MO HealthNet

Ongoing Change

The National Medicaid Congress

June 4, 2008

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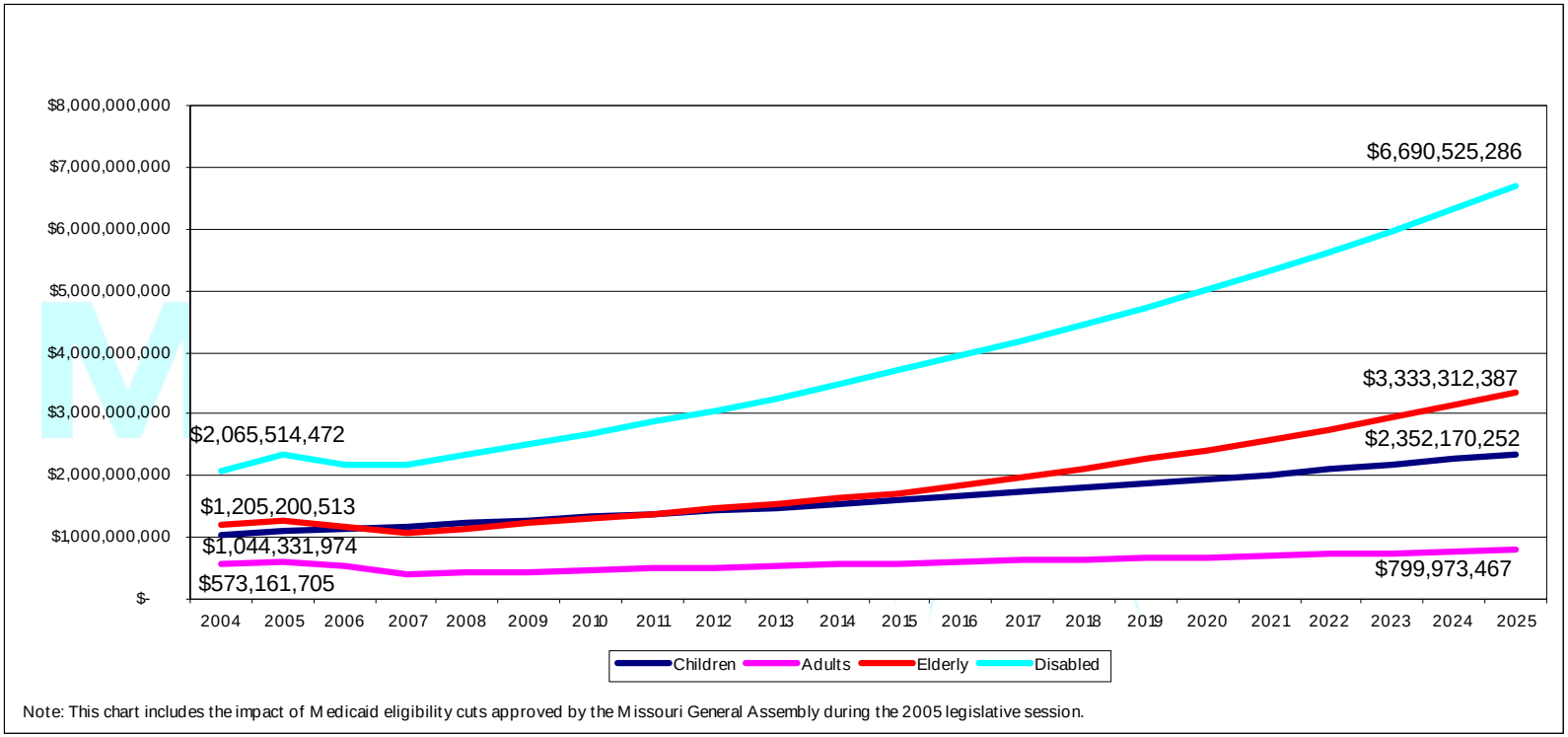
MO HealthNet Division

Projected Future Medicaid Spending by Eligibility Group, 2004-2025



Note: This chart includes the impact of Medicaid eligibility cuts approved by the Missouri General Assembly during the 2005 legislative session.

