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A summary of findings from the *Rapid Response Review of MO HealthNet by McKinsey & Co.* and additional considerations

Missouri Medicaid Transformation:
A Dialogue on Implementation

The fourth event in the *Transforming Healthcare in Missouri* series

Note:

“Solution Concepts” for each section are broad summaries of the McKinsey Report’s suggested areas for improvement.

The Appendix contains the full, itemized list of recommendations in each section and estimated cost savings from the McKinsey Report.

State of Missouri Medicaid, 2018

- **Total Medicaid spending (SFY2018): $10 billion**
  - 53% from federal funds
  - 21% from state general revenue
  - 26% from provider taxes and other funds
- **As a percent of state general revenue, Medicaid spending was**:
  - **17%** in SFY2009
  - **24%** in SFY2018
  - **26%** (projected) by SFY2023; or **30%** by SFY2023 in the case of an economic downturn

1. Acute Care Services – Efficiency

McKinsey Report Findings

- *Current spending* on acute care SFY2018: $4.2 billion (+ $1.5 billion in pharmaceuticals)
- Value of care, in terms of dollar spending vs. outcomes, varies significantly across counties.
  - >15% of acute care expenditures may be associated with potentially avoidable exacerbations and complications (PECs); plus 5-10% of expenditures associated with inefficiencies
- MO is unique in making add-on payments to hospitals for services provided to beneficiaries of other states' Medicaid programs ($177 million in SFY2019)
- Minimal incentives to contain costs:
  - Hospitals are paid through base rates plus "add-on payments"
  - Physicians & Behavioral Health Providers are paid fee-for-service

Solution Concepts[1]

- Adjust rate-setting methodologies (including inpatient and outpatient base rates & add-on payments for non-MO residents)
- Move to value-based payment and increase cost transparency
  - E.g. incentives to reduce avoidable re-admissions; PECs
- Increase transparency of outcomes
- Better care coordination

Additional Considerations & Successful Policies from Other States

- Are the PECs reflecting upstream factors? How can Medicaid payments cover services that would mitigate upstream factors (e.g. lifestyle, diet, health literacy)?
- How did comorbidities and upstream factors exacerbate COVID-19?
- MO already has experience with PCMHs (Patient Centered Medical Homes) and Health Homes in Medicaid—how could MO expand on these to coordinate physical, behavioral & substance use care for patients with multiple/chronic conditions?
- Reimburse for preventive care services provided by Community Health Workers
  - "In rural Arkansas, one CHW program for the elderly and adults with physical disabilities reduced state Medicaid costs by $3.5 million, saving three dollars for every dollar invested in the program." (FamiliesUSA, 2016)
  - Options for reimbursing for CHWs include: State Plan Amendments (SPAs) for preventive services, Defined Reimbursement through Section 1115 Waivers, State legislation and SPAs for Broader Medicaid Reimbursement, Reimbursement through Managed Care Contracts (FamiliesUSA, 2016)

1. Acute Care Services – Access

McKinsey Report Findings

- Reimbursement varies significantly between hospitals (ranging from <50% to >150% of each hospital's UPL)
- Low reimbursement rate for doctors (79% of the national average)
- Physician shortages across the state, especially in rural areas
  - 80% of Missouri counties are physician shortage areas
- Provider tax compensation: if net contributors opt out and withdraw from voluntary transfers, then other recipients of pooled funds may struggle

Solution Concepts[1]

- Invest in rural and safety net infrastructure, including both primary care and behavioral health
- Redesign reimbursement methodologies to reflect the needs of rural and safety net providers

Additional Considerations & Successful Policies from Other States

- Consider global budgets for hospitals –Maryland and Pennsylvania use global budgets, which have helped insulate rural hospitals from some of the financial volatility of COVID-19; Pennsylvania's program focuses specifically on sustaining rural hospitals, with a Rural Health Redesign Center that "facilitates the all-payer contracting process, monitors hospital performance and provides technical assistance" (Fried, Liebers & Roberts, 2020)
  - Notably, the Pennsylvania program saw significant success only when the budget included both hospital facility payments *and* physician payments
- How can MO make payment more uniform and transparent across providers to encourage provider participation in Medicaid?
- Does the scope of telehealth coverage need to be extended?
- How can MO make decisions that adapt to anticipated federal decreases in DSH payments?
- How are scope of practice laws (for instance, those applying to RNs) limiting access to primary care in rural areas?
- Could MO use information from community health needs assessments (CHNAs) to reward hospitals for addressing population health needs?

