs and improve outcomes. Some strategies target managing specific diseases or conditions (e.g., asthma, diabetes, chronic obstructive pulmonary disease, or COPD), while others are implementing strategies that provide care coordination for targeted, high-cost individuals across all co-morbid conditions including mental illness. Both disease management and full-risk managed care strategies can include elements of consumer education and coaching to encourage individuals to take a more informed and active role in self-management of their medical conditions.

Throughout the 1990s, states became actively engaged in managing the cost of the Medicaid pharmaceutical benefit by introducing preferred drug lists, making more effective use of prior

authorization, and negotiating supplemental rebates directly with manufacturers. Some states even introduced efforts at counter-detailing to educate prescribing providers regarding more effective drugs.

Most states have pursued reform and rebalancing in the delivery and financing of long-term care services and supports, both to better support community integration for people with disabilities and to achieve a more cost effective delivery system for Medicaid. States have implemented home- and community-based waiver options that enable people with long-term care needs to receive in-home supports rather than moving into higher cost institutional settings. Federal grant funds have been made available to states through programs like Money Follows People to assist states in the development of rebalanced systems.

Several states are actively engaged in exploring ways to use information technology to improve the outcomes and cost of health care. Some states are involved in the development and use of electronic medical records. Other states have introduced electronic prescribing technology to improve information exchange and reduce costs associated with drug errors and drug interactions. States are experimenting with information exchange and the use of Internet-enabled consumer education and self-management support. And several states are introducing automated information and resource systems to help people seeking long-term care services find appropriate assessment, counseling, and referrals to the full range of services available.

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:

- The Missouri Health Insurance Pool (MHIP) was established by, and operates according to, legislation enacted by the Missouri General Assembly in 1991. Although MHIP is not an insurance company, it is supervised by the Missouri Department of Insurance. MHIP is funded by premiums paid by its enrollees, and assessments paid by health insurers and health management organizations (HMOs) that issue coverage to Missouri residents. There is no limit on the number of individuals who may be enrolled in MHIP. It offers individual health coverage through five major medical plans. Four plans differ only in the amount of the annual deductible and out-of-pocket maximums. Plan V is the high-deductible health plan designed only for use with a health savings account. Deductibles range from \$500 to \$5,000; out-of-pocket maximums range from \$2,500 to \$5,000. The maximum benefit payable on behalf of any individual during his or her lifetime under any plan or combination of plans MHIP offers is \$1 million for all injuries and illnesses combined.
- MO HealthNet requires some populations to enroll in managed care health plans in 54 counties, with approximately 391,000 enrollees as of January 2009.¹¹ However, people covered by Medical Assistance (ABD population) are excluded from these arrangements.

11 McCaslin, Ian (July 30, 2010) *How Are Our Patients Best Served* presentation on managed care. Accessed October 18, 2010. Retrieved at <http://dss.mo.gov/mhd/mc/pdf/mhdpresentation.pdf>.

The Missouri Health Improvement Act of 2007 strongly supported 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 care homes, and to receive health risk assessments.

- Missouri policy strongly supports prevention of institutional care to maximize quality of life and program cost containment. MO HealthNet offers seven home- and community-based service waivers to targeted populations to enable individuals to receive long-term care services and supports in their own homes, rather than enter an institutional setting.¹² In addition, the Missouri Health Improvement Act of 2007 provided for development of a long-term care partnership program, which encourages individuals to purchase private long-term care insurance by offering a level of asset protection if Medicaid coverage eventually becomes necessary. The first partnership policies were offered in April 2008.
- Beginning in November 2006, Missouri initiated the Chronic Care Improvement Program (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 works 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 2007.¹³ However, funding for this forward-thinking program was eliminated in summer 2010 because of budget reductions.
- Missouri has several community-level health information technology initiatives that have the potential to improve chronic disease care management through the use of electronic health records (EHRs) and an electronic health information exchange (HIE). One such example is the St. Louis Integrated Health Network for safety net providers. Also, the Missouri Department of Health and Senior Services is sponsoring a statewide telemedicine

12 Section 1915(c) waivers include: Aged and Disabled Waiver, AIDS Waiver, Independent Living Waiver, Physical Disabilities Waiver, MR/DD Community Support Waiver, Missouri Children with Developmental Disabilities Waiver, and Mental Retardation and Developmental Disabilities Comprehensive Waiver.

