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*Making Health Care More
Responsive & Efficient:*

MISSOURI'S MEDICAID WAIVER

Mel Carnahan
Governor

Submitted to the
U.S. Department of Health & Human Services
June 30, 1994

E X E C U T I V E O F F I C E O F T H E P R E S I D E N T

30-Jun-1994 11:52am

TO: Carol H. Rasco
TO: Rosalyn A. Miller

FROM: Elise Deal
Intergovernmental Affairs

SUBJECT: Mtg w/Governor Carnahan

FYI - the following staff will be attending the meeting with you and Governor Carnahan today at 12:45 in your office:

Jill Friedman, Director of Policy and Development for the state of Missouri

Brad Douglas, Director, State of Misery's Washington office

Marc Farinella, Governor Carnahan's Chief of Staff

and Marcia Hale and John Hart.

MEMORANDUM

TO: CAROL RASCO
FR: JOHN HART
DT: JUNE 29, 1994
RE: MEETING WITH GOVERNOR CARNAHAN

I. Purpose

Governor Mel Carnahan has requested a meeting to present his Medicaid 1115 waiver request and to emphasize the importance of this waiver being granted in order for him to implement his health care proposal, Missouri SecureCare. Following this meeting, he will be meeting with Secretary Shalala to present the waiver.

II. Background

The waiver is a Medicaid managed care expansion; it originally was a component of a more comprehensive statewide health care reform plan proposed by Governor Carnahan and defeated in the Missouri Legislature this spring. Governor Carnahan's proposal has several basic features including: 1) expanded eligibility to 200% of poverty; 2) use of employer's plan (People who are employed but have incomes below 100% of poverty would not be required to participate in their employer's plan if the low income worker must pay part of the premium. Workers with incomes above 100% of poverty would be required to participate in employer plans); and 3) extensive use of managed care.

III. Talking Points

Governor Carnahan has been very supportive of the Administration and should be commended for his health care reform efforts in Missouri and his commitment to expanded health care coverage and containing costs. We should emphasize that we are aware that this waiver is a priority to him but that the granting of this waiver is entirely an HHS decision. Missouri has not submitted any preliminary documentation or concept papers to HCFA so it would be premature to comment on the prospects of Missouri's waiver request.



N E W S R E L E A S E

GOVERNOR MEL CARNAHAN

CAPITOL BUILDING

ROOM 216

JEFFERSON CITY MO 65101

PHONE: (314) 751-3222

FAX: (314) 751-4458

For Immediate Release
June 30, 1994

For more information,
call Chris Sifford
at 314-751-3222

CARNAHAN MOVES TO OVERHAUL MEDICAID SYSTEM, PLAN WILL CUT COSTS WHILE EXPANDING ACCESS TO HEALTH CARE

Underscoring his commitment to improving the health care system and gaining control over spiraling Medicaid costs, Governor Mel Carnahan today delivered Missouri's innovative Medicaid waiver request to Health and Human Services Secretary Donna Shalala.

If granted, the waiver will enable Missouri to reduce the inefficiency in the Medicaid system, emphasize primary and preventive care, and potentially extend health coverage to up to 330,000 uninsured Missourians including over 110,000 children. Many of these uninsured Missourians -- those in low wage jobs that don't provide health coverage -- will be able to buy health coverage on a sliding scale based on their financial status.

"I am pleased to personally present this waiver application to Secretary Shalala," Carnahan said. "By overhauling the Medicaid system, Missouri can do more for less. This will help us cut the outrageous growth in the state's Medicaid budget without having to cut benefits."

"If the federal government will give us the flexibility we need, we can make the changes that will enable us to help more people at less cost to Missouri taxpayers," Carnahan added.

- more -

Medicaid costs are the fastest growing component of the state's budget. The waiver will enable Missouri to reduce state and federal Medicaid spending over the next five years by more than half a billion dollars. Costs will be held down by utilizing managed care and by redirecting state money to preventive care instead of more expensive types of care such as over-utilization of emergency rooms. Under the waiver, the state will also collect revenue from currently uninsured consumers who will buy into the plan on a sliding scale basis. These revenues will receive federal matching dollars.

If the waiver is approved, for the first time in Missouri history the state will be able to offer a comprehensive benefit package that can be purchased by lower-income uninsured persons, with fees assessed according to people's ability to pay.

For example, an adult with an annual income of \$14,000 would be able to buy the standard benefit package for \$150 per month. That same adult could purchase coverage for a child at \$70 per month. Lower income individuals not eligible for Medicaid under current regulations, would pay less. People who are eligible under the current Medicaid program would receive the same benefits they receive now.

The standard benefit package includes a variety of basic services such as: physician office and clinic visits, hospital treatment, and mental health and substance abuse. It does not include coverage for long-term care.

Carnahan said that uninsured individuals will be able to get coverage regardless of pre-existing conditions. "Also, if you change jobs, you can take your coverage with you," he said.

"This waiver will help Missouri improve health care quality and access for Missouri's children and families and, at the same time, help relieve some of the growing Medicaid burden on Missouri's taxpayers," said Carnahan.

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Executive SUMMARY

The Waiver will meet the needs of thousands of Missouri families and hundreds of thousands of Missouri residents who have had to search for basic health care but found the system unresponsive.

With the Waiver, Missouri will redirect Medicaid funding to primary care and reduce Medicaid spending over the next five years by more than one-half billion dollars while extending health coverage to 330,000 — about 55 percent of the people in Missouri who have no health insurance. Spending will be held down through a combination of managed care savings, redirecting state money already spent on the uninsured, and through cost sharing by patients able to pay all or part of their premiums

Competitive bidding, managed care, and strict quality standards will create financial incentives for providers to replace fragmented delivery systems with primary care networks. The payoff for providers will be found through effectively managing the care of the Waiver members to reach clearly stated objectives. The reward for members will be better health.

A 25-year-old mother in Springfield, trying to work her way off welfare, needs a physical before being admitted to nursing school; yet she can't find a doctor willing to accept Medicaid's payment. She has even been turned down while face-to-face with a doctor in his office for another matter.

The Waiver will offer a comprehensive, standard benefit package to all families and individuals in Missouri who lack access to private health insurance. Members will pay according to their ability.

- Residents with incomes above 200 percent of the federal poverty level can join by paying the full cost of the Waiver premiums — monthly about \$150 for adults and \$70 for children for the first year of the program.
- Individuals and families with incomes between 200 percent and 100 percent of the poverty level will be able to buy into the Waiver on a sliding-scale that corresponds to their income.

A family of four making \$1,300 each month would pay about \$33 in monthly premiums. The same size family making \$2,300 a month would pay a monthly premium of \$325.

- Medicaid-eligible the Waiver members and those with incomes below 100 percent of the poverty level will receive full coverage without paying premiums.

To assure that no current or future Medicaid-eligible adult loses benefits under the Waiver, they will receive a slightly enhanced benefit package composed of such services as hearing aids and dental care. All the Waiver children and young adults up to 21 years of age will be eligible to receive the same extended package of medically necessary services regardless of income. The standard benefit package available to all the Waiver members will include, but not be limited to:

- Physician-office visits
- Inpatient and outpatient hospital treatment
- Laboratory and X-ray services
- Family planning
- Pharmacy
- Emergency transportation
- Durable medical equipment
- Podiatry
- Transplants
- Behavioral health and substance abuse

Individuals eligible for both Medicaid and Medicare will not be affected by the Waiver; neither will the disabled, the aged, nor those residing in nursing homes and other institutions. Some services — such as private nursing for AIDS patients, respite care, and an array of services that allow some disabled to remain in their homes — will remain unaffected by the Waiver.

Improving the health of children and their families requires more than just making health care available. People need to know where to receive the services and how to enroll. Missouri will utilize two proven and innovative approaches to facilitate outreach, enrollment, and efficient utilization of the Waiver services. First, the state will work with the Waiver providers to link them with schools and become partners in Missouri's state-wide initiative to build an integrated system of school-linked, health and human services. This will not only improve access to health services but address some of the root causes of poor school performance.

In St. Louis, after decades of steady employment and health coverage, a middle-aged couple and their 17-year-old son find themselves without insurance after the father was laid off by a local corporation. They don't qualify for Medicaid. The parents, while willing to live without insurance for themselves, worry daily about their son. "It's frightening," says the mother, who works part-time.

Missouri will also utilize participants in the FUTURES program — Missouri's welfare-to-work program — for outreach, education, and enrollment of the Waiver members. FUTURES clients will not only gain valuable work experience and find meaningful employment, but because of their experience with public systems they will be able to help families navigate through the the Waiver enrollment process and obtain services.

Once enrolled, members will choose among managed care plans that have contracts with the state through a negotiated bidding process. After selecting a plan, each member will choose a primary care physician within that plan. This doctor will become the member's personal physician, available 24 hours a day, seven days a week and be responsible for coordinating the member's access to all services covered by the Waiver.