2. Long-Term Services & Supports

McKinsey Report Findings

- *Current spending* on long-term care SFY2018: roughly $2.9 billion
  - For ~106,000 people: 39% of ABD population receives LTSS, but LTSS is 71% of MO's total spending on the ABD population
- Nursing facilities are reimbursed with a per diem cost-based payment—no adjustments for acuity, quality of care, or outcomes
  - Little incentive to provide differentiated care for higher-needs patients, or to transfer lower-needs patients back to their home/community
  - HCBS (Home and Community-Based Services) not held accountable for readmission
- Eligibility for LTSS is determined across three state agencies (DSS, DHSS, DMH)—MO's "no wrong door" system has helped streamline people into ideal LTSS options, though is still complex
  - Point system for eligibility; several different waivers
- MO's system could better incentivize & support individuals living at home, e.g. through the "Money Follows the Person" program

Solution Concepts[2]

- Transition the relatively high number of low-acuity Medicaid residents residing in nursing homes to their homes and communities
- Simplify patients' path to getting LTSS across multiple agencies
- Improve consistency in costs for services provided across multiple providers, services & agencies
- Use level of care assessments in care planning
- Add a value-based component/quality incentive to nursing facility rates

Additional Considerations & Successful Policies from Other States

- Data show better outcomes and lower costs for home- and community-based care as opposed to institutional care, and a preference for home and community-based care among 90% of elderly respondents (Super, Kaschak & Blair, 2018):
  - In Nevada, a house call program with 91 clients in an HMO resulted in a 62% reduction in hospital stays, amounting to nearly half a million dollars in savings (Phillips et al., 2004).
  - "A 2017 survey of 12 states with Medicaid managed long-term services and supports programs found that states have experienced sharp reductions in long-term nursing home stays and hospitalizations." (Super, Kaschak & Blair, 2018)
- How does the quality of care in long-term care facilities vary in urban vs. rural areas?
- In states like Missouri with certificate-of-need (CON) laws (compared to states without) Medicaid spending on nursing home care grew faster, whereas spending for home health care grew more slowly (Rahman et al., 2016). How do CON laws affect LTSS cost & quality?
- How does COVID-19 risk in nursing homes intersect with Medicaid reimbursement?

3. Pharmacy

McKinsey Report Findings

- *Current spending* on pharmaceuticals in SFY2018: about $1.5 billion
  - 25 drugs accounted for ~25% of spending; 4141 accounted for the remaining ~75% of spending
- MO is one of only four states that carves pharmacy out of managed care arrangements, giving the state full responsibility for paying for & managing utilization of drugs
  - State pays for retail drugs via and ingredient cost & a dispensing fee
- Payment for drugs is entirely fee-for-service
- Preferred Drug List (PDL) : prior authorization, step therapy, quantity limits
  - "Grandfathering" – MO doesn't require participants on a non-preferred drug to switch to a preferred drug
- Rx costs grew 5% in the past 3 years; mainly driven by ADHD, hepatitis C, behavioral health conditions, hemophilia, rheumatologic conditions, diabetes, asthma, growth deficiency syndromes & pain

Solution Concepts[3]

- Eliminate "grandfathering in" drugs (implementation underway)
- Other states have medical necessity policies/utilization management (e.g. quantity limits, prior authorization) for high-cost drug classes, like oncology and hemophilia management
- Increase MO's rebate capture rates, which are below the national average (e.g. through a purchasing consortium with other states)

Additional Considerations & Successful Policies from Other States

- Michigan and Oklahoma received CMS waivers in 2018 for value-based contracting with pharmacy manufacturers with supplemental rebates based on performance/outcomes (Sweeny, 2018).
  - However, Oklahoma saw only four drug manufacturers sign contracts within the first year due to the financial risks involved—how can pharmacy contracts be value-based while still being an attractive option to drug manufacturers?
  - An alternative in Louisiana is a new subscription-based model in which the state pays 5-year flat rate for unlimited access to hepatitis C drugs (Deslatte, 2019)
- What is the role for MO HealthNet reimbursement in ensuring equitable access to care for COVID-19 treatment, including hospitalization, and potential long-term effects on survivors' health?

