Transforming Healthcare in Missouri Meeting Summary Report:

December 14, 2018

Jefferson City, Missouri

Transforming Healthcare in Missouri Overview

The Center for Health Economics and Policy (CHEP) and the Clark-Fox Policy Institute (CFPI) of Washington University in St. Louis convened more than 100 healthcare providers, payers, consumers, researchers, economists, advocates and policymakers to generate and discuss ideas for healthcare reform in Missouri. Over the span of 18 months, CHEP and CFPI organized three events under the banner of *Transforming Healthcare in Missouri*. The first two conferences took place in October 2017 and October 2018, and were held in St. Louis, Missouri. These events led to the development of a series of nonpartisan evidence-based policy recommendations for the state.

The third event, held on December 14, 2018, in Jefferson City, Missouri, was designed to bring these recommendations to a meeting with state leaders from the Missouri Departments of Health and Senior Services, Social Services, and Mental Health, and to representatives from statewide health and healthcare organizations. The purpose of this meeting was to discuss and further refine the recommendations gathered from the previous two events.

The stated goals for the participants of the December 14th meeting were to:

- Reflect on the current state of health and healthcare in Missouri;
- Discuss pressing topics that have significant bearing on health outcomes for the state's rural and urban residents; and
- Recommend innovative approaches for the delivery of preventative, acute and long-term care.

This three-part series has helped to facilitate dialogues and generate ideas that have the potential to advance local and state healthcare policies, ultimately improving the overall health of the people of Missouri. The challenge in Missouri, like the rest of the nation, is to offer affordable, quality healthcare to its citizens while also maintaining fiscal health. This report summarizes activities at the December 14th meeting and the policy recommendations from the discussion groups, as well as the recommendations for moving forward.

Overview of Health and Healthcare in Missouri

Timothy McBride, Washington University Professor and Co-Director of the Center for Health Economics and Policy, opened the meeting and presented some pertinent data and statistics to keep in mind when considering ways to improve and transform health and healthcare in Missouri. Among these were:

- Health spending as a percent of GDP both nationally and in Missouri are rising rapidly

- The United States spends much more on health services expenditures than other developed counties, but less on social service expenditures.
- Missouri currently ranks 38th in the nation for overall health at the state level after a previous ranking of 40th in 2017.
- Missourians face many health challenges including:
    - 19.5% report excessive drinking
    - 31.7% are obese
    - Missouri ranks 43rd for states in violent crime
    - Missouri has rates higher than the national average for premature death, infant mortality and obesity
- Rural areas of Missouri have particular challenges: rural Missourians have higher rates of uninsurance, smoking, and obesity; lower educational attainment; and fewer primary care providers and dentists per capita
- The uninsured percentage in Missouri has dropped from 13.2% in 2010 to 9.1% in 2017, while nationally the change has been from 15.5% to 8.7% respectively.
- There have been 6 hospital closures in rural Missouri since 2014.
- The Missouri population is aging, causing additional demands on our healthcare system.

Keynote Address

The keynote address, *Evidence-based practice and policy: Are we making legislation or sausage?,* was provided by Ross Brownson, Professor at the Brown School at Washington University in St. Louis. The presentation centered on using evidence to inform policymaking at both the state and organizational levels. He provided examples of evidence to be used including scientific literature, public health surveillance data and advice from friends or colleagues. While we have made progress toward grounding practice in evidence, there are still many barriers to using it as effectively as possible.

Dr. Brownson highlighted the following considerations when using evidence to inform policy:

- Equality does not equal equity, and there are often unequal access and opportunities when policies are developed
- One must consider the type of policy one is trying to inform when reviewing the evidence
- Academic researchers producing the evidence and policy makers wanting to use it don't always have the same perspective or look at the policy situation in the same way
- The approach in disseminating research to policymakers needs to be tailored to the audience being targeted
- "Upstream" causes for health challenges need to be addressed, and this may result in multi-level policy changes.