A variety of consumer protections and a state-of-the-art quality assurance system will ensure that health plans provide all services required of them and treat members with the same courtesy and respect shown to patients covered by private insurance. A portion of the plans' payments will be withheld by the state until they show compliance with quality standards. Members will be able to change plans for any reason within 30 days after enrollment, and once a year during an open enrollment period. At any time during the year, members can change plans if they establish just cause.

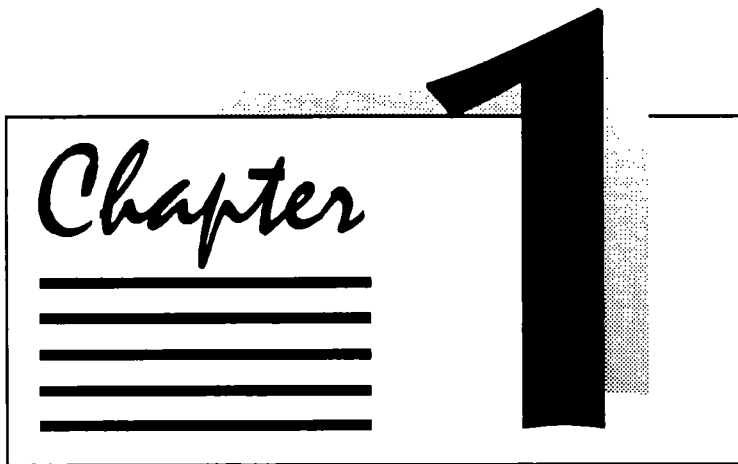
In addition, a Quality of Care Advisory Council consisting of consumers, health care workers, and advocates will develop quality measurements and monitor plan performance. To hold plans and the state publicly accountable, data and performance information will be gathered and published in a consumer guide book.

"I hate to use the emergency room. I took my 4—month old to a doctor and he gave us some medicine and sent us home. But that night I was in the emergency room, and my baby almost died. He was in the ICU for three days on a ventilator. I put off taking him because I knew ... and that made me feel like ... I almost let him die because I knew that they hate for you to come in there when you have Medicaid. They think you don't try to find a doctor."

—Medicaid recipient

The Waiver will be phased in by geographic region and by population within each region. Committees and task forces will be formed to guide the implementation of the program to ensure that existing systems are not disrupted and new ones have sufficient capacity.

The Waiver will demonstrate that Missouri can increase access to quality health care for all Missourians — health care that will provide positive and measurable improvements in the health of the Waiver members while controlling the growth of Medicaid spending. Most importantly, the Waiver will address the concerns of Missouri residents who have found publicly provided health care unresponsive to their real-life needs.



OVERVIEW

GOALS

With this request to establish the Waiver, the State of Missouri is seeking to improve medical care for its low-income and uninsured individuals and families by increasing their access to comprehensive health and medical services. The Waiver will allow Medicaid recipients and new enrollees under the waiver to establish ongoing relationships with primary care physicians who stress preventive medical care and early intervention. With the Waiver, Missouri will change the nature of government-provided health care, control the growth of Medicaid spending, and offer health coverage to more people.

The Waiver addresses the concerns and needs of not only Medicaid recipients, but the working poor who have no health insurance. For Medicaid recipients, the Waiver will help end their frequent and frantic searches for doctors willing to accept Medicaid payments. For the working poor, the Waiver will allow them to continue working without being forced to choose between a job and quitting that job in order to qualify for Medicaid. The Waiver will offer low-income individuals and families an affordable health plan. The Waiver was developed with input from many groups and individuals, including Medicaid recipients and the uninsured, working poor. The Waiver responds to their real-life challenges and difficulties. (See Appendix 1A, Exhibits 21 & 26.)

REQUEST FOR WAIVER

Missouri asks that the Health Care Financing Administration allow the Department of Social Services to restructure the Medicaid program so that the state may:

- Offer access to health care to those who lack it and initially to extend publicly supported coverage to about 330,000 Missourians living in families with incomes below 200 percent of the federal poverty level.
- Link the Waiver to Medicaid services provided by schools in an innovative state initiative to enroll schools as Medicaid providers and administrative case managers for Early Periodic Screening, Diagnosis, and Treatment (EPSDT) services.
- Provide AFDC recipients and JOBS program graduates (In Missouri, this program is called FUTURES.) employment as Health Benefit Managers. These managers will be responsible for the enrollment of Waiver members.
- Improve the health of Waiver members.
- Utilize resources that provide health care to 580,000 Medicaid recipients more effectively and efficiently.

- Hold providers accountable for the medical outcomes of patients enrolled in the Waiver program.
- Control the rapidly rising cost of public spending on health care.

The Waiver will demonstrate that Missouri can increase access to quality health care for low-income families and individuals — health care that will provide positive and measurable improvements in the health of participants. Missouri will define these outcomes, then utilize its purchasing power and a state-of-the-art system of quality assurance to let market dynamics achieve a more responsive and rational system.

"You call around. You tell them you have a Medicaid card, their tone of voice changes and they say, 'We don't take Medicaid,' and click." —Medicaid recipient

"A lot of jobs won't let you work full time because they don't want to pay the benefits. At my job, I get up to 36 hours. They'll work you to death, but they don't want you to work that 40 hours so you get the insurance." —Working mother

The Waiver will achieve its objectives through managed care and by restructuring traditional Medicaid payment methods. The Waiver will redirect health care spending toward preventive, primary care by implementing incentive payments, i.e., pre-paid capitation, in which providers are rewarded for providing preventive care and improving the health status of their clients. The payoff for providers will be found through effectively managing the care of their clients to reach clearly stated objectives. The reward for members will be better health.

Managed care, pre-paid reimbursement, and quality assurance will create financial incentives for providers to replace fragmented delivery systems with primary care networks that increase patient access to family physicians and front-end, preventive care. These networks will offer members:

- Accountability.
- Choice.
- Continuity of care provided by the recipient's personal physician.
- Guaranteed access to primary care physicians.
- Coordinated referral to specialists and tertiary services.
- Higher quality care.

These aspects of medical care enhance patient satisfaction, lead to more informed medical decision making, and contribute to optimal use of medical resources. In areas of the state where networks and managed care plans are not yet in place, traditional fee-for-service Medicaid will continue for the interim. However, data indicates that for most Missourians, networks exist. The majority of Missouri residents who will be eligible for the Waiver live in counties with two or more managed health plans. The Waiver will create market incentives to spur the further development of health plans and their managed care networks. And in addition, an interagency network development team staffed by the Department of Health and the Department of Social Services will be formed, and in fact has already begun working.

MISSOURI'S MEDICAID PROBLEM

Missouri's population totals 5.2 million, with more than 10 percent of the state's residents receiving Medicaid, and over 10 percent remaining uninsured. Meeting the state's health care needs is particularly challenging because of the distribution of the population in two densely populated

Emergency room use:

Early in 1994, the state examined emergency room use by Medicaid recipients in St. Louis. The findings:

- Hospitals in general report that nearly one-third of all emergency room admissions would be better served by a physician office visit.
 - Most emergency room visits were caused by lack of access to a primary care physician.
 - 50 percent of the visits were for children under 12. The most frequent reasons given for the visits were to obtain primary care for colds, ear infections and basic viruses.
-

metropolitan areas — Kansas City and St. Louis — and sparsely populated rural areas. Access to specialists and primary care providers is restricted in the rural areas, but also a significant number of urban communities remain medically underserved by primary care providers.

A statewide task force reported that the most substantial obstacle to primary care for Medicaid recipients is the unwillingness by physicians to accept Medicaid patients. In short, the stated goal of Medicaid recipients' being able

"If you find a provider, they only want to do short-term, crisis intervention. How do you get preventive care if you can't get someone who consistently sees your child so they know whether the child is different from one visit to the next?"

—Medicaid recipient

to select the doctor of their choice is unreachable under the present system. Overutilization of inappropriate services hides the root problem: underutilization of primary care physicians.

The Waiver will address this problem by requiring that managed care organizations guarantee an appropriate number of primary care physicians for the Waiver enrollees. Also, by creating incentives for preventive care, the Waiver providers will have a vested interest in ensuring physician office visits for the Waiver participants. Pursuing measures to bolster the primary care network is essential to improve the health of Missouri residents. Research consistently shows that primary care — care by physicians who have long-standing relationships with patients — leads to greater patient satisfaction and better health outcomes.

In providing services to Missouri's low-income families, Medicaid has become a burdensome and complicated system. Currently, Missouri has about 40 categories of Medicaid eligibility with nearly 1,000 categories of payment to manage and process. A low-income family of four — two parents with children ages 4 and 6 — is likely to find: The father ineligible for Medicaid. The mother only when pregnant. The 4-year-old if the family's income is under 133 percent of poverty, and the 6-year-old if their income is under 100 percent of poverty.