4. Managed Care – Efficiency

McKinsey Report Findings

- *Current spending* in managed care ~$2.2 billion
- *Rate setting methodology:* currently "encourages efficiency, adjusts payments based on risk, and manages non-benefit expenses"
- New participants remain in fee-for-service before selecting or being assigned to an MCO
- For some health home enrollees, the state pays both MCOs and health homes for care management services—there is an opportunity to clarify or delegate
- There are additional levers available (both penalties and incentives) to incentivize MCO performance (e.g. rewarding high-performing MCOs with more participants)

Solution Concepts[4]

- Additional efficiency adjustments
- Greater specificity and enforcement of MCO contracts
- Use additional levers to incentivize MCO performance
- Updates to MMIS to capture more types of encounter data for performance management
- Partnerships with MCOs that are based more on performance than simply on monitoring contractual compliance

Additional Considerations & Successful Policies from Other States

- MO already requires MCOs to offer local community care coordination programs (LCCCP) with referrals to community/social supports, plus the option to participate in health homes for those with multiple/chronic conditions – these could be extended
- States are required to collect race, ethnicity, sex, language & disability status info—but some have missing REL variables
  - Does MO do an adequate job stratifying quality measures by demographics? How can we use that information to improve managed care?
- How could MCO contracts be clarified to require coordination of care management with providers?
- Iowa, Massachusetts & New Jersey tie MCO incentive payments to a social determinants measure (Gifford et al., 2018)
- Several state plans offer services beyond those specifically required in their waivers to address social determinants including: routine sports/school physicals, diabetic & weight loss services, plus other services like GED coaching, housing support, mother and baby supports, and food access assistance, or safety items like helmets and infant car seats (Gifford et al., 2018)

4. Managed Care – Scope

McKinsey Report Findings

- Managed care program only encompasses children, parents & pregnant people (*excludes* most pharmacy and behavioral health, and all Aged, Blind and Disabled (ABD) spending)
- Managed care program for children and families was expanded under three capitated managed care organizations (MCOs)

Solution Concepts[4]

- Increase the scope of managed care to include:
  - Pharmacy & behavioral health
  - Parts of the ABD population

Additional Considerations & Successful Policies from Other States

- Thirteen states have carved in behavioral health services to MCOs
  - Beginning in 2019, Arkansas makes global payments to shared savings entities serving Medicaid recipients with complex behavioral health and intellectual and developmental disabilities service needs. It includes additional services such as respite care, supportive life skills development, adaptive equipment and environmental modifications to facilitate living in home/community settings (AK DHS, 2020).
  - Other states using physical and behavioral health care coordination (MN, OR, VT) have seen savings due to fewer emergency department visits and lower hospital admissions & readmissions (Center for Health Care Strategies, 2017)
- How can the state maintain choices (of provider, facility, etc.) for populations in managed care?
  - When the Medicaid population of people with disabilities transitioned to managed care (KanCare), participants reported overall satisfaction with care, but cited problem areas including provider networks, limited covered benefits, and care coordination (Hall et al., 2015).