Missouri Change in Philosophy

- From: Social Service Role
  - Passive Claims Payment
  - Enrollment
  - Safety Net
- To: Healthcare Consumer and Payer Role
  - Care Management Programs
  - E.H.R. to engage and inform Providers
  - Define Standards and Identify and Resolve Treatment Gaps
  - Consumer Directed

The Tenets of MO HealthNet

- Make decisions on medical evidence and best practices not intuition or expenditures
- Provide management that is as transparent to patients and providers as possible
- Produce outcomes reports for all programs
- Review and insure quality assurance for program policy
- Don’t punish the many for the sins of a few

MO HealthNet Roll Out

- Promote health and wellness
- Focus on preventive medicine
- Engage recipients to become *participants* in their health care
- Advance the use of evidence-based practice
- Incorporates technology to improve transparency
- Increase the information available to participants and providers for decision making
- Reward providers for engagement and performance
- Increase access through improved provider reimbursement

MO HealthNet Ongoing Change

- Key Components:
  - Health Care Home
  - Health risk assessment
  - Electronic plan of care
  - Provider Access
  - New Role for Participants and Providers

Progress to Date…

- Physician Rate Increase
- Durable Medical Equipment
- Managed Care expansion to an additional 17 counties
- Procurement of a business and clinical intelligence tool
- Telehealth Projects
  - Rule filed in January 2008
  - Working on a project funded in the FY2008 Budget to deploy telehealth to Rural Health Clinics