Primary care is shortchanged. Emergency room visits are substituted for routine office visits, and medical decisions are made in clinically inappropriate settings. Sometimes, recipients see more than one doctor for the same illness, resulting in uncoordinated and duplicative services being rendered.

The Waiver presents Missouri and the federal government with an opportunity to not only control the rising cost of Medicaid, but to take significant steps toward building primary care networks and improving the quality of care provided to low-income individuals and families.

THE WAIVER: THE SOLUTION

Members and Services

The foundation of the Waiver will be managed care — managed care that will improve the quality of care, increase access to care, and efficiently utilize public funds. The standard benefit package will stress the importance of preventive care such as Early Periodic Screening, Diagnosis, and Treatment for children, immunizations, early prenatal care, and screenings for adults. Some Medicaid services and eligibility categories — such as care for AIDs patients and home- and community-based services — will not be included in capitated payments, but the services will continue on a fee-for-service basis with Waiver physicians coordinating access to these services. All current and future eligible Medicaid recipients will continue to receive the full services available to them. New adult enrollees will receive the same capitated, standard benefits as the Medicaid-eligibles, but the new enrollees will not have access to a very small number of ancillary services such as adult dental care. However, children in both groups — both Medicaid-eligible and the newly-eligible — will enjoy full access to all EPSDT services.

A budget burden:

Partly due to inefficient use of services, and partly because of the rising cost of health care in general, Medicaid costs are straining state resources. By the end of next year, Medicaid costs will have jumped nearly fourfold since 1987 — up to \$2.5 billion from \$634 million. Currently, more than one of every five dollars of the state's budget is spent on Medicaid. Just to maintain the present level of services, increases in Medicaid will use half of the state's new revenue for the present fiscal year.

Consumers will be protected. (See Appendices 1B and 1C.) They will also have the opportunity to choose doctors and health plans and change either for good cause or once a year during an open enrollment period. The state will monitor provider marketing activities and implement quality assurance mechanisms that will include patient surveys and outcome standards. Participants will have a right to second opinions. Before implementing the Waiver, an extensive state-sponsored client education process will be developed. The implementation of this educational program will utilize FUTURES/JOBS participants and graduates, offering them a means to achieve self-sufficiency and capitalizing on the proven effectiveness of peer counseling.

Missouri's 10 years of experience running a Medicaid managed care program in Kansas City offers the state a solid base for the Waiver. Performance measures used in Kansas City include: recipient satisfaction surveys, monitoring providers to assure they offer 24-hour access, on-site audits, and investigation of transfer requests. Preliminary data indicates that quality of care for Medicaid recipients in Kansas City has improved, primary care physician visits have increased, and treatment in clinically inappropriate settings has decreased.

"I had health insurance until last year. I had a heart attack and they canceled it. They told me I was high risk so they canceled it. I mean right there in the middle. How much money did I put into it? It's gone. I don't get it back. There's no refund. That's money down the drain and I still have bills to pay."

— Uninsured mother

The Waiver initially will offer publicly supported coverage to about 330,000 Missourians who lack health insurance, more than half of the uninsured. Enrollment for this group will be voluntary. Families under 200 percent of the federal poverty level will be able to buy discounted premiums on a sliding scale based on their income. Anyone over 200 percent of the poverty level can join by paying the full premium. Medicaid-eligible members and those below 100 percent of the poverty level will have no premiums to pay. No newly-eligible Missouri resident will be excluded because of a pre-existing illness or condition.

THE BENEFITS OF OUTCOME-DRIVEN MANAGED CARE

The Waiver will counteract what researchers have labeled the “Medicaid Syndrome,” a health care delivery system marred by clinically inappropriate care and little coordination of patient needs by a physician who has established a relationship with his or her patients. The Waiver will demonstrate how outcome-based quality assurance, managed care, integration of health services with schools, peer counseling, pooled purchasing, and market dynamics can:

"It's very frightening to have no insurance ... especially when you have a 17-year-old who skateboards."

–Working mother

- Increase access to health care.
- Improve school readiness and performance.
- Help AFDC recipients obtain self-sufficiency.
- Strengthen the primary care network.
- Improve the quality of care and produce better health outcomes.
- Control rising costs.
- Engender patient responsibility and increase their knowledge of their health needs.

Increase Access

The Waiver will utilize resources more efficiently and demonstrate that with managed care, an emphasis on preventive care, and pooled purchasing, the State of Missouri can increase access to quality health care.

With its pooled purchasing power and through offering a large number of health care consumers – about 20 percent of the state's population – Missouri will utilize a competitive bidding process to keep costs down and allow a greater number of people to be included in the Waiver program than in the current Medicaid program.

Improve School Readiness

Poor school performance is intertwined with troubled families, distressed communities, and inadequate health care. Children with unmet needs rarely begin school ready to learn. Once there, problems from outside the school frequently erupt in classrooms. Teachers and school officials are left to deal daily with the fallout. Yet isolating children's educational needs from their health and social needs leads to incomplete solutions. Under the Waiver, the state will actively work with and encourage health plans to establish formal agreements with schools to facilitate the access of children enrolled in the Waiver to all medically necessary health services.

More than any other state, Missouri is moving the concept of integrated, school-linked health and human services from a pilot-project concept to a statewide reality. Currently more than half of the state's 540 school districts are enrolled as Medicaid providers; 30 offer administrative case management, giving them the ability to help students and their families access comprehensive support services. These numbers are growing rapidly.

Without the Waiver, the current fee-for-service delivery system is simply too fragmented to move rapidly or in a coordinated fashion toward significant integration of school-linked services and health care. With the Waiver, Missouri will be able to help families and children address the root causes of poor school performance and the diminished futures that follow.

Help AFDC Recipients Obtain Self-Sufficiency

The Waiver will offer AFDC recipients opportunities to become self-sufficient through two means:

1. By becoming employed as Health Benefits Managers.
2. By making health coverage affordable for low-income, working families.

Health Benefit Managers

With the offering of health coverage to 330,000 uninsured, Missouri will face a difficult task of enrolling those who choose the Waiver program. To help these uninsured families and individuals enroll in the Waiver program, the state will contract with vendors and require them to hire AFDC recipients who are either enrolled in FUTURES or recent graduates of the program. FUTURES is Missouri's welfare-to-work initiative under the Family Support Act of 1988. The AFDC recipients will become Health Benefit Managers, and their duties will be threefold:

- Outreach:** Attending community meetings and working through neighborhood organizations to inform eligible individuals about the availability of the Waiver and encourage their enrollment.
- Education:** Meeting with individuals and community organizations to explain the benefits available under the Waiver. This task would involve detailing the Waiver recipients' choices and responsibilities under a managed care system.
- Enrollment:** Helping enrollees fill out application forms, determine eligibility, and choose an appropriate health plan and physician.

The FUTURES program trains participants for employment and develops their work skills, but too often, at the end of their training, no jobs are available in their neighborhoods. At other times, the jobs available are beyond their experience level. FUTURES participants and graduates would make ideal Health Benefit Managers because of their experience with state systems. They would be sensitive to the worries, issues, and concerns of families needing to turn to the state for support.

In helping families and individuals navigate the the Waiver enrollment process and obtain services, FUTURES clients would not only be providing a valuable service to the community, but also working their way toward self-sufficiency.

"I'm not concerned about myself. I'm going to be alright. But I have an 8-year-old child who is heck-on-wheels. I can't go out and take a \$4.50-an-hour job without health insurance. But I would go out and get that job tomorrow if my daughter would be insured and I could afford it."

—Medicaid recipient

Affordable Health Coverage

In addition to providing employment opportunities for AFDC recipients, the Waiver will address one of the primary causes of welfare dependence — lack of health insurance. Focus groups conducted for the development of the waiver application, input from a Medicaid consumer advisory group, and the experience of front-line workers, make it evident that the health coverage available for children through Medicaid is one of the primary reasons public assistance is a rational, economic decision for low-income parents. In many cases, parents want to work, but they simply can not afford to. By offering affordable health coverage to low-income families, the Waiver will pick up where Medicaid leaves off, enabling them to work and leave the AFDC rolls.

Strengthen the primary care network

Health plans will only be deemed qualified to contract with the state once they demonstrate they have an adequate primary care network in place. By virtue of its purchasing power and large population, the Waiver will wield significant financial leverage to redirect resources within the existing health care system toward primary care. Three mechanisms will ensure this:

1. A capitated payment methodology will provide an economic incentive for health plans to provide primary and preventive care.
2. Financial withholdings and incentives will be used to hold health plans accountable for outcomes; providers will have an interest in preventing health problems before they occur.
3. Educational activities and financial incentives — such as copayments for non-emergency use of emergency room services — for members will redirect them toward primary care providers.

