Using Blunt Force

On Missouri's Most Vulnerable Population

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Families USA
1201 New York Avenue, NW, Suite 1100
Washington, D.C. 20005
Phone: 202-628-3030
Fax: 202-347-2417
E-mail: info@familiesusa.org

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www.familiesusa.org

Introduction

In 2005, faced with a severe budget shortfall, the state of Missouri made some of the largest Medicaid cuts of any state in recent years. More than 100,000 Missourians lost their Medicaid coverage entirely, and more than 300,000 people were affected by service reductions.[1] The state legislature also agreed to end Missouri's Medicaid program by June 30, 2008.

The state's Medicaid program will sunset about a year from now. The Missouri legislature must come up with a plan to either extend the sunset date or replace the program. On February 22, 2007, a proposal to replace Missouri's current Medicaid program, SB 577, was introduced in the state legislature. The proposal builds on plans unveiled by Governor Blunt and by the Missouri Department of Social Services in January 2007, but SB 577 incorporates some new—and very troubling—ideas not seen in either of the earlier plans.[2]

The economic crisis Missouri faced in 2005 no longer exists. In his 2007 State of the State Address, Governor Blunt proclaimed that Missouri's "days of economic uncertainty are in the past" and that "the state of the state is strong, prosperous, and vibrant."[3] Many other states are also experiencing an economic rebound, and they are expanding health coverage to the uninsured using public programs such as Medicaid as a foundation.

With a strong economy now in place, Missouri should be working to repair the damage done by the 2005 Medicaid cuts. Yet, SB 577 does absolutely *nothing* to restore the services that were eliminated or the people who were cut from the state's Medicaid program. Adding insult to injury, SB 577 could make things even *worse* in Missouri. The proposed legislation moves the most vulnerable Missourians to private managed care plans, which may be ill-equipped to handle their health care needs. If vulnerable populations are not transitioned with extreme care, and if the proper protections are not in place, this move could be disastrous.

What Is Wrong with SB 577?

There are many reasons to be concerned about SB 577, but this report focuses on the aspects of the legislation that are the most troubling. One of the biggest problems is that the legislation contains many components that are extremely vague, and it gives the Medicaid agency license to determine most of the details. Where SB 577 is concerned, the devil is in the details: Without proper implementation, this legislation will have catastrophic consequences for vulnerable and chronically ill Medicaid recipients.

Medicaid recipients will be moved into managed care plans regardless of their health needs

SB 577 would move most Medicaid recipients into "health improvement plans" by 2013. The bill calls for the MO HealthNet Division, the new name for the state's Medicaid agency, to offer a choice of three types of health improvement plans. All Medicaid recipients would have to enroll in one of the following plans:

1. A risk-bearing, capitated managed care plan. The state would pay a set dollar amount to such a plan for care for each enrollee. If the enrollee's health care costs exceeded that amount, the plan would be "at risk" for those costs (it would have to pay those costs itself).
2. An "Administrative Services Organization," which is a managed care plan that is not capitated and which provides health care services on a fee-for-service basis. Although the cost per enrollee would not be limited by the state, the plan would still be "at risk" because its fees would be reduced if it failed to meet savings and quality targets set by the state.
3. A care management point of service program administered by the state. The legislation provides virtually no information about how this type of plan would work. This lack of clarity is unacceptable—it is important that state legislators and stakeholders know how all three health improvement plans will operate.

Parents and children would transition to a health improvement plan by 2009, while all aged, blind, and disabled Medicaid recipients would move into these plans by 2013. Aged, blind, and disabled Medicaid recipients would be enrolled in a health improvement plan automatically, but they could choose to opt out (as discussed below).

Vulnerable populations will be at risk

Moving aged, blind, and disabled Medicaid recipients into private managed care plans could have disastrous consequences. This population is extremely diverse and has many different kinds of special and complex health care needs. This group includes not only the elderly, but people with physical and developmental disabilities, people with severe mental illness, and people who are dually eligible for Medicare and Medicaid. Many of these individuals require a variety of medical and supportive services from multiple providers in a range of settings.[4]

If these individuals fall through the cracks during the transition to managed care and suffer a lapse in care, real harm could result. Without access to their medications, people with mental illness could end up homeless. Without access to regular therapy or daily medications, people with chronic physical illness could worsen and seek care in the emergency room, which would ultimately be much more expensive for the state.