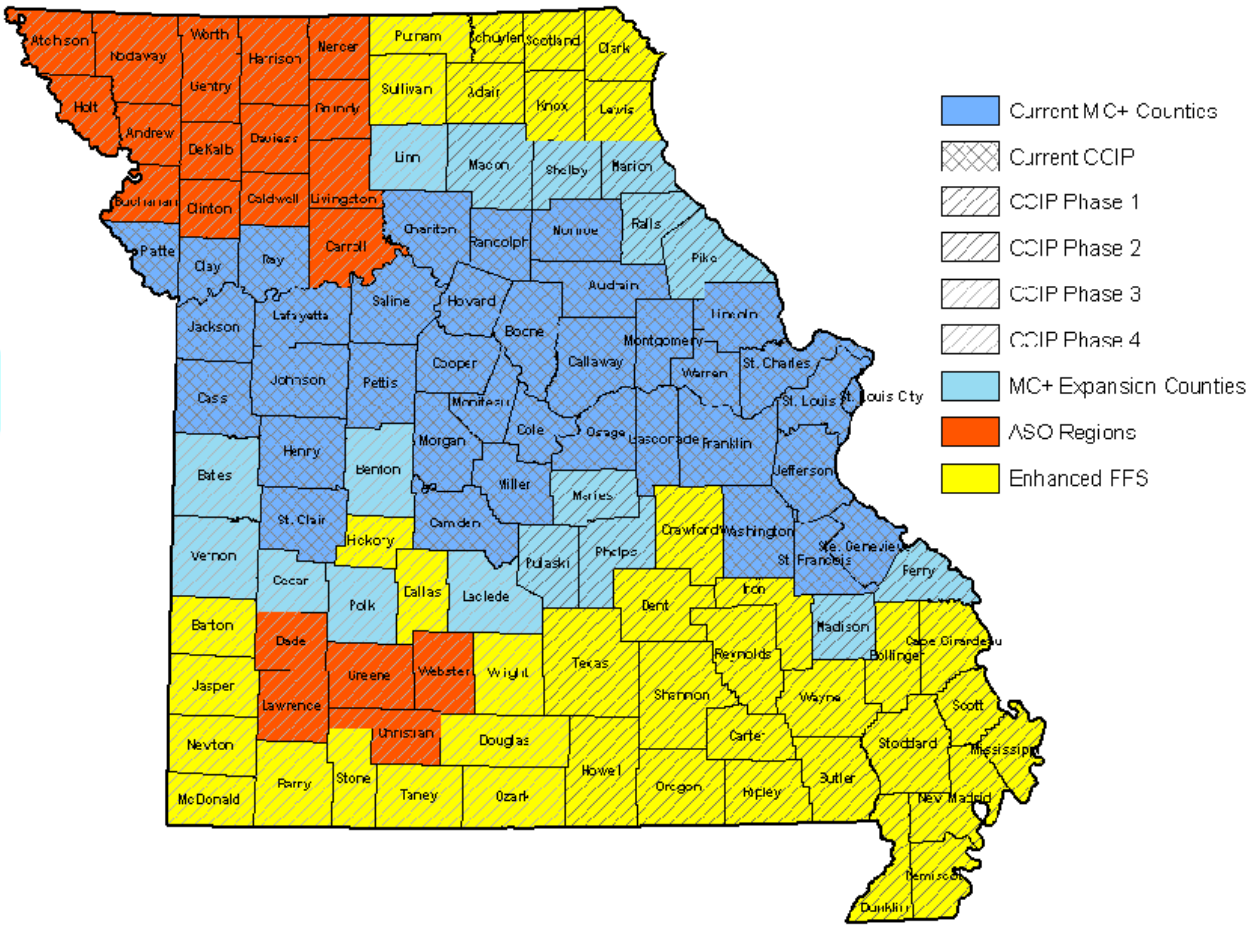
Overall Missouri Participant Goals

- All Participants Will Have A Healthcare Home
  - Primary focus is the wellness of the patient
- Achieve Wellness and Length of Wellness
  - Education and resource coordination
    - Chronic care management
    - Consistent with disease severity and process
    - Focused on medically necessary level of care
- Encourage Personal Responsibility
- Balance Care with Wellness and Public-sector Investment