13 Wolken, Lucie, Columbia Missourian (November 2, 2007), *Medicaid Program offers "Coaches" to nurse chronic ailments*. Accessed October 21, 2010. Retrieved at <http://www.columbiamissourian.com/stories/2007/11/02/medicaid-program-offers-coaches-nurse-chronic-ailm/>

initiative, and the Critical Access Hospital Network is providing statewide technical support for critical access hospitals that want to adopt EHRs and develop electronic HIE.¹⁴

- In 2007, Senate Bill 577 established the MO HealthNet Oversight Committee to evaluate the MO HealthNet program and its implementation. 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 program operations. Included in these reports were information about the highest-cost Medicaid recipients and strategies for better managing costs and improving health outcomes. These reports could better inform program administration and design, and aid policy decisionmaking.¹⁵

Improving Access to, and Affordability of, Coverage under Health Reform for People with Chronic Conditions

ACA represents a major step forward in providing coverage for people who have faced difficulties in acquiring affordable health insurance, including the chronically ill. Although some of the most important protections do not go into effect until 2014, the changes incorporated in the law will have a major impact on reducing the number of uninsured.

- *Guaranteed issue and rating limits:* With respect to the chronically ill, the most important provisions guarantee that after 2014 no one can be denied coverage because of any personal characteristic—including, most importantly, health status—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 vary rates only on the basis of age (with a limit of a 3-to-1 premium difference), geographic area, use of tobacco, family size and level of benefits. These provisions, if effectively enforced, will guarantee that after 2014, chronically ill people will be at no disadvantage in being able to purchase affordable coverage.
- *Standardized benefit plans:* To ensure that the benefit packages cover necessary services, the regulations authorized under the law will specify the broad range of medical services that all individual and small-group plans must cover. The number of plans offered will be limited to four standardized plans that cover the same services but differ with respect to the amount of consumer cost-sharing, essentially co-payments and deductibles. This provision protects chronically ill people—and everyone else—from getting stuck with policies that do not provide coverage of needed services, although people may still find the level of cost sharing to be a burden, depending on which benefit package they choose or can afford.

14 Center for Health Transformation Missouri Project. (2010). *State Solutions Map*. Accessed October 18, 2010. Retrieved at <http://www.healthtransformation.net/cs/missouri>.

15 Missouri Department of Social Services, *Comprehensive Review Reports*, Accessed October 18, 2010. Retrieved at <http://dss.mo.gov/mhd/oversight/reports.htm>.

- *Coverage mandate and subsidies:* The law requires everyone to have health coverage after 2014 or pay a substantial penalty. Of course, imposing such a requirement makes no sense without the protections just described, and without subsidies to make coverage affordable for people of modest means. To make coverage more affordable, the law provides subsidized premiums for people with incomes between 133 and 400 percent of FPL, with the amount of the subsidy declining as income increases. People eligible for these subsidies will purchase coverage through the new Health Insurance Exchanges that will be available in every state. In addition, people in this income group will qualify for tax credits if they incur significant out-of-pocket costs for their health care. People with incomes below 133 percent of FPL will be eligible for Medicaid coverage.
- *Health Insurance Exchanges:* Exchanges are mechanisms created to help individuals and small businesses purchase health insurance coverage. Beginning in 2014, an Exchange will be established in each state to help consumers make valid comparisons between plans that are certified to meet benchmarks for quality and affordability. The Exchanges will also administer the new health insurance premium subsidies and facilitate enrollment in private health insurance, Medicaid, and the Children's Health Insurance Program (CHIP). Nobody will be required to purchase health insurance through the Exchange, though subsidies will be available only for plans sold through the Exchange.
- *Providing increased options for purchasing coverage through Medicaid or the Exchange:* Beginning in 2014, single adults earning between \$10,830 and \$14,400 a year will be able to choose whether to enroll in Medicaid or purchase coverage through the Exchange with a generous federal subsidy. Those earning less than \$10,830 will be eligible for their state's Medicaid program but not for subsidies in the Exchange.
- *Removing Medicaid asset and disability eligibility requirements:* Effective January 1, 2014, eligibility for Medicaid for the nonelderly will be based on income and will no longer consider assets. Low-income individuals between the ages of 19 and 64 will be eligible for Medicaid irrespective of disability or family status. This will result in a significant number of additional Missourians being eligible for health care coverage under Medicaid.

These important provisions do not go into effect until 2014. But a number of other initiatives will take effect more immediately. New consumer protections in the insurance market in effect since September 23, 2010, 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 coverage 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 the nature of annual limits.)

- *Bans on rescinding coverage:* Insurance companies are banned from dropping people from coverage when they get sick, protecting the 296,000 individuals who purchase insurance in the individual market.¹⁶
- *Protections for children:* Insurance companies cannot exclude children from coverage because of a pre-existing condition, if the policy also covers the parents. And adult children up to the age of 26 can be covered under their parents' policies.
- *Protections for high-risk individuals:* MHIP operates a federal high-risk pool program called the Pre-existing Conditions Insurance Pool (PCIP), which has made temporary coverage available since July 2010 to residents with pre-existing medical conditions who have been uninsured for at least six months. The coverage has a \$1,000 annual medical deductible and a \$100 pharmacy deductible. The annual out of pocket maximum is \$5,950. The maximum benefit payable on behalf of any individual during his or her lifetime is \$1 million for all injuries and illnesses combined. The premium ranges from \$243 to \$972 per month.¹⁷ The program is funded entirely by \$81.3 million from the federal government. Administered by MHIP, the coverage is a bridge to 2014, when insurance companies will be prohibited from denying coverage to Americans with pre-existing conditions and will have access to affordable coverage options in the Exchanges with subsidies for those with incomes below 400 percent of FPL. This new high-risk pool is separate from Missouri's existing high-risk pool, which has been operated by MHIP since 1991.