5. Program Integrity

McKinsey Report Findings

- Two divisions largely responsible for preventing fraud, waste & abuse (FWA):
  - *Missouri Medicaid Audit and Compliance* (MMAC) – enrolling, auditing, investigation, sanctioning providers
    - Produced ~$40 million in savings for MO in SFY2018
  - *Welfare Investigations Unit* (WIU) – preventing participant fraud
- Cost Recovery Unit – identifies third party liability (Medicare, workers compensation, etc.) to ensure that these are the primary source of payment before the state pays
  - For MCO enrollees, identifying third party liability is the MCO's responsibility
- State identifies Medicare leads and, to save costs, pays Medicare premiums for people eligible for certain social services such as Aid to the Blind and Temporary Assistance for Needy Families

Solution Concepts[5]

- Minimize silos between departments to detect fraud, waste and abuse
  - Different divisions currently have their own computer programs, eligibility criteria, service delivery, audits, etc.
- Enroll more dual-eligible participants into Medicare (current levels are below the national average)
- Promote proper medical coding
- Identify experimental, investigation, and unproven (EIU) medical procedures

Additional Considerations & Successful Policies from Other States

- Are there system biases that lead FWA to be detected at higher rates among certain demographics or provider types?

6. Federal Financing

McKinsey Report Findings

- MO could capture between $10 and $20 million in grant funding and additional matching (see 'Solution Concepts')
  - However, MO has already captured a significant portion of the federal funds for which it is eligible
- Federal funding is ~65% of total spending in the top Medicaid spending categories, which include, ranked from highest to lowest spending:
  - Managed care, pharmacy, hospital care, nursing facilities & physician payments

Solution Concepts[6]

- Leverage new federal grants/waivers that fund innovative Substance Use Disorder/Opioid Use Disorder (SUD/OUD) & behavioral health models
- Opportunities for more federal matching funds in areas including: Alzheimer's services, communicable diseases, autism, crisis intervention, and emergency room enhancements (ERE)

Additional Considerations & Successful Policies from Other States

- Hospital payment: MO is now above the DSH cap and is only able to distribute ~85% of the amount calculated from hospitals' cost reports as Medicaid and uninsured uncompensated care
  - This is largely due to hospital payments that are indexed to rates based on 1996 costs, forming the foundation for a complex and opaque payment methodology.
- In a study of spending in all 50 states, "From 2014-2017, Medicaid expansion was associated with a 4.4 percent to 4.7 percent reduction in state spending on traditional Medicaid" (Ward, 2020).
  - In expansion states, savings outside of Medicaid (such as in mental health care, the correctional system and uncompensated care)—though variable from state to state—were often substantial: 14 percent of the cost of expansion in Kentucky, and 30 percent in Arkansas, for instance" (Ward, 2020).
- How could MO use the USDA's telehealth infrastructure expansion grants for rural areas in a way that would increase rural access in MO HealthNet?
- Are there additional opportunities for federal match due to COVID-19?

7. Medicaid Management Information System (MMIS)

McKinsey Report Findings

- <u>*Current spending:*</u> ~$85 million for SFY2019
  - Two contractors: Wipro (60% of spending) & Conduent (40% of spending)
- MMIS is a mainframe-based computer system dating back to 1979
  - Not modular/agile; difficult to change one component without needing changes to many others
  - Difficulty finding staff & vendors to service outdated technology will be a growing issue
- McKinsey: "While the level of spending on technology is not misaligned with the needs of a Medicaid system of Missouri's size, the functioning of the technology does not meet current or future needs."
- MO needs a more specific replacement plan
  - CMS outlines criteria for which states can be eligible for a 90/10 federal match MMIS replacement initiatives- modular replacement
  - Federal match for MMIS is currently increasing (75% in 2020)
- There is often confusion regarding the meaning of 'MMIS', as it is an integrated set of technologies

Solution Concepts[7]

- Updating outdated MMIS technology is critical
- Balance extensive workaround/rebuilds with changes within the existing system (the latter likely has a greater return on investment.)
- Greater alignment between Information Support team and broader Medicaid program
- Optimize decisions about which elements to insource vs. outsource

Additional Considerations & Successful Policies from Other States

- Is MMIS able to collect & manage the data required to answer questions about health inequities and social determinants of health?
- Consolidate HIE (health information exchange) and HIT (health information technology) to make them more interoperable
  - How does the lack of coordination between different HIEs and HINs in the state impact care? How does this hinder flexibility during a pandemic?