Overall Goals of Missouri Delivery System

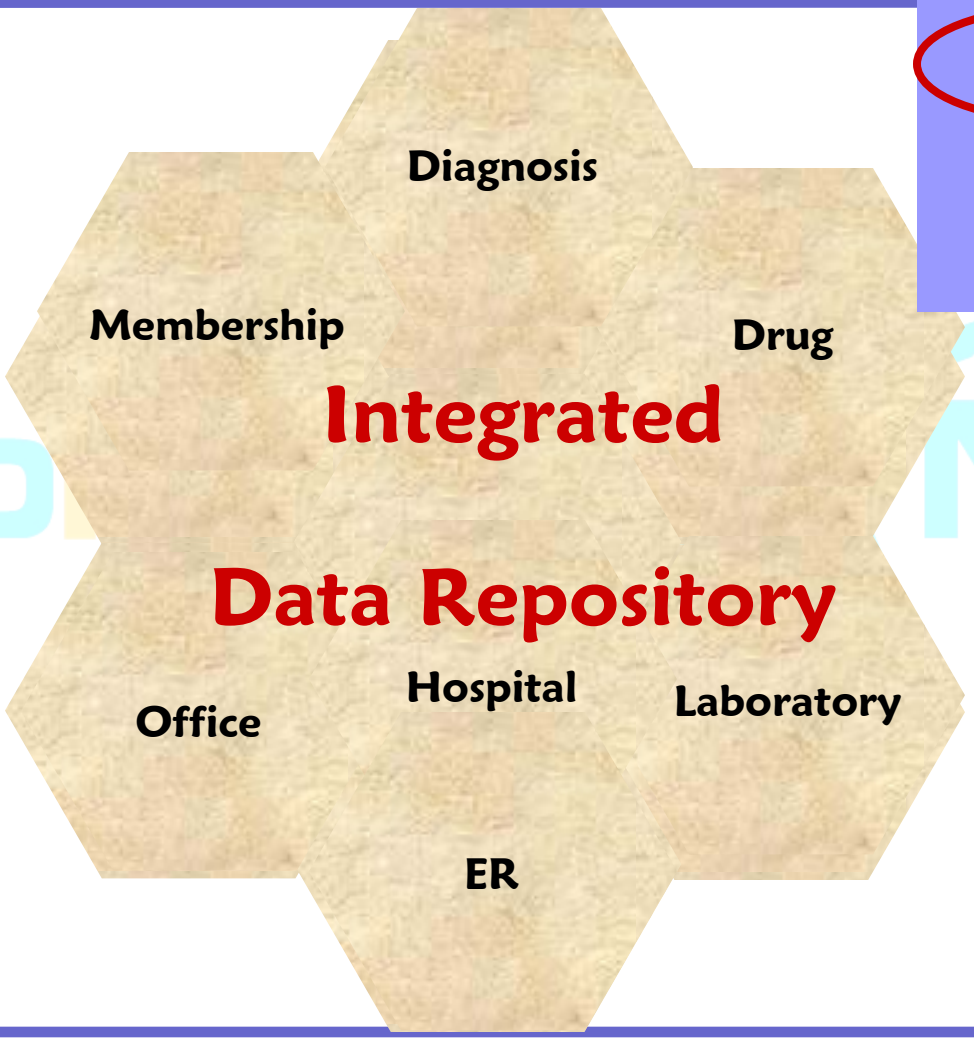
- Appropriate Setting – based on disease stratification
- Appropriate Cost
- Targeted to Ensure Integrity of Pathway
- Empower Patient to Participate As Possible
- Focus of Access to Care and Payment
  - Best Practices
  - Medical Evidence
- Targeting of Guidelines to Assure
  - Necessity of Care
  - Diagnosis Based Treatment
  - Quality
  - Prudent Resource Allocation and Utilization