Produce Positive Outcomes

Primary care will improve the health status of the Waiver participants. Primary care means better health.

- Quick access to health care lessens the potential for minor illnesses to develop into more complicated medical conditions.
- Ongoing relationships between patients and their doctors lead to more informed medical decisions on the part of the doctor and a greater likelihood that patients will adhere to their doctors' instructions.
- Coordination of care by a primary provider assures that medically appropriate referrals are made to specialty providers and ancillary services.

Although primary care has been associated with the above, Missouri will not depend on market forces alone to create the primary care network or ensure quality. Plans will be held strictly accountable and expected to meet strong quality assurance guidelines. Financial penalties, even expulsion from the Waiver, will result if plans fail to meet standards established by the state.

Control Costs

Competitive bidding and an emphasis on managed, primary care will combine to hold down the growth of health care costs. Currently, the fee-for-service system gives patients or providers little reason to exercise cost-conscious health care purchasing. Prepaid reimbursement and competitive bidding will create incentives for providers to emphasize primary care as their most critical service. With primary care physicians seeing patients regularly, specialty care and ancillary services will be accessed only when medically necessary. The need for such services will also be lessened. A state-of-the-art quality assurance system will ensure that less costly care does not mean lower quality care.

"My sister is married with two children, and her husband is a construction worker. Half the year he makes really good money and has insurance to cover the family. The other half, he's off. Then my sister is a bundle of nerves hoping her children don't get sick because Medicaid refused to cover them. They said he made too much money during the part of the year he worked."

—Medicaid recipient

Educate Consumers

An extensive consumer education initiative will be undertaken as the Waiver is phased in across the state. Members will be informed of their rights and responsibilities under the new health care program. In addition, through receiving continuous service through a primary care provider, patients will have a single source of information applicable to their particular needs.

Patients will be held responsible; fees will be charged for inappropriate use of health services. With providers being held accountable for outcomes, both providers and patients will share an interest in making sure that the patients use health services wisely.

The State of Missouri will also be accountable and responsible for making sure that the objectives outlined for the Waiver are met. The state is committed to providing the leadership, resources, and technical assistance needed to ensure that the Waiver serves and improves the lives of Missouri residents. The Waiver will be phased in gradually so as not to disrupt existing systems and not to overload new ones. Local committees and task forces will be formed to guide the implementation of the Waiver. Technical assistance teams will be available to these groups. More than being committed to a specific plan of action, Missouri is committed to providing better health care to more residents, and the state recognizes that the broad principles that support the Waiver will be shaped to fit the needs of different communities.

Chapter 2

DEMONSTRATION PROJECT DESIGN

The Missouri Waiver Demonstration Project will allow the State of Missouri to:

- Offer publicly supported health coverage to half of all uninsured Missouri residents.
- Hold providers and the State accountable for producing measurable improvements in the health of those covered.
- Integrate school-linked and school-based health services with Waiver providers.
- Provide FUTURES/JOBS participants and graduates opportunities to work in outreach and enrollment of Waiver participants, thereby helping them achieve self-sufficiency.
- Improve the health of its Medicaid and uninsured low-income population by increasing access to preventive health care and decreasing reliance on emergency rooms and sporadic physician office visits.
- Control rising Medicaid costs.

"I hate to use the emergency room. I took my 4-month-old to a doctor and he gave us some medicine and sent us home. But that night I was in the emergency room, and my baby almost died. He was in the ICU for three days on a ventilator. I put off taking him because I knew ... and that made me feel like ... I almost let him die because I knew that they hate for you to come in there when you have Medicaid. They think you don't try to find a doctor."

–Medicaid recipient

This Chapter describes the elements of the Missouri Waiver Demonstration Project:

- 1) Health Care Delivery Systems;
- 2) Covered Benefits;
- 3) Eligibility and Cost Sharing;
- 4) Enrollment; and
- 5) Quality Assurance.

ORGANIZATION OF WAIVER DELIVERY SYSTEMS

Under the Waiver, Missouri will transform the traditional fee-for-service Medicaid program into a managed care system that offers members expanded choices, increased access to primary care, greater coordination and continuity of care, cost-effective health services, and better health outcomes through effective care management.

Managed Care Plans

The Waiver members will enroll in private managed care plans. Within these plans, enrollees will

choose a personal physician who will take responsibility for the primary care and case management of each member. This provider will coordinate and follow-up each client's health services. The primary care provider will make sure that clients receive preventive health care and that specialty services are utilized appropriately.

"We need more doctors available so that emergency rooms can be for emergencies." –Working mother

The Waiver will utilize capitated payments in which Missouri will pre-pay plans every month a specific fee for each Waiver member enrolled in that plan. Because capitation pays the same for each member whether healthy or sick, capitation creates an incentive for providers to prevent illness and treat conditions early before they become complicated and costly. Capitated managed care intrinsically promotes ongoing member education and case management that benefit both the patient and provider. Resources will shift from emergency room care and other inefficient settings to doctor office visits.

Integration with School-based Medicaid Services

The Department of Social Services, through a partnership with the Department of Elementary and Secondary Education, has enrolled nearly 300 of the State's 540 school districts as Medicaid providers of direct services. Thirty offer administrative case management. Efforts are underway to assist all

School readiness:

Teachers know: Sick children make poor learners. Many of a child's health needs are seen in schools, rather than in a physician's office, and can lead to learning and behavioral problems that diminish a child's chances of success in school.

school districts that wish to participate, with efforts concentrating on districts with the highest percentages of Medicaid-eligibles. Both direct services and case management are components of the federal Early Periodic Screening, Diagnosis and Treatment (EPSDT) program. Missouri leads the nation in this unique and innovative service delivery model, which helps to ensure that children are ready to learn and successful at school. Currently, schools enrolled as Medicaid providers offer three types of service:

- **Direct Services:** These include occupational therapy, physical therapy, and other therapies as required by the Individuals with Disabilities Education Act (Public Law 94-142) when those services are identified in an Individual Education Plan. Additionally, schools may offer psychological counseling.

- **Administrative Case Management:** Under interagency agreements with the State, schools are reimbursed for enhancing children's, and their families', access to necessary health services. Case management includes outreach, referral, follow-up, and coordination of services.
- **Primary and Preventive Health Care:** When communities and school boards agree, schools may operate school-based health clinics. These clinics receive Medicaid reimbursement only after meeting state standards as Medicaid providers and securing Medicaid credentials.

The Waiver will significantly improve the coordination and access of these school-based services for both the children who are currently Medicaid-eligible and those who will become eligible for the Waiver. Through the Waiver, the State will work with and strongly encourage providers to establish formal agreements linking them with schools. Schools could subcontract with plans to establish school-based clinics, or plans could staff these clinics.

An opportunity:

Teachers and principals see children every day, have regular contact with their parents, and frequently are the first to recognize when health and other unmet needs interfere with learning. The Waiver will capitalize on this opportunity.

School staff will provide outreach to children and their families, and direct them to Waiver enrollment sites. Working closely with the Waiver providers, school staff can help coordinate access to the full range of services needed to keep children healthy and ready to learn. Schools will:

- Provide outreach for plans to children and their families, helping them become aware of the Waiver and directing them to enrollment sites.
- Help children and their families access community health services.
- Coordinate delivery of other human services by state, local and community service providers.

With parental permission, critical information regarding a child's health and social needs will be available to both school officials and medical providers, resulting in better health outcomes, stronger families, and improved school performance. (See Benefits for Children below for further detail.)

WAIVER BENEFITS

Through the Waiver, Missouri will provide comprehensive health coverage to all Missouri residents with incomes up to 200 percent of the federal poverty level. Those with incomes over 200 percent of the poverty level will be able to buy in at full cost. Some variation in benefits will exist. Medicaid-eligible members will receive a few more services than newly-eligibles, and all children up to 21 years of age will have the full range of EPSDT services.

Standard Benefit Package

Both Medicaid-eligible and newly qualified adult members will receive the same capitated, standard benefit package. However, Medicaid-eligible adults will have a slightly enhanced supplemental benefit package to ensure that they retain all services currently offered under the Medicaid program. The supplemental package will include dental, audiology, personal care, adult day care and optical services. These services will be coordinated by the Waiver providers, but paid on a fee-for-service basis. Table I outlines the Waiver's standard package for all members and the benefits that Medicaid recipients will continue to receive.