8. Operations

McKinsey Report Findings

- Family Support Division (FSD) and MHD are responsible for participant- and provider-focused functions
    - E.g. eligibility determination, participant enrollment, provider enrollment, prior authorizations/medical management, claims processing, queries from participants & providers
- Support functions like contact centers and data and analytics are executed through a mix of staff and vendor contracts
- State staff identified opportunities for improvement in:
    - *Managed care enrollment*- Agencies determine eligibility and provide data to MO HealthNet for MCO enrollment; enrollment errors are manually reconciled; participant status is updated as needed based on information from state agencies
    - *Claims processing*-Providers verify eligibility (preauthorization if needed), claim is adjudicated, and payment is made
    - *Contact centers*- Family Services Division handled 3.2 million calls in 2018; calls about Medicaid eligibility and constituent health services are mostly outsourced
        - Incoming calls are routed into tiers- wait times are 10 minutes on average, up to an hour

Solution Concepts[8]

- Use best practices for allocating operational resources, including outsourcing, automating and digitizing
- Better tracking of key performance indicators
- Automate tasks that staff are doing manually and repetitively (especially those involved in participant enrollment)
- Integrate communication with participants across MO HealthNet Division and Family Services Division to avoid confusing/repeated communication
- Increase non-phone self-service options, highlight alternatives to phone call

Additional Considerations & Successful Policies from Other States

- What issues in the system operations lead *eligible* people to not enroll or be disenrolled? Are these issues operating in a systemic way to create inequities?
- Could expanding presumptive eligibility to additional categories minimize administrative errors in which eligible people are being inadvertently disenrolled?
- How can participant contact information, such as phone numbers and email addresses, better be shared across the various state programs, including between DSS and MCOs?

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[1]*Appendix*: Acute Care

McKinsey Report – Proposed Improvements

(estimated net savings $250 to $500 million)

1. Implement an inpatient hospital readmissions policy.
2. Expand prior authorization (PA) to additional outpatient procedures.
3. Adjust outpatient base rate methodology
   E.g. anchor base rates to a percent of Medicare fee schedule, rather than a percentage of charges across all outpatient services
4. Adjust inpatient base rate per diem methodology
   E.g. a stratified per diem with different base rates for different patient types, such as medical, surgical, maternity
5. Consider case rate methodology for inpatient and/or outpatient services
6. Reevaluate add-on payments for out-of-state (non-MO) residents.
7. Modify Direct Medicaid payments methodology
8. Apply UPL caps to individual hospitals
9. Adjust MCO hospital payments
10. Improve physician and behavioral health reimbursement
11. Re-examine payment levels for financially vulnerable rural and safety net providers
12. Transition to value-based payments (an incentive to invest in prevention, primary care, coordination, integration of physical and behavioral health care, home health care)
    Population-based models; Bundled payments or episode-based models; Global budgets for rural hospitals
13. Create transparency for outcomes of care
14. Include MCOs in a VBP program to maximize impact and align incentives for providers across the total Medicaid population
15. Explore multi-payor VBP alignment
16. Update the DME fee schedule

[2]*Appendix*: Long-Term Services & Supports

McKinsey Report – Proposed Improvements

(estimated net savings $90 to $270 million)

1. Include an acuity adjustment in the nursing home reimbursement methodology.
2. Rationalize rates for similar HCBS services provided through different programs and funding authorities
3. Complete and expand upon revisions currently underway to assessment algorithm and process
4. More directly employ assessment results in care planning process
5. Improve the consistency of the approval process for personal care services
6. Extend Money Follows the Person (MFP) through a new grant or waiver (eg. a rent subsidy to allow living at home)
7. Implement additional waivers (e.g., waiver for children with developmental disabilities who do not require habilitative services) or expand current waivers
8. Missouri could consider introducing Alternative Payment Models (APMs) for LTSS services
9. Create transparency of the outcomes of care

[3]*Appendix*: Pharmacy

McKinsey Report – Proposed Improvements

(estimated net savings $35 to $60 million)

1. Implement medical necessity guidelines and prior authorizations in drug classes that do not have such policies
2. Reduce grandfathering.
3. Join a purchasing consortium to increase supplemental rebate capture.
4. Require NDC submission on claims for non-J-code HCPCS drugs
5. Consider whether to contract with a specialty pharmacy.
6. Apply for a value-based contracting wavier from CMS.