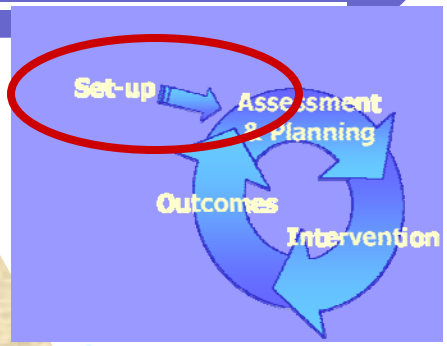
MO HealthNet Statewide Roll Out



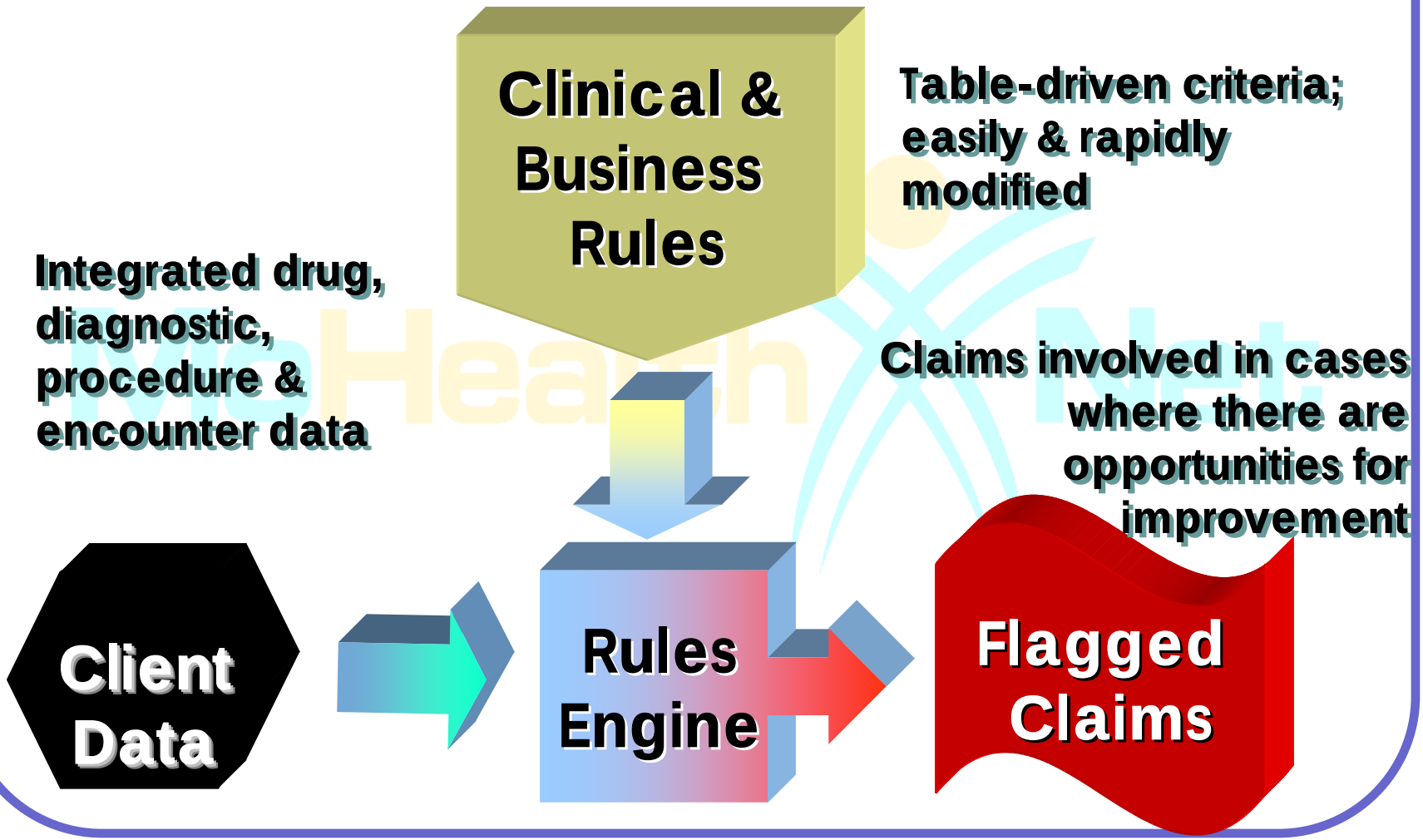
Mapping & Data Integration

- Pharmacy Claims
- Medical Claims
- Reference Data

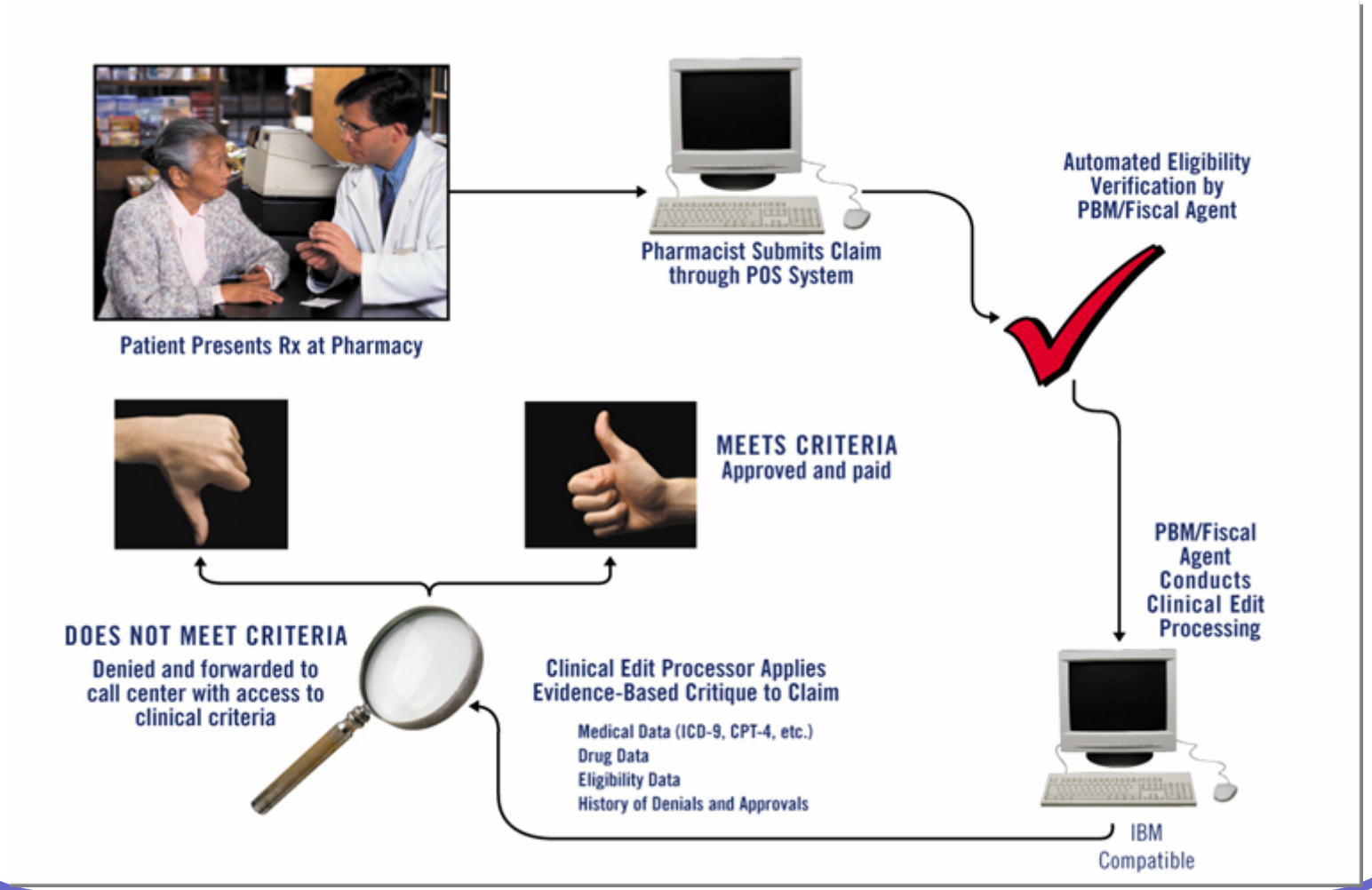




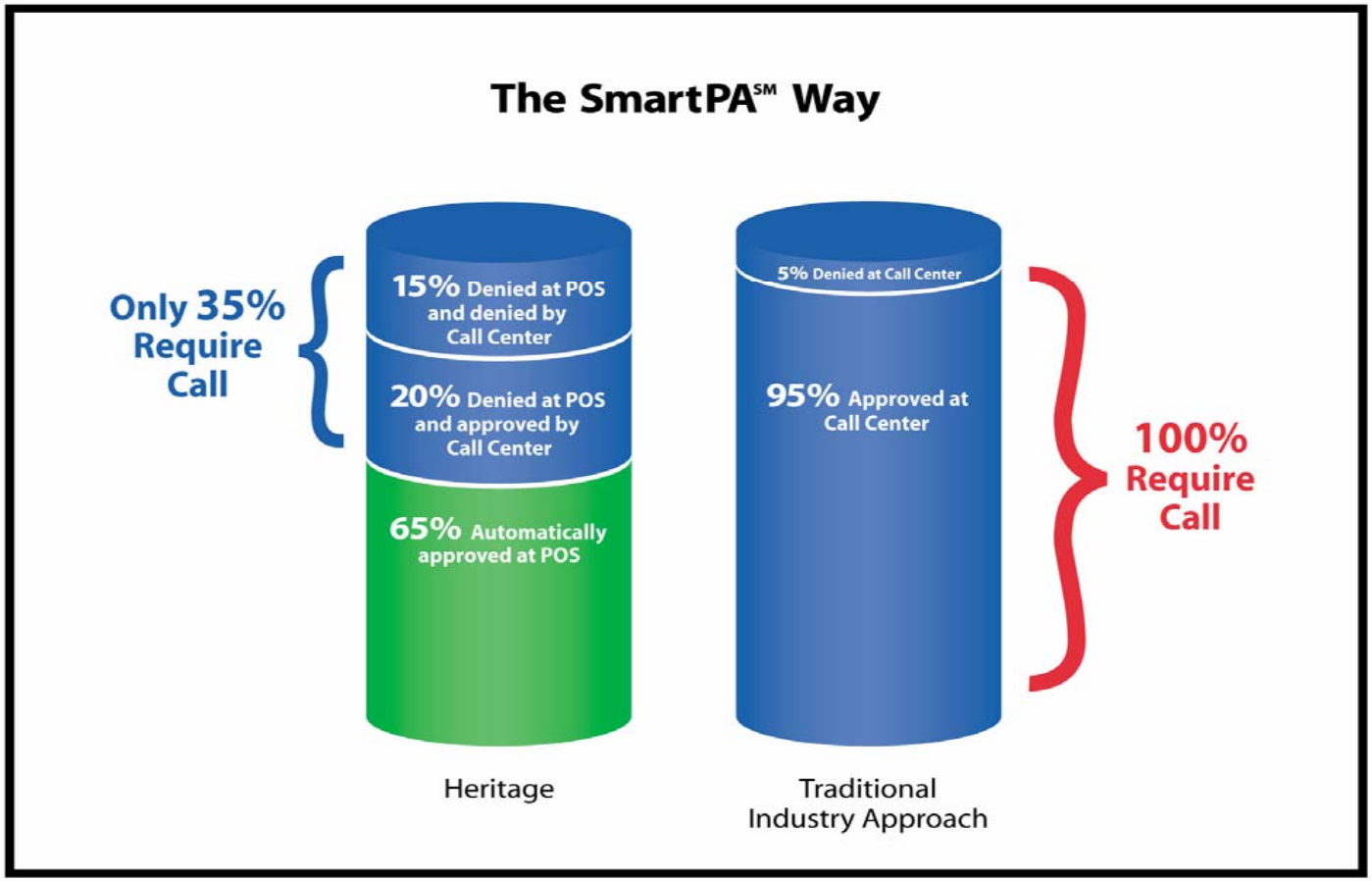
Clinical Rules System



SmartPA℠ Process



Evidence-Based vs Traditional Approach



CyberAccess℠
Electronic Health Record