Moving populations with numerous and special health care needs to private managed care plans needs to be done with care, and it should be done slowly.[5] Successful Medicaid managed care programs are often first tested on a pilot basis and then expanded only after careful evaluation.[6] SB 577 does not specify exactly how the state will transition these groups to health improvement plans. It states only that half the aged, blind, and disabled population will be moved to health improvement plans by 2009, while the rest will be moved by 2013. If the phase-in is not working, SB 577 should have a mechanism for halting the transition before all populations are moved into health improvement plans.

Of most concern is whether Missouri will be able to ensure that elderly and disabled Medicaid recipients receive proper care in private managed care plans. As AARP notes, Missouri health plans have very little experience with providing services to these populations.[7] Considering this lack of experience, it does not seem likely that private managed care plans would be the best option for elderly and disabled Medicaid recipients. If the state does move these populations to managed care, the private companies that offer health improvement plans must have experience managing high-cost care and caring for populations with complex health care needs.

Missouri also has a shortage of providers in many regions of the state, including the types of specialists needed to treat people with disabilities and the elderly. This shortage will make it more difficult for plans to meet the health care needs of the enrollees they serve.[8] For people with disabilities, ensuring access to appropriate specialty care is extremely important. And because much of Missouri is rural, it is important that individuals living in rural areas maintain access to primary care providers and specialists.

How Could SB 577's "Health Improvement Plans" Affect Rural Missourians?

- Eighty-nine percent of the state's counties are defined as "rural," and 40 percent of Missouri's population lives in rural areas of the state.[9]
- Even though the state is largely rural, only 25 percent of the state's primary care physicians are located in rural areas. This makes it extremely difficult for rural Missourians, including Medicaid recipients, to find a doctor. In fact, 21 rural counties in Missouri have only one primary care physician for every 3,500 residents.[10]
- There is also a shortage of specialists in rural areas of the state. What's more, 40 percent of rural counties in Missouri do not have a hospital, which indicates a lack of availability of several kinds of care, including specialty care.[11]

If a move to health improvement plans further restricts access to primary care and specialty physicians, it will be exceedingly difficult for people with disabilities and the elderly to get the health care services they need.

Automatic enrollment could create problems for recipients

One of the most alarming aspects of moving elderly and disabled Medicaid recipients into managed care is how they will be enrolled. SB 577 stipulates that the MO HealthNet Division will automatically enroll these individuals in one of the health improvement plans, but it is unclear whether recipients' specific health care needs will be taken into account when they are enrolled. Enrollees can choose to opt out of these plans if they wish.

The legislation fails to address many important details about enrollment: How will individuals receive health care benefits if they opt out? Will they then be able to choose only between the other two plans? Will individuals receive the information they need to help choose another plan? Will the opt-out process be simple enough for individuals to do themselves? The answers to these questions are critical to ensuring that individuals are not harmed by this proposal. If the state moves ahead without examining these questions, it could experience problems similar to the difficulties dual eligibles faced when enrolling in Medicare Part D just one year ago.

The legislation also allows individuals who opt out of their assigned health improvement plan to return to their original provider. However, the measure does not specify how this would happen. Will the plan take time to process the opt-out request, keeping these individuals in managed care for a certain length of time? If so, this could be extremely disruptive to an individual's care.

Finally, the importance of consumer protections cannot be overlooked. Careful attention should be paid to how companies are allowed to market their plans to vulnerable populations. All plans must also have strong grievance and appeals processes in place. And even with the health care advocate (discussed below), there is a need for an ombudsman program—a neutral counseling program that would help enrollees navigate the new Medicaid program and choose a health improvement plan.

New "health care advocates" may act as barriers between individuals and their physicians

Under SB 577, the state would attempt to give every Medicaid recipient a "medical home." Medical home is defined as "primary health care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally-effective."[12] According to SB 577, however, this medical home would be in the form of a "health care advocate," which would be a physician or licensed health care professional who is trained and certified by the state. It is unclear, however, if the health care advocate would be the individual's primary care physician, another treating physician, or someone else entirely.

The legislation assigns a long list of responsibilities to the health care advocate, including providing comprehensive, coordinated physical and behavioral health care; creating and discussing with the enrollee a complete physical and behavioral plan of care; and advising

the enrollee regarding appropriate health care expenditures. If the health care advocate is not a person's treating physician, it is unclear how the treating physician's traditional role of caring for patients will be reconciled with the responsibilities of the health care advocate.

It is important that the health care advocate does not create a barrier between an individual and his or her physician. It is also important that the advocate be able to act as a case manager and have the knowledge necessary to help individuals obtain all the different types of health care they need, including acute care, community-based and institutional long-term care, behavioral health care, and social supports such as transportation.