SERVICES AFFECTED BY WAIVER

Benefits	Age 0-20	Age Over 20 Medicaid Population	Age Over 20 Expanded Population	Unaffected Medicaid Eligibles
Ambulance	Managed Care	Managed Care	Managed Care	✓
Adult Day Health Care		✓		✓
Case Management	Managed Care	Managed Care	Managed Care	✓
Pregnant Women				✓
MRDD				✓
SED				✓
EPSDT Case Management	Managed Care			✓
Community Psych Rehab				✓
Dental	Managed Care	✓		✓
Durable Med. Equipment	Managed Care	Managed Care	Managed Care	✓
EPSDT Screens	Managed Care			✓
EPSDT Serv Treatment (1905a)	Managed Care			✓
Family Plan	Managed Care	Managed Care	Managed Care ✓ *	Managed Care ✓ *
Audiology	Managed Care	✓		✓
Home Health	Managed Care	Managed Care	Managed Care	✓
Hospital Input-Output	Managed Care	Managed Care	Managed Care	✓

Managed Care – Covered by Plan

✓ – Traditional Medicaid

* Offered 24 months following pregnancy regardless of income and resources on Fee For Service basis

SERVICES AFFECTED BY WAIVER

(CONTINUED)

Benefits	Age 0-20	Age Over 20 Medicaid Population	Age Over 20 Expanded Population	Unaffected Medicaid Eligibles
Behavioral Health Serv 30ip/20op	<i>Managed Care</i>	<i>Managed Care</i>	<i>Managed Care</i>	✓
Hospice	<i>Managed Care</i>	<i>Managed Care</i>	<i>Managed Care</i>	✓
Independent Lab & X-Ray	<i>Managed Care</i>	<i>Managed Care</i>	<i>Managed Care</i>	✓
Nursing Home	✓	✓		✓
Optometric Services	<i>Managed Care</i>	✓		✓
Eye Glasses & Exams	<i>Managed Care</i>	✓		✓
Personal Care	✓	✓		✓
Pharmacy	<i>Managed Care</i>	<i>Managed Care</i>	<i>Managed Care</i>	<i>Managed Care</i>
Physician	<i>Managed Care</i>	<i>Managed Care</i>	<i>Managed Care</i>	✓
Podiatry	<i>Managed Care</i>	<i>Managed Care</i>	<i>Managed Care</i>	✓
Private Duty Nurse	<i>Managed Care</i>	✓		✓
Psychological Counseling	<i>Managed Care</i>	<i>Managed Care</i>		✓
Rehab Serv OT, PT, ST	<i>Managed Care</i>	✓		✓
Transplant	<i>Managed Care</i>	<i>Managed Care</i>	<i>Managed Care</i>	✓
Transportation	<i>Managed Care</i>	<i>Managed Care</i>	<i>Managed Care</i>	✓

Benefits for Children and Young Adults

"I work at a hospital. I work with high-risk moms that are in trouble. I also work at a restaurant. I work a lot but don't have insurance."
—Working mother

Children and young adults under

21 in the Waiver — whether Medicaid-eligible or newly-eligible — will receive the full range of EPSDT services. Under federal EPSDT regulations, States must provide any federally-allowable medical service a health care professional finds medically necessary even if that service is not in the state Medicaid plan. These include psychological and dental services, as well as physical and speech therapies.

Full services for children:

Both Medicaid-eligible children, about 340,000 children, and newly-eligible children, about 113,000, will have access to all medically necessary services allowed by federal law.

The following EPSDT services currently provided will remain unaffected by the Waiver: (1) administrative case management services by school districts, the Department of Health Bureau of Special Health Care Needs, and the Department of Mental Health; and (2) therapy services determined medically necessary by an Individual Education Plan that are provided in a school setting; and (3) all other medically necessary services not covered by the Standard Benefit Package.

All children in state custody will be eligible for the Waiver, and Missouri requests that its targeted case management program for Jackson County foster children continue so that the state may demonstrate the benefits of multiple-agency service coordination.

Behavioral Health Services

All adults in the Waiver will receive behavioral health benefits consisting of 30 inpatient and 20 outpatient days of treatment. This will include alcohol and drug rehabilitation, counseling, and clinic services. The 30/20 breakdown is intended as a guideline for cost estimates; alternative treatments proven effective and approved by the State may be substituted. As a Waiver member nears the 30/20 limit, health plans must notify the State so that the member can be appropriately transitioned to a managed behavioral health program that will be administered by the Department of Mental Health. These transitions will be monitored closely by the state to guard against inappropriate patient dumping.

These behavioral health services beyond 30/20 will be managed by the Department of Mental Health. Individuals eligible for Medicaid because of a behavioral health disability will be automatically enrolled in this system. (See Appendix 2A for details.)

Pilot Project for the Permanently and Totally Disabled

Current Medicaid-eligibles with permanent disabilities, whether they live in institutions, will be unaffected by the Waiver and remain in the traditional fee-for-service system. However, a pilot project for the non-institutionalized disabled will be established for voluntary participation in a fully capitated, managed care program in Central Missouri. This pilot project is sponsored by the Medicaid Working Group of Boston University and involves a partnership between the University of Missouri School of Medicine, GenCare/Sanus (a managed care corporation based in St. Louis), The Robert Wood Johnson Foundation, Pew Charitable Trusts, and the Department of Social Services.

The project will utilize University clinics located in a 10-county area of Mid-Missouri, and be designed as a “hub and spoke” program. Participants will choose a gatekeeper clinic and primary care provider. A key component of this project is that the primary care physician will be a physiatrist. Physiatrists receive special training to treat the chronically disabled and routinely work with interdisciplinary teams including physical therapists and social workers. (See Appendix 2B for further detail.)

"I was working, but I couldn't get insurance for my kids. They told me I can not work and get Medicaid. So, you don't work."
 –Medicaid recipient

The project will be reviewed and monitored by a consumer panel that will meet every six months.

Extended Family Planning

The Missouri Medicaid program currently offers family planning services as part of the benefits available to post-partum women for 60 days following the end of pregnancy. The Waiver will offer family planning services to all enrollees as part of the Standard Benefit Package. In addition, as part of the Demonstration Project, Missouri will offer all Medicaid-eligible post-partum women and Waiver members an additional 24 months of family planning services following the current 60-day post-partum coverage. For this benefit only, resources and income will be disregarded in determining whether or not a post-partum woman is Medicaid- or Waiver-eligible. These family planning services outside of the Waiver will be reimbursed fee-for-service.

"It's really hard to find a doctor that will accept Medicaid patients. We have to drive 20 miles to see a doctor and he's only there for a few hours in the morning."
 – Medicaid recipient

Pharmacy

Pharmacy will be included in the standard benefit package of all Waiver members. In addition, Missouri will contract with a managed pharmacy network to provide pharmaceutical services to those Medicaid-eligibles who will not be part of the Waiver (see Eligibility, below).

Services Unaffected by the

Waiver

Services provided by nursing homes, intermediate care facilities for the mentally retarded (ICF/MR), and state mental hospitals will continue to be provided to the Medicaid-eligible population on a fee-for-service basis and remain unaffected by the Waiver. In addition, certain services that Missouri currently offers under existing waivers will be unaffected by the Waiver. (Note: the Jackson County managed care program, currently under a 1915(b) waiver, will be included in the Waiver.) These services are:

- Private duty nursing, attendant care, and medical supplies needed to prevent hospital placement of AIDS patients.
- Homemaker/chore and respite care to Medicaid recipients over 65 who would otherwise require nursing home care.
- An array of services provided to the mentally retarded and developmentally disabled, including therapies, habilitation, and independent supported living.
- Support services to the mentally retarded and developmentally disabled that enable the State to provide care in community-based settings rather than residential facilities.
- Optical, adult dental, audiology, personal care, adult day care, respite care, and homemaker/chore.

ELIGIBILITY

Who is covered:

The Waiver will be available to any Missouri resident who lacks access to health insurance.

- Individuals and families with incomes above 200 percent of the federal poverty level will be required to pay the full premiums.
 - Those with incomes between 100 percent and 200 percent of the poverty level will pay discounted premiums that are state-subsidized. The discount will be based on a sliding scale that corresponds to income. (See Appendix 5D, Exhibit 5 for details)
 - Waiver members who are Medicaid-eligible or earn less than 100 percent of the federal poverty level will have no premiums.
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Although the Waiver will be available to anyone who lacks access to health insurance, this waiver request focuses principally on those who will receive government-subsidized coverage. This waiver refers to two Waiver eligibility groups:

1. Medicaid-eligibles: current and future residents eligible for Medicaid.
2. The newly-eligible: individuals and families with income at or below 200 percent of the federal poverty level and who have had no insurance for the six months prior to their Waiver application.

Those Medicaid-eligible individuals who are not included in the Waiver will continue to receive services on a fee-for-service basis through the ongoing Medicaid program.

Medicaid Eligibility in Missouri

Following federal law and regulations, the Missouri Medicaid program offers health care services to 580,000 individuals, most of whom are eligible because they qualify under a designated category of federal financial assistance. Missouri Medicaid is available to all of the categorically needy whose coverage is mandated under federal law as well as to some of the categorically needy for whom coverage is optional. Missouri has not extended Medicaid to the medically needy, i.e., those who are unable to afford health care but are not categorically needy.