- First step toward a comprehensive EHR for MO HealthNet participants
- Web-based tool with HIPAA-compliant portal for MO HealthNet providers
- Electronic prescribing capability
- View patient ICD-9,CPT codes, and paid drug claims over the past 2 years
- Identify clinical issues that affect the patients' care

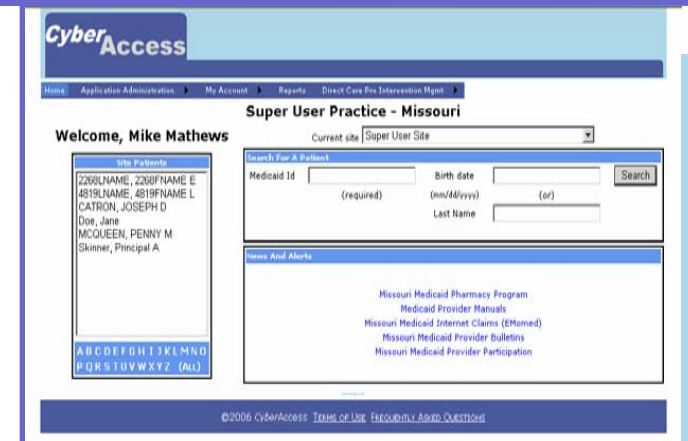
CyberAccess℠
Electronic Health Record

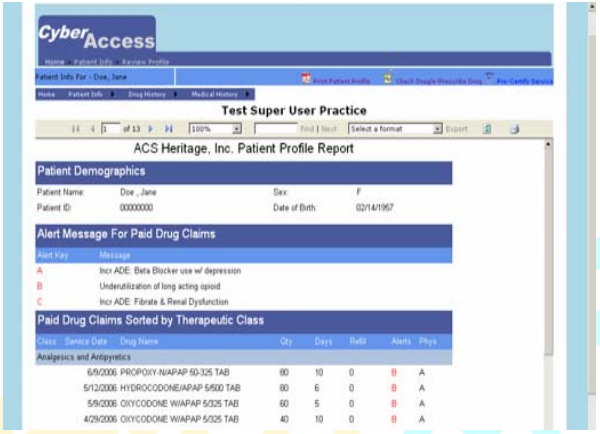
- Prospectively identify how PDL and CE criteria affect individual patients by running meds through rules engine
- Electronically request PA or CE overrides
- Electronically request pre-certification for certain medical procedures or equipment
- Identify existing authorizations issued for a patient
- Receive patient-specific best-practices and guideline alerts