[4]*Appendix*: Managed Care

McKinsey Report – Proposed Improvements

(estimated net savings $175 to $300 million)

1. Incorporate additional efficiency measures into the managed care rate-setting process.
2. Implement stop-loss provision and combine small rate cells.
3. Expand day one managed care eligibility and passive enrollment to additional populations.
4. Further specify contract provisions regarding key operational processes and timelines.
5. Clarify and strengthen care management requirements.
6. Clarify and strengthen incentive programs and programs intended to encourage adoption of value-based payment.
7. Deploy additional levers to incentivize MCO performance on key metrics.
8. Optimize financial penalties to better regulate MCO performance on key metrics
9. Streamline MCO reporting requirements and improve accuracy and timeliness of information reported by MCOs; establish cadence for performance management dialogues.
10. Carve in additional services to managed care for the current managed care population.
11. Transition to a single-MCO model with specialized capabilities for the foster care population.
12. . Expand the scope of the managed care program to include the ABD population (in whole, in part, or on a phase-in basis).

[5]*Appendix*: Program Integrity

McKinsey Report – Proposed Improvements

(estimated net savings $65 to $100 million)

1. Expanding the national correct coding initiatives (NCCI) coding edits that the state has in place.
2. Create an experimental, investigation, and unproven (EIU) medical procedure policy to prevent improper payments.
3. Expand the analytical funnel to identify additional improper payments that can be prevented using claims edits and pre-pay changes or can result in recoveries.
4. Optimize the state's ability to identify and enroll participants who are currently and may become Medicare eligible.
5. Improve TPL Identification.

[6]*Appendix*: Federal Financing

McKinsey Report – Proposed Improvements

(estimated additional federal financing available $10 to $20 million)

1. Access enhanced match by strengthening SUD focus in health homes.
2. Pursue a State Plan Amendment to access federal funds for SUD services provided in IMDs.
3. Apply for the Serious Mental Illness/Severe Emotional Disturbance (SMI/SED) demonstration through a Section 1115 Waiver.
4. Apply for CMMI grant funding through the Maternal Opioid Misuse (MOM) and Integrated Care for Kids (InCK) Models.

[7]*Appendix*: Medicaid Management Information System (MMIS)

McKinsey Report – Proposed Improvements

1. Improve alignment between IS and program.
2. Evaluate the current modular replacement strategy and define an updated strategy informed by clear strategic direction from the program and reflecting better alignment to the market, other states, and CMS.
3. Strengthen IS capabilities through hiring, partnering for talent, and retraining/upskilling.
4. Optimize insourcing vs. outsourcing.

[8]*Appendix*: Operations

McKinsey Report – Proposed Improvements

1. Develop process guides for staff member efficiency improvement and error reduction.
2. Develop job aides for high-volume tasks.
3. Implement workforce management.
4. Adopt performance management practices.
5. Within the participant enrollment flow, integrate mailer and correspondence process with FSD.
6. Improve medical record matching to reduce incorrect denials in participant enrollment.
7. Improve accumulator accuracy to help manage spend down errors.
8. Assess prior authorization (PA) list for high pass rate codes and optimize through quarterly refreshes.
9. Redesign root-cause drivers (e.g., participant communication & notification) to reduce call volume to contact centers.
10. Revise policy guidance on MAGI helpdesk to avoid rework.
11. Implement macros and automation to replace repetitive manual tasks.
12. Improving upstream systems to help reduce manual rework.
13. The state could engage inbound data stream owners to align on data feed formats.
14. Invest in improvement of auto adjudication rates.
15. Implement issue and project tracking system.
16. Build digital participant engagement platform.
17. Provide self-service options for Tier 1 calls to reduce live calls and wait times.
18. Evaluate engaging additional vendors.
19. Define future operating model for state contact centers to balance in-house vs outsourcing options.