Medicaid recipients in Missouri are classified according to 41 separate categories of eligibility. For the most part, program participants can be divided into three principal groups: recipients of Aid to Families with Dependent Children; children and pregnant women; and the aged, blind, and disabled. (See Appendix 2C for details.) Each category is subject to particular income and medical guidelines, and within each category are subcategories subject to more specific eligibility standards. People in many of these categories are limited to assets of \$1,000 for individuals and \$2,000 for couples, with a homestead exemption.

The Waiver and the Uninsured:

The Waiver will extend publicly supported health care to most of the uninsured in Missouri.

Recent data indicates that approximately 590,000 Missouri residents have inadequate or no health insurance. By making the Waiver program available to the uninsured with incomes below 200 percent of the FPL on a discounted sliding scale, Missouri will offer public health coverage to roughly 55 percent of its uninsured population. The remainder may buy into the Waiver program by paying the full cost of the premiums. The Waiver will achieve this while keeping spending within the amounts that would have been spent by Medicaid if this program remains unchanged.

Waiver Eligibility

Current and future Medicaid-eligibles will not bear any additional costs due to this waiver request. Medicaid eligibility determinations will continue in order to:

- Identify those who will not have to share costs.
- Determine those individuals eligible for additional fee-for-service benefits outside of the Waiver standard benefit package.
- Guarantee continued access to all Medicaid services for all current and future Medicaid-eligibles.

Medicaid-eligible Individuals Unaffected by the Waiver

Most of the current Medicaid-eligible population will be enrolled in health plans under the Waiver. For a few categories of Medicaid recipients, however, the Missouri Medicaid program will continue to provide services on a fee-for-service basis. These categories of recipients will include individuals in at least one of the following:

"I went to the welfare office because I lost my job. They cover my kids, but they don't cover me because I'm not pregnant or disabled. So I have nothing just because I'm not pregnant?"

—Medicaid recipient

- Individuals eligible for both Medicaid and Medicare (dual eligibles), including Specified Low Income Medicare Beneficiaries (SLMBs) and Qualified Medicare Beneficiaries (QMBs).
- The aged.
- Individuals with permanent and total disability not participating in the pilot project
- Institutional residents including those living in:
 - ICF/MRs;
 - Nursing homes; and
 - Correctional institutions.

Although these categories of recipients are unaffected by the Waiver, pharmacy benefits will be managed under the Demonstration Project.

Newly-Eligible Individuals

Eligibility determinations for the new enrollees in the Waiver will be based only on gross family income and the unavailability of private insurance, as outlined below. (See Appendix 2D for details of income and household guidelines.)

The FPL is established yearly by the U.S. Department of Health and Human Services and published in the Federal Register. The Waiver will adopt the latest FPL, effective July 1 each year, as the standard by which to determine Waiver eligibility.

Eligibility determination will use a simple review of gross household income. Resources of up to \$100,000 (excluding a homestead) will not be considered. In determining resources, the declaration of an applicant will suffice; verification will be required only when there is reason to doubt the applicant's declaration.

Lack of Health Insurance

Applicants must demonstrate that they did not have health insurance in the six months prior to applying for the Waiver. Lack of insurance coverage will be verified through:

- Employers and employer-sponsored plans, such as health benefits for retirees;
- Professional, career, social and other types of organizations that offer insurance to members; or
- Governmental plans other than Medicaid, such as Medicare and veterans' benefits.

Access to insurance will be verified by contacting employers and appropriate organizations.

Optional coverage:

Medicaid-eligible and any newly-eligible individuals whose income does not exceed 100 percent of the FPL with access to private insurance will still be eligible for the Waiver if they are required to pay all or part of the premium of the private insurance. If the benefits offered by the private insurance are comparable to the Waiver, and if the premium is less than the cost of enrolling the applicant in the Waiver, Missouri will exercise its option to pay the private insurance premium rather than enrolling him or her in the Waiver program.

Third-party Liability

Under federal law, Missouri is required to identify legally liable third parties and pursue them as a resource for Medicaid recipients. Under the Waiver, Missouri will continue to take responsibility for liable third parties. The Division of Medical Services will access electronically a national health claims clearinghouse to determine which Waiver members have health needs that should be paid by other payors.

This arrangement has several advantages. It interferes minimally with Waiver members' care; providers and members can concentrate on health care rather than payment. Also, it provides administrative simplicity and efficiency by having only one agency — in this case the State — responsible for third party liability. Waiver members with TPL will be capitated at the same rate as those without.

Eligibility Periods

The Waiver eligibility for each individual or household group will be determined on a yearly basis. Coverage will be guaranteed for the initial six months. If after this six-month period, the individual or family has reported no change in eligibility status, automatic

"This is something totally new for us. We've always had insurance, but now with all the layoffs ... You're just working part time, all of a sudden you're thrust into something and you can't even buy insurance. It's so frightening."

—Working mother

enrollment for the next six months will take place. Thereafter, eligibility will be redetermined annually with the initial enrollment date as the starting point.

Interim Reporting Requirements

A household will be required to report changes in income, access to private insurance, household composition, or changes of address that occur during the one-year eligibility period. Other changes may be reported at the discretion of households, and their files will be updated accordingly.

Prior-Quarter Coverage

Prior quarter coverage will continue to be available to the Medicaid-eligible population, whether enrolled in the Waiver or unaffected, on a fee-for-service basis. There will be no prior quarter coverage for the newly-eligible population enrolled in the Waiver.

Loss of Eligibility

Loss of eligibility for discounted rates will occur when a household's income increases above 200 percent of the FPL, or when an enrolled member moves out of State. Loss of eligibility also will occur when a member has access to private insurance. In addition, as today, failure to cooperate fully in the re-determination process will result in loss of eligibility.

If ineligibility occurs in the first six months, the individual or family will not be re-enrolled for the second six months. If ineligibility occurs anytime after the initial six months, the individual or family will be dropped from the Waiver, but will be able to appeal the decision through the grievance process.

Cost-Sharing

The Waiver will charge certain premiums and co-payments to new eligibles with incomes above 100 percent of the FPL; Medicaid-eligibles will not be assessed any premiums. The waiver-eligible population with incomes between 100 percent and 200 percent of the FPL will pay premiums on a sliding scale. (See Appendix 5-D, Exhibit 5 for details.) Individuals and families with incomes above 200 percent of the FPL may buy into the Waiver program by paying the full premium without state subsidy.

"I have friends that actually got off the welfare system, went out and worked and made under \$6.00 an hour for their family. They decided they couldn't cut it as working poor and jumped back on welfare. The only thing they could do to take care of their medical needs was to get that Medicaid card." –Medicaid recipient

The Waiver will assess co-payments for certain services. To discourage the use of inappropriate emergency room care, one of the most expensive forms of medical care, Waiver members who are treated in an emergency room for a non-emergency matter will be subject to a co-payment of up to ten dollars. This co-payment will not be imposed on the Medicaid-eligible population. Enrollees will be informed of this co-payment prior to care being given and will be urged to see their primary care provider instead. All managed care plans that become Waiver providers must offer 24-hour access by phone to a physician and access to non-emergency, urgent care centers. .

"I think the co-payment is a good idea, even if you can pay only \$5 every time you go, they still might be able to expand the coverage a little." –Medicaid recipient

For certain groups where a preventive schedule of care is necessary, such as pregnant women, both the premium and co-payments will be waived in order to encourage the member to obtain the recommended preventive screening and follow-up care. For all others, primary and preventive care, such as yearly physicals, will be free of co-payments.

ENROLLMENT

Enrollment Campaign

Currently, nearly all Medicaid applications are taken by the Missouri Division of Family Services (DFS) at county offices and other access points. Medicaid-eligibility determinations will continue to be carried out by DFS and other state agencies. However, Waiver eligibility for the newly-eligible population and all enrollment activities, will be carried out by a separate Health Benefit Manager (HBM) that is independent of any managed care plan or Waiver provider. Medicaid-eligible individuals may enroll in the Waiver through an HBM, but because the HBM will not be able to determine Medicaid eligibility, any HBM-enrolled-member will receive only the Standard Benefit Package.

The State will conduct an extensive, multi-media informational and educational campaign to enroll eligible individuals into the Waiver as quickly as possible. The campaign will include mailing to current Medicaid-eligibles and to other low-income groups such as Food Stamp recipients.

Some HBMs will be co-located at state offices, but there will also be stand-alone sites. The use of independent enrollment managers will disassociate the Waiver from traditional Medicaid and other state and federal assistance programs, thereby removing the stigma attached to public programs. The HBMs may use enrollment methodologies — such as mail-in applications and telephone contact — adapted to the unique circumstances of communities throughout the State.