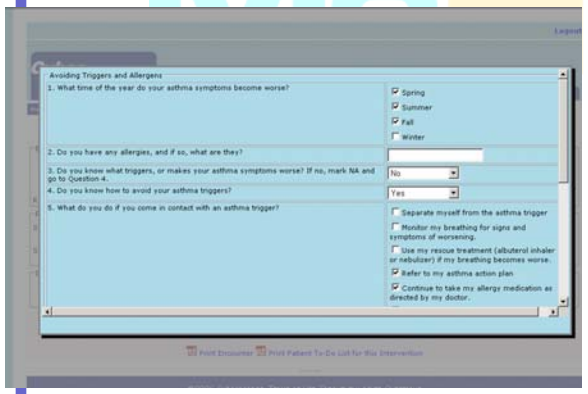
DirectCare Pro

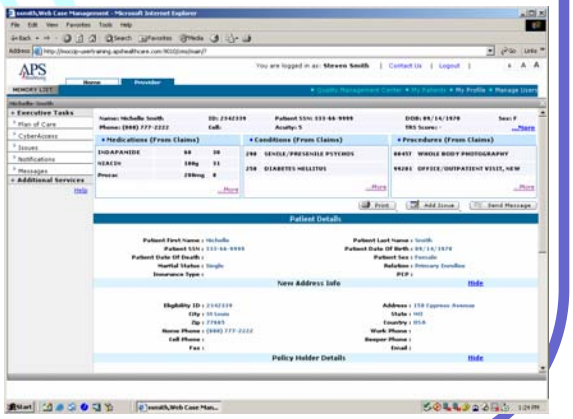
- Pharmacist Electronic Healthcare Tool
- Designed to engage RPh's to take more active role in the care of participants
- Targeted Care Interventions
- Improves adherence to care & treatment guidelines for chronic conditions
- Targeted Reporting
- "Real Time" Billing Tool

Driving Change Through Technology









Medicaid Drug Rebate Program

- Established in 1990 – Omnibus Budget Reconciliation Act (OBRA)
- Modified in 1992 – Veterans Health Care Act required manufacturers to rebate VA/DoD in order to have Medicaid Coverage
- Provide standards for manufacturer reporting, rebate calculations and confidentiality
- 550 pharmaceutical companies and 49 states* participate
- Based on AMP and “Best Price”
- **All except AZ*

Deficit Reduction Act (DRA) 2005

- Sales-based pricing information available to states monthly – for FUL calculation
  - Implementation halted
- Require state collection and submission of utilization data for physician-administered drugs
  - Requirement to connect J-Codes with NDC codes on provider-administered drugs
  - Ensures collection of drug rebates
  - Claims subject to program cost containment initiatives

Physician-Administered Pharmaceuticals J-Code Conversion

- HCPCS J-Code traditionally used by institutions and physician providers for reimbursement from Medicare/Medicaid
- Medicare reimbursement driven by J-Codes – Crossover Claims
- J-Codes = Unit
- NDC Codes = Decimal Quantity (e.g., mL's)
- One J-Code can be associated with multiple NDCs
- Identification of actual drug dispensed often impossible

How Missouri is Doing it

- MO HealthNet has required physicians (offices/clinics) to bill meds on a pharmacy claim form with NDC since early 1990s
- Currently, we are converting all other providers (beginning January 2008):
  - Hospital outpatient facilities
  - Rural health clinics (RHC's)
  - Federally-qualified health centers (FQHCs)
  - Dental providers
- All of these providers have percentage-based reimbursement related to federal subsidies
- Claims transmitted electronically on modified 837

Missouri Physician-Administered Drug Benefits

- Previously only few states *mandated* NDC billing for physician administered medications
  - Most are “slow adopters”
  - Resistance to change
  - Technology issues
- Claims included for drug rebate
- Subject to clinical cost containment initiatives
  - PDL edits
  - Clinical Edit Criteria
  - Retro-DUR

Discussion

- Questions?