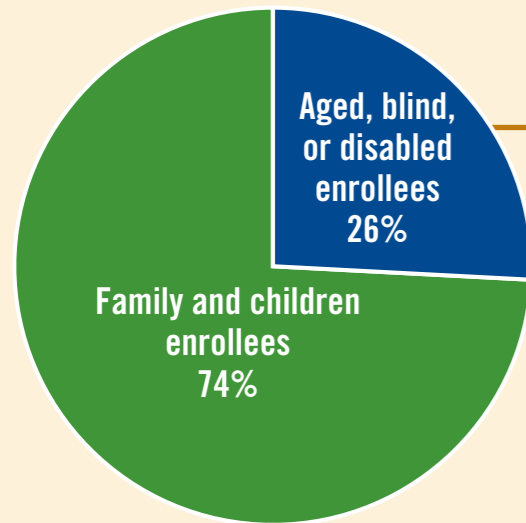


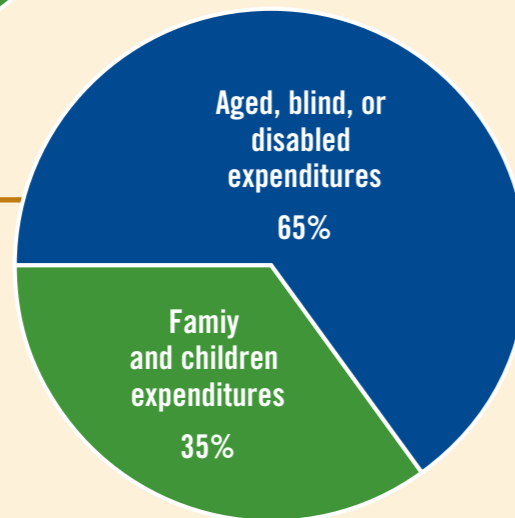
Missouri Medicaid

Who participates?

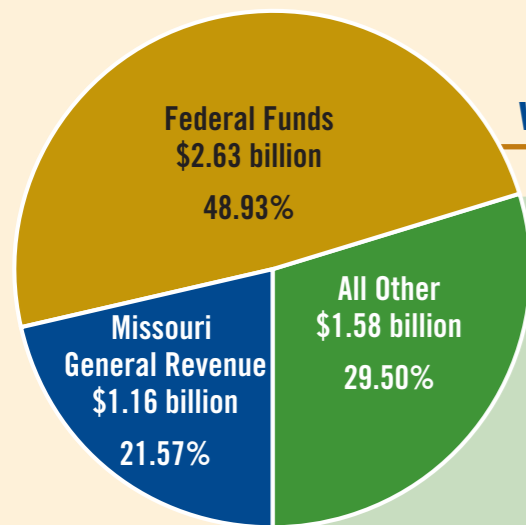
State Fiscal Year 2007



How is the money spent?



Who pays?



- Uncompensated Care Fund
- Pharmacy Rebates
- Provider Taxes:
 - Federal Reimbursement Allowance (FRA) (Hospitals)
 - Pharmacy Reimbursement Allowance (PRA)
 - Medicaid Managed Care Reimbursement Allowance
 - Nursing Facility Reimbursement Allowance (NFRA)
- Tobacco Funds:
 - Health Initiatives Fund
 - Healthy Families Trust Fund—Health
- Third Party Liability
- Healthcare Technology Fund
- Premiums
- Life Sciences Research Trust Fund
- Nursing Facility Quality of Care Fund

Source for charts on this page: Medicaid Basics Report 08, Missouri Foundation for Health

Glossary of terms

- ASO** Administrative Services Organization – a contractual arrangement under which an insurance company or other independent organization assumes responsibility for administering claims, benefits and other functions for a self insured group or on behalf of a public entity. An ASO manages risk but does not bear financial or medical risk. In a publicly funded program, for example, the state would assume the medical and financial risk for the covered population. (Source: compilation from the National Health Law Program)
- Carve-out** Health services not included in the managed care contracts. Effective 10-1-09, pharmacy will be carved out of all the health plans
- Case management** Locating, referring, coordinating and monitoring health care services for assigned beneficiaries or members
- CMS** Centers for Medicare and Medicaid Services – This is the federal agency that oversees the state-run programs and establishes requirements for service delivery, quality, funding and eligibility
- Core Competency** An area of specialized expertise that is the result of harmonizing complex streams of technology and work activity
- EQRO** External Quality Review Organization
- FFS** Fee for Service – This is the traditional Medicaid program administered by the Division of Medical Services (DMS). In this system a patient accesses care through any provider who has agreed to participate in Medicaid under a non-risk contract. Providers bill the state for each service provided
- HEDIS** Healthcare Effective Data and Information Set – A set of standardized performance measures designed to provide information about quality so performance may be evaluated and compared
- Low Birth Weight Babies** A category of babies weighing less than 2500 grams (5.5 lbs.)
- MO HealthNet** In 2007 SB 577 established MO HealthNet which replaced the state Medicaid program. The new program emphasizes prevention and employs managed care principles (e.g. establishment of a healthcare home). The details of the program continue to be defined by an Oversight Committee
- NICU** Neonatal Intensive Care Unit
- PMPM** Per Member Per Month – This is the contracted rate paid by the state to managed care plans to cover the health care costs of enrollees
- SSI** Supplemental Security Income
- TANF** Temporary Assistance for Needy Families