Welfare to work:

All enrollment vendors will be required to employ FUTURES/JOBS graduates who are qualified to serve as health benefit managers. In addition, the state may place current FUTURES/JOBS participants with the enrollment vendors.

The enrollment process conducted by the HBMs will include outreach, education, and enrollment. HBMs will seek eligibles through community meetings and organizations, describe to Waiver enrollees the benefits available through the health plans, and explain how to choose a primary care physician and obtain services.

"What are you going to do with recipients who are abusive? Will there be a penalty for the abuse of the emergency room and missed appointments? Medicaid recipients are not babies. We have the capacity to be responsible — to call the doctor with a cancellation."

—Medicaid recipient

The Waiver will be phased in both geographically and by population during the first two years of the demonstration project. (See Chapter 3 for details.) Until they are enrolled in the Waiver, benefits for Medicaid-eligibles, including pharmacy, will continue to be reimbursed on a fee-for-service

basis. After the State reaches enrollment for all covered groups up to 200 percent of the federal poverty level, Missouri's current Medicaid spenddown program will be eliminated.

Enrollment Process

Enrollment in The Waiver

Currently, DFS staff determines whether an individual is Medicaid-eligible and then enters the information into the DFS computer system. The system generates a Medicaid card with a Department

Client Number (DCN). This system will be modified to permit enrollment and eligibility verifications for the Waiver. Elements of the system include a Point of Service (POS) network which can be used either via POS terminal or dial-up computer to access the Medicaid Management Information System (MMIS) eligibility files, and an Automated Response Unit with toll-free lines. The Waiver enrollees will receive a Waiver card with a DCN, similar to the Medicaid cards now issued by DFS. HBMs will use the system — which will distinguish between Medicaid-eligibles and the new group — for the new enrollment group.

As part of a statewide electronic benefits transfer project, Missouri is considering the issuance of a plastic, mag-stripe, photo identification cards. The cards would be used to access a variety of public assistance benefits, and could also be used for the Waiver.

Enrollment in Health Plans

At the time an applicant enrolls in the Waiver, the HBM will help him or her to choose a health plan in the geographic area. (Each designated geographic area should have at least two health plans in operation.) If a Waiver member fails to make a selection within 14 days, or is indifferent, the HBM will assign him or her to a health plan based on location, capacity of plan, and special needs of the member. Plans must accept any member who selects that plan or who is assigned by the HBM. Once enrolled, each member will select his or her primary care provider. Patients with chronic illnesses or special conditions may request that their primary care provider be a specialist. Efforts will also be made to enroll members with their most recent provider at members' request.

Changing plans:

Once a member is assigned to a health plan, he or she has 30 days in which to change plans for any reason. After the initial 30-day period, individuals will have guaranteed enrollment in a health plan for six months from the effective date of enrollment, unless there is just cause to switch to another plan. Members can change doctors within plans at any time. At the end of each year, there will be a 30-day open enrollment during which any Waiver member can change plans for any reason. Transfers between plans may be accomplished either by contacting an HBM or by submitting changes by mail.

Prior to the end of each year, individuals will be notified that they may change to another health plan. If no change is requested at least two weeks prior to the start of the next year, enrollment in the current health plan will continue.

QUALITY ASSURANCE / QUALITY IMPROVEMENT

The State will conduct outcome-based internal and external reviews of the quality of care delivered by health plans. The goal of the Waiver's Quality Assurance and Quality Improvement program is to monitor the quality and appropriateness of services, health outcomes and health status of Waiver members. And most importantly, the quality assurance program will be used to actually improve the care members receive and the resulting outcomes.

The major principles that will guide the quality assurance program are:

- Quality is a measure of multiple dimensions of care such as:
 - resources and capacity of providers
 - process for providing care
 - outcomes and health status indicators
 - patient satisfaction

- A planned and systematic review will be undertaken.
- These reviews will include input from patients, providers, and the payor, as well as review of EPSDT and other screenings and immunizations of children.
- Public input into the creation of quality standards is essential, as is public accountability of the plans.

Consumer protection:

Patient confidentiality must be guaranteed throughout all surveys, grievance and complaint procedures.

Plans must assure access to covered services for Waiver members, provide outreach, and establish an internal quality assurance program that addresses areas of need as identified by the state. The internal program must include patient surveys and fair hearings for grievances.

Monitoring Quality of Care

During the year following approval of this waiver request, a Quality of Care Advisory Council — consisting of consumers, state officials, providers, academics, advocates and others — will develop quality assurance measurements based on the Health Plan Employer Data and Information Set (HEDIS), a widely utilized quality assurance system developed by the National Commission on Quality Assurance. HEDIS has defined a core set of performance measures and a standardized, systemic method for making these measurements and allowing comparisons to be made among health plans. It examines four performance areas:

1. Quality.
2. Access and patient satisfaction.
3. Membership and utilization.
4. Finance.

HEDIS requirements will be identified in the contracts between Missouri and health plans. Beginning with the first day the Waiver becomes operational, plans will be required to submit encounter data on a monthly basis that is consistent with the formats of HCFA 1500, UB92 and NCPDP Versions 3.2 or 3.C until such time as another form is selected by Missouri. Periodic on-site visits and audits will be conducted to make sure plans comply with contract requirements. Consumers will benefit from all consumer protections detailed in Appendix 1B.

Consumer guidebooks:

A high level of public accountability will be maintained by the Waiver. Missouri will publish data from consumer surveys, summaries of the results of grievances filed against Waiver providers, and the measurements of outcome evaluations. These guides will help consumers make informed decisions. The consumer guides also will hold both the state and managed care plans accountable to the public.

During the first year, quality assurance will necessarily focus on data collection. At the end of the first year, plans will be required to produce HEDIS reports based on the first year's data. During the second year, the Division of Medical Services and the Quality of Care Advisory Council will develop additional measurements that will be incorporated into HEDIS. By the third year of the Waiver, HEDIS reports with the additional measurements recommended by the Quality of Care Advisory Council will be published in Consumer Guidebooks. These additional measurements could include data on functional outcomes such as those used in SF 36. (See Implementation Schedule next page.)

Quality Assurance Implementation Schedule

- Year 1: Data collection and encounter data monitored by state. HEDIS and provider reports due at end of year. Patient surveys and monitoring of transfers and grievances.
- Year 2: HEDIS and provider reports submitted to state. Additional measurements (HEDIS Plus) adopted by state and Quality of Care Advisory Council. Patient surveys and monitoring of transfers and grievances continues.
- Year 3: Publication of HEDIS Plus. Patient surveys and monitoring of transfers and grievances continues. Consumer Guidebooks published with results of all Quality Assurance mechanisms.

Standard Indicators

Missouri will adopt standard indicators of quality that will be included in provider reports prepared by the health plans and submitted to the State periodically. Indicators that will be considered include: immunization rates, EPSDT screenings, communicable disease outbreak rates, low birth weight rate, Cesarean delivery rate, a variety of screenings and other performance indicators .

If the state determines that a health plans has not met Missouri's standards, the State will conduct a more in-depth review, including review of individual medical records. Failure of the plan to meet guidelines could result in financial penalties, or even termination of a contract between the State and the plan.

Encounter Data

The State will gather and monitor encounter data from the health plans to assess over- and under-utilization. Health plans will be required to submit encounter data to the State via electronic media, using a standardized claim transaction form. Compliance with reporting requirements will be enforced by withholding a portion of the capitation payment until encounter data requirements are met.