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

Health Care Reform Initiatives to Reduce the Cost of Chronic Care through Better Coordination of Services

The federal health reform law also seeks to reduce the cost of services and improve health outcomes by achieving better care coordination for persons with multiple chronic conditions. These efforts seek to better align Medicare and Medicaid policies for coverage of dual-eligible persons, improve the provision of primary care, and improve transitions from one care setting to another.¹⁸

Most of these initiatives are offered as demonstration grants to test new models of service delivery or payment structures. Many are focused on Medicare beneficiaries, although there are some opportunities for state Medicaid programs. These initiatives may provide opportunities

16 Kaiser State Health Facts: <http://www.statehealthfacts.org/profileind.jsp?cmprgn=1&cat=3&rgn=27&ind=125&sub=39>.

17 <http://www.healthcare.gov/law/provisions/preexisting/states/mo.html>.

18 Justice, Diane. (April 2010). *Long Term Services and Supports and Chronic Care Coordination: Policy Advances Enacted by the Patient Protection and Affordable Care Act*, State Health Policy Briefing: National Academy for State Health Policy. Accessed October 11, 2010. Retrieved from <http://www.nashp.org/sites/default/files/LongTermServ%20Final.pdf>.

for Missouri to promote better coordination of care for persons with chronic conditions and explore options for reducing unnecessary costs of chronic care.

- *Federal Coordinated Health Care Office*: This office is charged with improving coordination between Medicare and Medicaid programs on behalf of persons who are dual-eligible. Differences between Medicare and Medicaid program requirements have been a barrier to true coordination of care.
- *Medicare Special Needs Plans*: Special Needs Plans (SNPs) are plans that target enrollment of beneficiaries who are dual-eligible, nursing home residents, or individuals who have chronic disabling conditions. The ACA reauthorizes SNPs through December 31, 2012, by which time all dual-eligible SNPs must have contracts with the state Medicaid agency to improve coordination of services between Medicare and Medicaid. These provisions also impose more standardized enrollment, quality, and payment rate criteria.
- *Medical (Health) Homes*: This provision establishes a federal grant program to create community health teams that support patient-centered medical homes. States, state-designated entities, and American Indian tribal organizations are eligible to apply. The teams funded under this program must contract with primary care providers to deliver support services such as care coordination, chronic disease management, and care planning.
- *Independence at Home Demonstration Program*: This Medicare demonstration grant program will fund projects to test models of care that promote independence at home medical practices. These projects are centered on primary care teams of physicians, nurse practitioners, and others to deliver care to high-need populations at home and coordinate care across all treatment settings. There are beneficiary eligibility criteria, and there is a cap on enrollment. Incentive payments are available to the Independence at Home practice if it meets certain quality performance and expenditure measures.
- *National Pilot Program on Payment Bundling*: This pilot program was established to explore the most clinically appropriate ways to coordinate post-acute care after a Medicare beneficiary has been hospitalized for one of 10 conditions. The goal is to better manage patient transition from the hospital to the post-acute setting. The pilot must begin no later than January 1, 2013. The Secretary of Health and Human Services has the authority to expand the program on or after January 1, 2016, if certain criteria are met.
- *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 may apply for funding under this program. The program began on January 1, 2011, and runs for five years. At the time of publication, it was not known if any Missouri community-based organizations were award recipients.

- *Accountable Care Organizations:* This program will provide financial incentives to reduce the growth of Medicare expenditures and improve beneficiary 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 the financial incentive payments. They must also meet criteria related to evidence-based medicine and patient engagement, report on quality and cost, and coordinate care.

Missouri has a rich history of innovation and implementing forward-thinking programs. Federal health care reform can provide additional leverage to improve care and reduce the cost of care for Missourians with chronic illness.

Implications for Missouri

Adults with chronic and disabling conditions make up a small but significant share of the uninsured population. It is important for the state to recognize the challenges presented by this population.

The chronically ill may need access to more extensive services than healthier populations.

Even with the subsidies that will be available in 2014 under health reform, some chronically ill people may find that the coverage is too costly, given their premiums and out-of-pocket costs.

Although the federal law requires people to get coverage or pay a penalty, some people, including some chronically ill people, may choose to pay the penalty, which, for many, will be substantially less costly than purchasing coverage even with a subsidy. The likelihood, however, 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.