Key suggestions for developing policy solutions include:

- Addressing social determinants of health through state and local laws (minimum wage laws, Medicaid expansion)
- Adopting public health department policies and practices for a departmental workforce that acknowledge the historical and structural barriers to achieving equity
- Departmental commitment of resources to carry out plans
- Departmental capacity building to facilitate the skill sets needed to advance health equity (e.g., cross-sectional collaboration, community engagement)

- Departmental strategic plans and mission, vision, and value statements that codify and publicize these commitments and guide public health priorities.

Breakout Discussion Summaries

Following the keynote address, participants spent the majority of the event discussing pressing healthcare topics, challenges and ideas that emerged from the previous *Transforming Health in Missouri* meetings. These discussion groups were charged with discussing these ideas and shaping them into innovative and feasible policy solutions with achievable outcomes. Summaries from the group discussions are outlined below.

Topic: Medicaid Payment Innovation/Reform (Group A)

Broad ideas:

- In the current system, rewarding value or sharing savings is challenging, due to IT and budgetary constraints
- Saving on "inappropriate" or avoidable care is a low-hanging fruit in terms of possible improvements
- A new emphasis on primary care is needed
- It is difficult to design a mechanism that pays for good health when the majority of primary care practices are owned by hospital systems and serve as a conduit for patients who then receive services at that hospital

Areas of agreement:

- A pilot project extending the successful primary care health home model in MO (possibly by adding additional at-risk populations to it and) by introducing a shared savings component could demonstrate the efficacy and cost savings to be realized by addressing health needs at the primary care level
- It would be best for Missouri to provide incentives for private agencies providing social support services to consolidate/collaborate so as to be a better resource for addressing SDHs
- It is important to assess differentials in urban/rural experience especially if designated health homes or PCMHs or service networks are located where Medicaid enrollees are concentrated, i.e. in urban areas

Specific details to be determined:

- Are more health homes needed and if so, how will they be added?
    - Are special rules needed to ensure enough participation by primary care practices owned by hospital systems?
- If there are up-front costs with savings realized later, is there a budget to cover this?
    - Can the initial per-member, per-month (PMPM) be higher to cover system-level investments (gradually decreasing to be revenue neutral compared to current values)?
    - Is more staffing needed to ensure compliance by health homes to receive the PMPM?
- What quality metrics will be used? Can it be a manageable number?
- What is the specific formula for determining shared savings?

    - Is it at the clinic level or the overall provider level? If payouts are made based upon quality measures, but these are only calculable at the overall level, does this sufficiently reward the actual work?
    - Are cost savings measured against baseline, or against a hypothetical value coming from a risk-adjusted predicted cost for each member?
- Initially, at least, there will be winners and losers as some providers do not achieve savings and are penalized. Given this, how will those providers be encouraged to succeed? Will there be technical assistance?
- Will savings to the state be re-appropriated to other departments or invested into delivery innovation?

Topic: Medicaid Payment Innovation/ Reform (Group B)

Broad ideas:

- The current system does not provide incentives that focus on prevention, primary care, and care coordination, which are all critical elements for the Medicaid population. As a result, quality and outcomes of care are suboptimal and spending on potentially preventable events is too high.
- We need a payment model that provides incentives for providers to care for the "whole patient" and provide high-quality care coordination, but there are barriers to innovation in payment models
- Social determinants of health drive adverse health outcomes in Medicaid, and should be incorporated into our thinking about how to improve care and reduce costs for this population

Areas of agreement:

- Long-Term Thinking: An MMI System is a requirement for all innovation and is needed for the long term in order to better manage enrollment (including contact information and concurrent enrollment in other state and federal programs), care coordination (including payment and linkages across social service organizations), and payment reform (including bundled payments, medical homes, and other novel payment models).
    - Further postponing this needed upgrade to the system is likely increasing costs of doing so in the long run, and also hindering a move to a more value-based payment system
- A Payment Reform Task Force should be created to help develop payment models
    - Such a task force would have the advantage of being nonpartisan and longer-lived than the typical election cycle, allowing members to focus on long-term sustainable change rather than short-term temporary solutions.
    - A task force would include different stakeholders working together, including representatives from public and private sectors, insurers, care delivery organizations, and patient advocacy groups.
    - A task force could consider the existing evidence from other states or from local efforts across Missouri to identify areas of high priority. Possibilities would include recommending the expansion of health homes to incorporate prevention rather than making them conditional on existing illness; pilots around payment innovations for specific at-risk populations; a rethinking of potential payment models and supports for the ABD population; consideration of

linkages with other efforts across the state in mental health service expansion, use of community health workers, etc.