Another important element missing from the legislation is the establishment of staffing standards for the health care advocate (assuming that the health care advocate is not the treating physician). The health care advocate component of the legislation will not be successful unless an adequate number of advocates are hired by the Medicaid agency and unless the state sets limits on the number of patients assigned to each advocate. The ratio of health care advocates to patients should be spelled out so that people receive the individual attention and support they need.

Health improvement agreements will cause some Medicaid recipients to lose access to services

SB 577 would require Medicaid recipients to sign a "health improvement participant agreement," engage in "healthy practices," and make "reasonable lifestyle choices" in order to earn points to pay for approved health care expenses. Earned points could be used for certain types of expenses, such as Medicaid-eligible services, copayments, and over-the-counter drugs. The legislation does not specify what kind of healthy behaviors and practices will be required of people, what the health improvement agreements will look like, or how compliance will be monitored. The legislation does say that physical, speech, and occupational therapy services and comprehensive day rehabilitation services will be available only to people who discuss their plan of care with their health care advocate, and only as long as the legislature appropriates funds for these services.

The health incentive system and participation agreement in SB 577 are reminiscent of similar programs that have been established in Florida and West Virginia. Plans in these states require individuals to engage in "healthy" practices in order to receive some health care services. In Florida's system, any points earned may be used to pay for extras like vitamins or over-the-counter medications. In West Virginia's system, individuals must sign an agreement to adhere to several practices in order to obtain certain Medicaid services, including important benefits like mental health services. These types of plans are virtually untested. Florida's system has been in operation for only a few months, and the state Medicaid agency admits that the program is not popular with recipients.[13] West Virginia's pilot program was scheduled to begin on March 1, 2007, so it has just barely gotten underway. Missouri should wait and see whether these pilot programs are successful before deciding to adopt a similar incentive system.

The danger of using incentive systems is that they have the potential to hurt people more than help them. In "regular" Medicaid, enrollees may obtain any services that a physician deems "medically necessary." This is not true for health incentive systems. If individuals fail to follow their health improvement participation agreements, they could lose out on critical services. And it may not always be a matter of "choosing" to live up to those agreements. For example, people may not have the reliable transportation they need to get to a smoking cessation class, or they may not be able to afford a doctor-prescribed exercise class or other kind of wellness activity. Requiring low-income individuals to adhere to a set of responsibilities in order to get medical services or prescription drugs imposes a huge burden on those who are just struggling to get by.

Furthermore, this focus on healthy practices is unlikely to save the state much money, at least in the short-term, and it could end up costing the state more in administrative costs. Creating and managing systems to track enrollee participation in health improvement programs, compliance with these agreements, and earned points will take time and money. And taking away critical health care services that people depend on could exacerbate their chronic health conditions and lead to higher health care costs in the long run.

If Missouri moves ahead with these agreements, depending on the types of "healthy practices" the agency requires, the state should ensure that the proper supports are in place to help individuals succeed and have a real chance at becoming healthier. These supports include health literacy programs, exercise and weight management programs, and smoking cessation services.

Cost-sharing increases will create barriers to care

SB 577 establishes a "level of copayments" that enrollees must pay for services that are not federally mandated, such as prescription drugs. The legislation does not specify these copayment amounts. Since Missouri already requires copayments for mandatory and optional Medicaid services,[14] this new cost-sharing provision is troubling.

Raising copayments for low-income people discourages them from seeking necessary health care services.[15] This is especially true for people with chronic health care problems, such as the elderly and people with disabilities. With their increased need for health care services and prescription drugs, even small copayments can quickly add up and become unaffordable.[16]

SB 577 also establishes copayments for use of the emergency room. The Deficit Reduction Act of 2005 (DRA) allows states to institute cost-sharing for certain low-income people for use of the emergency room for non-emergencies. But the SB 577 provision on emergency room cost-sharing appears to go further than the DRA, imposing cost-sharing even when the emergency room is used for a true medical emergency. SB 577 allows the copayment to be waived only if the individual is eventually admitted to the hospital.

It is still unclear how the premium assistance program will work

SB 577 authorizes MO HealthNet Division to implement a "premium offset" program (otherwise known as a "premium assistance" program) to give standardized, private health insurance to "qualified" individuals who have been uninsured for a year. In most premium assistance programs, the Medicaid agency, the employer, and the Medicaid enrollee each pays a share of the premium. There are limited details in the legislation, but it is clear that there will be no Medicaid wraparound program to fill in any gaps in private coverage.

In the states that offer them, premium assistance programs have generally had low participation rates.[17] Much of the success of this program would depend on details that are absent from the legislation. For example, how much of the "offset" would the department pay, and how much would the enrollee pay? Who would be considered "qualified individuals"? What would the "standardized" health coverage be? If this standardized coverage lacks a comprehensive benefit package, then the lack of a wraparound program becomes even more troubling.