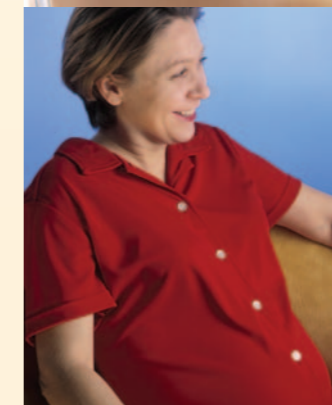
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MO HealthNet Managed Care



*the right care
 at the right time
 for the right cost*

What is MO HealthNet?

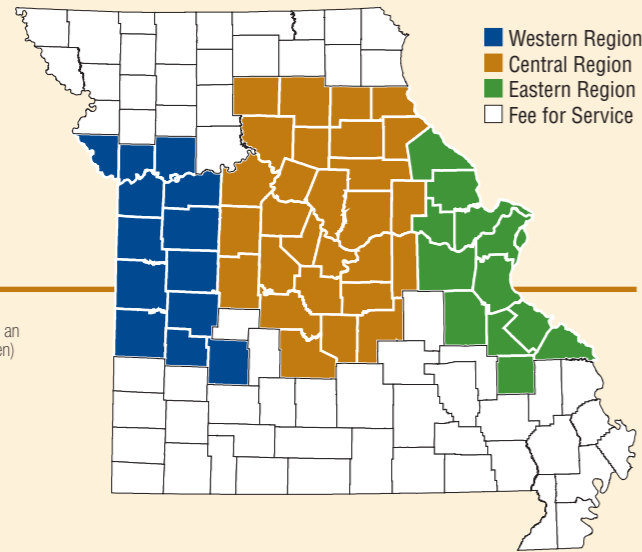
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see inside for more information about MO HealthNet ▶

Missouri Medicaid

Where is MO HealthNet managed care in Missouri?

Effective January 1, 2008, the MC+ Managed Care Program expanded to an additional 21 counties (shown in green) for a total of 54 counties.

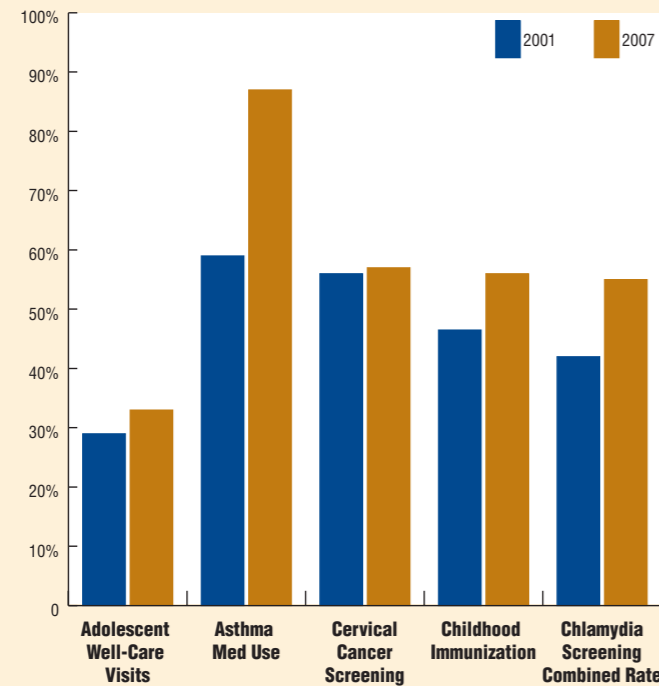


Plans participating in MO HealthNet managed care

Blue Advantage Plus of Kansas City, Inc.	www.bcbskc.com
Children's Mercy Family Health Partners	www.fhp.org
Harmony Health Plan of Missouri	www.harmonyhpm.com
HealthCare USA	www.hcusa.org
Missouri Care Health Plan	www.missouricare.com
Molina Healthcare of Missouri	www.molinahealthcare.com

MO HealthNet managed care plans demonstrate improvement on several HEDIS measures