Specific details to be determined:

- MMI System update/ development
- Task force composition and scope

Topic: Community Health Workers

Broad Ideas:

- The use of community health workers could be expanded to improve access to healthcare services for Missouri Medicaid patients.
- The majority of programs throughout Missouri are funded by short term grants or pilot funding, which causes uncertainty around the ability to continue the programs.
- Funding for the education of community health workers is often grant funded and again causes uncertainty around the sustainability of these programs.

Areas of agreement:

- Community organizations and the Missouri Department of Social Services are in discussions about expanding access to community health worker access, there is agreement that expanded access to these services would be beneficial for Missouri Medicaid beneficiaries.
- The Department of Social Services operated a pilot program providing community health worker services to a limited number of Medicaid beneficiaries and it had positive health outcomes for the patients and cost savings.

Specific details to be determined:

- Inclusion of an advisory board around community health worker payment in Missouri Medicaid has been suggested. The proposed advisory board would include community providers, community health workers, payers and Department of Social Services representatives.
- The State of Missouri Department of Social Services is currently considering a state plan amendment to provide community health worker services for preventative health services for specific populations of Medicaid patients with chronic diseases. Community representatives would like them to consider some alternative options:
    - There is interest in the State exploring the feasibility of submitting an 1115 Waiver to provide the funding for these services.
    - Expanding the scope of the community health workers services for Medicaid patients to include additional patient populations and supportive services in lieu of limiting the scope to preventative health.

Topic: Providers and Professionals

Broad Ideas: Children's mental health

- Promoting preventative care and earlier access to behavior health services for children prior to families utilizing hospital emergency rooms;

redirecting access to care from emergency room visits to other points of entry, including schools, pediatrician well-child visits, and law enforcement.
- Improving access to behavioral health services through Medicaid enrollment; many children eligible for health insurance are not enrolled and barriers to enrollment need to be addressed.

Areas of agreement:

- There are multiple points of access to healthcare services, depending on the age of the child.
    - Hospitals are often the main point of entry for children from birth until they enter preschool.
        - Earlier diagnosis of mental/behavioral health issues; specifically targeting 1-3 year olds through child-care providers and pediatricians/well-visits
    - Schools could serve as an optimal "gateway" to healthcare coverage and services for school age children.
        - Recently schools became an eligible place of service for Medicaid reimbursement;
        - School nurses have knowledge of the students' health needs, medication requirements, and often are aware of their familial situations;
        - Schools manage the collection and reporting of key data regarding the children they serve; and
        - Some schools already include community-based health clinics.

Specific details to be determined:

- Recommendations around improving access to mental health services for children include:
    - Enroll all eligible children in Medicaid
        - Provide Medicaid eligibility specialist at every hospital and / or in the community (schools, childcare centers, law enforcement agencies, mental health centers);
    - Expand trauma-informed care in various settings, including schools, early childhood education facilities; and
    - Explore funding models/sources that support behavioral health professionals as a resource for schools, law enforcement.

- Recommendations to improve the enrollment of eligible children into the MO HealthNet program – how can we make it easier?
    - Address the barriers in communication between enrollees and those who create registration materials
    - Create a parent advisory group to inform the development of enrollment processes
    - Create a client advisory council for all social service agencies that help design the enrollment process
    - Create an easier, faster process for school systems that identify children who need Medicaid
    - Encourage hospitals to enroll eligible families in Medicaid at the time of the child's birth

Next Steps

The Center for Health Economics and Policy and the Clark-Fox Policy Institute are committed to exploring pathways for building upon the connections and ideas developed through the *Transforming Healthcare in Missouri* events. In particular, a key goal for the Jefferson City meeting was to better understand and identify specific details needed for additional discussion and alignment by agency leaders, staff, and stakeholders. We will continue to investigate collaborative opportunities to catalyze policy changes and connect researchers and policymakers in order to advance evidence-based policy decisions.