There is no mention of how many individuals the agency anticipates enrolling in the premium offset program, but if the intention of the program is to make up for the 2005 Medicaid cuts, it is a poor substitute. Many low-income workers do not have health coverage available through their employer, and even if they do, low-income workers tend to lose or change jobs more frequently than higher-income workers, resulting in interruptions in health coverage.[18] Individuals who would qualify for this program would have to have an offer of employer-sponsored insurance and qualify for Medicaid. The individuals most likely to fall into both these categories are parents. But right now, the state's Medicaid eligibility level for parents is so low, they would be unlikely to be able to afford their portion of the premium. (Missouri currently covers working parents with incomes up to 21 percent of the federal poverty level, or $3,504 a year for a family of three.[19])

The Medicaid agency will have less oversight

The legislation states that by July 1, 2008, the MO HealthNet Division will operate as a "third party administrator," providing Medicaid recipients with a choice of health improvement plans. This change is extremely problematic, since a third party administrator serves only as an intermediary, processing claims, providing services, and issuing payments. The current Medicaid agency has far more duties and responsibilities, including providing general oversight of the Medicaid program and ensuring that Medicaid recipients receive the care they need. The agency will also assume new duties with the implementation of the health improvement agreement programs.

One lesson that can be learned from the history of Medicaid managed care is that to effectively operate Medicaid managed care programs, a considerable administrative investment must be made.[20] Under SB 577, the state is essentially leaving people at the mercy of the private managed care companies that run these health improvement plans. Whatever its name, Missouri's Medicaid agency must remain a strong government body that continues to be responsible for all its current duties.

What Should Happen Next?

In its current form, SB 577 is not the right approach for Missouri. The move to health improvement plans and the premium assistance program is based on an ideological belief that private coverage is better, although there is nothing to indicate that people will benefit from these changes. In fact, moving aged, blind, and disabled populations to private managed care plans could lead to serious disruptions in care and result in devastating health outcomes.

At a time when Missouri's economic outlook is positive, and when other states are making strides in covering their uninsured populations, SB 577 does nothing to restore the grievous 2005 cuts that affected more than 400,000 Missourians. Any attempt at reforming Missouri's Medicaid program must reinstate the critical health care services that were eliminated and restore coverage to the hundreds of thousands of individuals cut from the program. While Governor Blunt may want to dismiss this problem as talking about "yesterday," such a restoration is critical to any serious effort to reform Medicaid and expand coverage.

Endnotes

[1] Sharon Feltman, Jennifer Hill, and Timothy D. McBride, *Losing Health Care in Missouri Survey Results: Impact of 2005 Medicaid Cuts* (The Missouri Association for Social Welfare and the Missouri Budget Project, March 2006), available online at http://www.mobudget.org/Medicaid%20Survey%20Report%20March%2006.pdf.

[2] Although we refer to SB 577 throughout this report, this analysis also considers changes made to the legislation in the Senate Committee Substitute for SB 577.

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[6] Ibid.

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[17] Cynthia Shirk and Jennifer Ryan, *Premium Assistance in Medicaid and SCHIP: Ace in the Hold or House of Cards?* (Washington: National Health Policy Forum, July 17, 2006).

[18] Cynthia Shirk and Jennifer Ryan, op cit.

[19] Kaiser Family Foundation, *State Health Facts Online, Income Eligibility for Parents Applying for Medicaid by Annual Income as a Percent of Federal Poverty Level (FPL), 2006*, available online at http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=profile&area=Missouri&category=Medicaid+%26+SCHIP&subcategory=Medicaid+Eligibility&topic=Income+Eligibility%2d%2dParents+in+Medicaid, accessed on March 21, 2007.

[20] Statement of Jeffrey S. Crowley, op cit.

Credits

This report was written by:

Sarabeth Zemel, Health Policy Analyst
Families USA

The following Families USA staff contributed to the preparation of this report:

Ron Pollack, Executive Director

Kathleen Stoll, Director of Health Policy

Cheryl Fish-Parcham, Senior Health Policy Analyst

Peggy Denker, Director of Publications

Ingrid VanTuinen, Writer-Editor

Jenelle Partelow, Editorial Associate

Nancy Magill, Design/Production Coordinator

1201 New York Avenue, NW, Suite 1100 • Washington, D.C. 20005
Phone: 202-628-3030 • Fax: 202-347-2417
E-mail: info@familiesusa.org
www.familiesusa.org