Source: Missouri Department of Health & Senior Services



MO HealthNet Managed Care: *the right care at the right time for the right cost*

CRITERIA	FFS ¹	MCO ¹	
QUALITY OF CARE			
Establish health care home	○	●	Managed Care promotes quality through its coordinated approach and through adherence to strict standards.
Emphasize continuum of care over episodic care	○	●	Health care homes are a core competency of managed care organizations and have been a routine practice in Missouri managed care since 1995.
Emphasize preventative health education and initiatives	○	●	Managed care establishes a continuum of care rather than episodic care as in fee-for service.
Conduct care coordination	○	●	Managed care conducts health education throughout our membership, and communities served: in schools, churches, and community events.
Conduct case management	○	●	Managed care plans routinely provide coordination of care, disease management, health improvement programs, case management, and patient education. ¹
Conduct provider credentialing	○	●	Case management is a core competency of managed care organizations.
Conduct utilization management	○	●	Managed care plans administer provider credentialing to assure licensure, absence of sanction, and educational criteria are met.
Employ quality oversight strategies (Performance Improvement Program)	○	●	Utilization management is a core competency of managed care organizations; such initiatives assure the right care, at the right time, in the right setting; this is overseen by medical directors.
Meet HEDIS quality benchmarks	○	●	A 2004 national survey found that alternative fee-for-service programs were far less likely to use the quality oversight strategies employed by HMOs. ²
Utilize electronic care plans	○	⊖	Managed care organizations adhere to quality standards, meet benchmarks, and report on outcomes (e.g. HEDIS)
Conduct member satisfaction surveys (CHAPS)	○	●	Managed care organizations employ sophisticated electronic medical management software applications.
Conduct provider satisfaction surveys	○	⊖	Managed care organizations must conduct member satisfaction surveys and respond to participant needs; this information is available to the public.
			Managed care organizations conduct provider satisfaction surveys and respond to provider needs through professional education and customer service.
ACCESS TO CARE			
Comply with provider network requirements	⊖	●	Managed Care promotes access by requiring providers to meet standards for hours of operation, availability of services and acceptance of new patients.
Comply with state member access requirements	○	●	In 2008, managed care plans demonstrated their ability to develop networks in areas the state could not organize (i.e. SE Missouri).
Comply with state appointment standards	○	●	Managed care plans must comply with state guidelines on distance and provider networks—this expands availability and access for all Missourians.
			Managed care plans must comply with state guidelines on appointment standards—this assures timely access to care for all Missourians.
ACCOUNTABILITY			
Accountable to regulatory agencies (e.g. HEDIS/EQRO/CMS)	○	●	Manage care is accountable and its results transparent.
Accountable to State DIFP	⊖	●	Managed care plans are subject to extensive state and federal regulatory oversight (e.g. HEDIS, CMS, EQRO, member satisfaction, and financial solvency standards).
			Managed care organizations are accountable to the same standards in Missouri as its other commercial insurance plans.
PROVEN TRACK RECORD			
Receipt of services	⊖	●	With 17 million beneficiaries nationwide, managed care has a proven track record in terms of quality and cost. Data are currently available on quality of care, continued access, and outcomes. ³
			“According to Behavioral Health Concepts in their 2006 EQRO Report, MO HealthNet members are receiving more services than their fee-for-service counterparts. Claims data shows a much higher rate of claims per 1,000 members for MO HealthNet managed care members. This is likely due to a greater availability of needed services, more access points to care, and the timeliness in which those services are delivered.”
COST SAVINGS AND COST AVOIDANCE			
State financial risk/predictability	○	●	In the early stages of managed care, savings are extensive due to the lack of care coordination and a medical home in the system to be managed; once these initial savings are realized, as managed care matures, savings shift to costs avoided because of the coordination and intervention inherent with managed care; if that mechanism were removed, then costs would escalate once again.
State cost avoidance	○	●	The state pays managed care plans a fixed capitation to assume the risk for the state. The advantage to the state is predictability of cost and budgeting accuracy; the state can count on fixed costs per patient. If a plan loses money, the state is not at risk for that.
			Over the years the state has consistently avoided costs due to savings from managed care organizations.
EFFICIENCY			
	○	●	A dollar of administrative cost buys more in managed care than in fee for service. Representative comparisons of administrative cost in FFS to managed care must take into account that managed care administrative cost include a multitude of services unavailable through FFS, such as case management, utilization management, member education, community outreach, and provider relations 24 hour nurse advice lines, etc.

KEY
 minimal ○
 moderate ⊖
 superior ●

SOURCES

- Lewin Group Assessment of Medicaid Managed Care Expansion Options in Illinois, 2005.
- Eric Schneider, et. al., “Quality Oversight in Medicaid Primary Care Case Management Programs,” *Health Affairs* 23:6, pages 235-242 (2004).
- CMS website April 2007, available at www.cms.hhs.gov/MedicaidDataSourcesGenInfo/Downloads/MMCER05.pdf