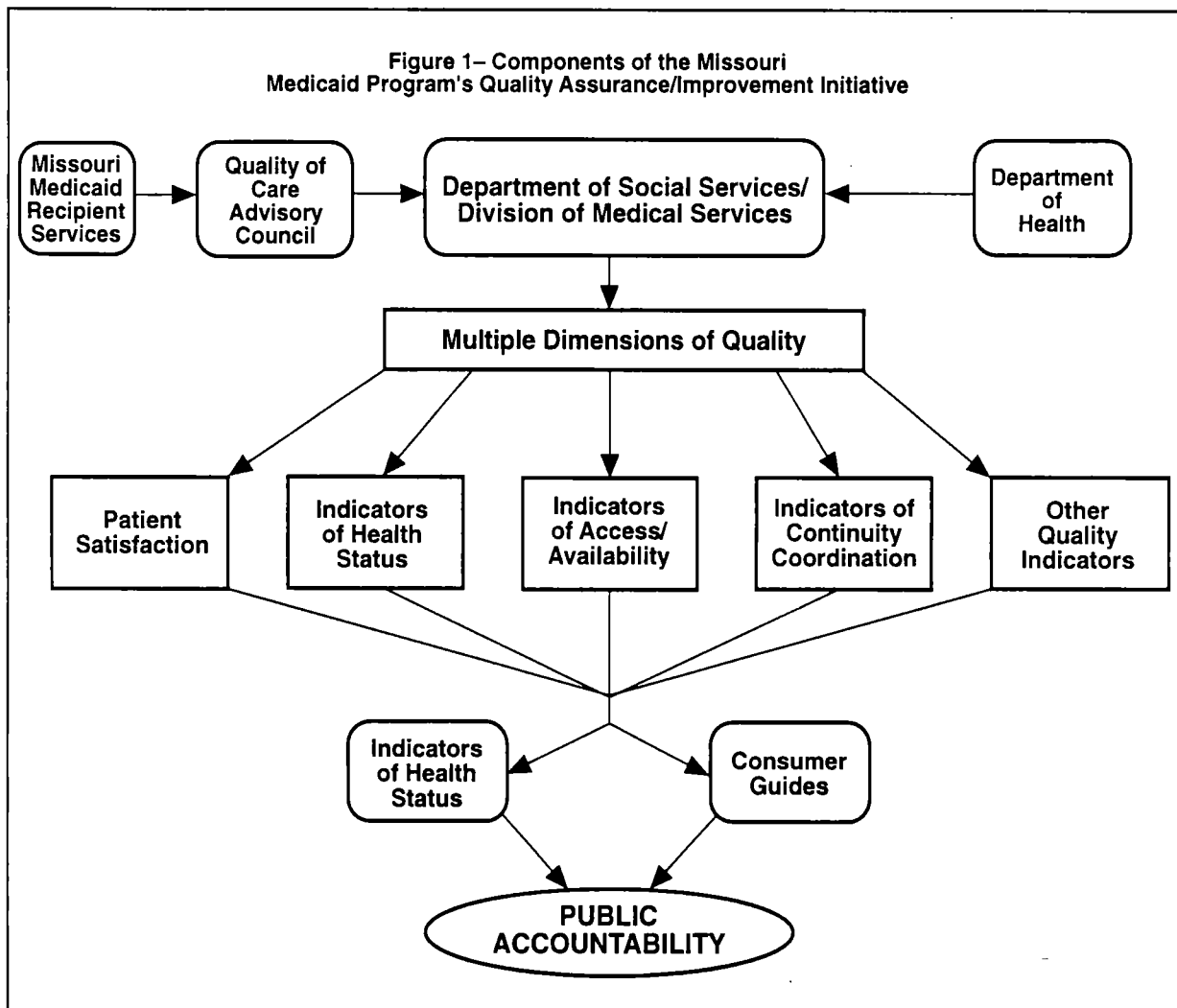
Monitoring Client Satisfaction

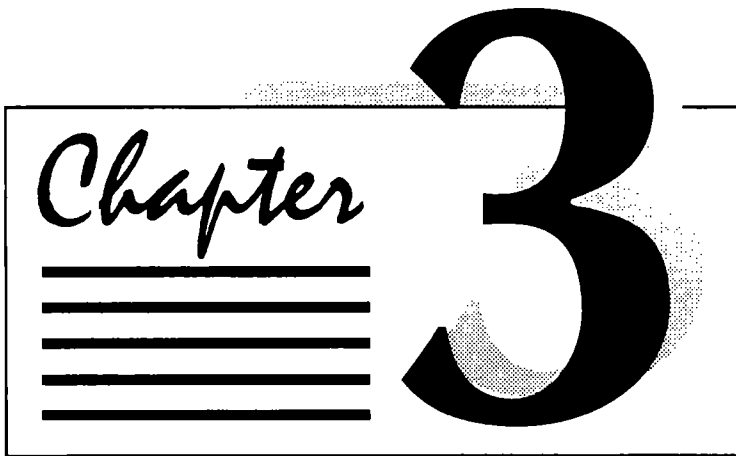
Members will be able to file complaints and grievances and ask for transfers between plans and among physicians within plans. These requests for transfers and doctor changes will be monitored by the state, and summaries will be published in the Consumer Guidebook. In addition, health plans will participate with the State in conducting surveys to assess client satisfaction with their health plans and primary care providers. The surveys will include:

- Overall satisfaction.
- Access to routine, urgent, and emergency care.
- Satisfaction with primary care, including location, hours, waiting times, and access to care when needed.
- Technical competence of providers.
- Communication, courtesy, respect, reassurance, and support.
- Understanding of information provided.

Processing Client Grievances

Plans will establish grievance procedures for members, and the State will also provide an external review process for members who wish to file complaints with the State. Members will be able to institute both grievance procedures simultaneously, although plans will be given an opportunity to settle the complaints before the State would hold a hearing. (For a detailed description of all consumer protections, see Appendix 1B.)





WAIVER ADMINISTRATION AND IMPLEMENTATION

The Waiver will be administered by the Department of Social Services (DSS), Division of Medical Services (DMS), the agency that currently manages the Missouri Medicaid Program under Title XIX of the Social Security Act. The Department of Social Services is the umbrella State agency that provides income support to needy families and individuals in Missouri as well as serves troubled families and their children, the elderly, and provides health care for the poor.

Fundamental change:

The Division of Medical Services will change from a fee-for-service claims processor to a regulator of managed care. Rather than simply paying bills, the Division will become actively involved in assuring that Waiver members receive quality health care that improves their health.

A Managed Care Unit already exists within the Division of Medical Services to administer the Jackson County (Kansas City) Medicaid Managed Care Program. This unit will be transitioned to support the Waiver. New personnel will be hired and existing personnel within the Division re-assigned to the the Waiver Unit. Eligibility determinations for the Medicaid-eligible members of the Waiver will be made by the Division of Family Services, the division within the Department of Social Services that manages income maintenance and family support services. Enrollment for the newly-eligible population will take place through private vendors.

PRESENT STRUCTURE: DIVISION OF MEDICAL SERVICES

The Division of Medical Services consists of the following sections:

Administration:	Administration is made up of the Director's Office, Divisional Counsel, the Managed Care Unit, and Personnel. The Managed Care Unit is responsible for the Medicaid Managed Care program that has operated under a 1915(b) waiver in Jackson County (Kansas City) since 1985.
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Institutional Reimbursement:	This section is responsible for reimbursements to hospitals, nursing facilities, and clinics under the State Plan. It develops and implements reimbursement methodologies as well as determines rates and analyzes provider costs.
Management Services:	Management Services administers contracts for consultant and professional services, including development of Requests for Proposals (RFPs). This section includes the Third Party Liability Unit, which pursues payment from third parties for Medicaid services, and the Buy-In/Cash Control Unit, which is responsible for Medicare Part B premiums and cash flow of the Medicaid Program.
Policy:	Policy is responsible for the research, analysis, development, implementation and monitoring of specific Medicaid programs as well as the overall Medicaid Program in Missouri.
Operations:	Operations oversees the electronic and data collection systems needed to run the Medicaid Program. Its responsibilities include identifying providers with questionable utilization patterns, researching the background of new providers and educating them once enrolled, and responding to provider questions and concerns. Operations also handles Medicaid recipient questions and complaints.
Planning and Budget:	This section prepares and tracks the annual budget request of the Division of Medical Services. It also forecasts and monitors Medicaid spending during the fiscal year.

THE WAIVER ADMINISTRATION

The traditional Medicaid program will continue as the Waiver is phased in. Therefore, the present administrative structure will remain in place, and the current Managed Care Unit will be expanded to include the Waiver. Some Waiver functions will co-exist within existing units that will support both traditional Medicaid and the Waiver. The following positions will be developed as new positions under the Division Director.

Deputy Director for the Waiver:	The Deputy Director will report to the Division Director and lead the Waiver team. This person will be responsible for developing managed care policy, planning the implementation phases, organizing community and public input, overseeing the rate setting process, and managing the work of the personnel listed below.
Quality Assurance:	This unit will evaluate and monitor the data reported to the Division by health plans. It will draw staff from and build on quality assurance programs already in place such as Surveillance and Utilization Review Services (SURS). The quality assurance unit will review all provider and HEDIS reports and analyze utilization data and consumer surveys to check for compliance/noncompliance with State standards. The Quality of Care Advisory Committee will have their work coordinated by this unit.

	In addition, this unit will be responsible for the overall evaluation of the Waiver Demonstration Project and work with an independent evaluator as specified in Chapter 4.
Education & Enrollment:	A team from the Divisions of Family Services and Medical Services, both within the Department of Social Services, will design educational materials and coordinate the enrollment campaign. This team will also provide training and technical assistance to the FUTURES/JOBS participants and graduates who become Health Benefit Managers. It will review and approve all marketing materials developed by health plans. DFS county-based staff will enroll Medicaid-eligibles in the Waiver. This team will coordinate the activities of the Consumer Advisory Committee. This Committee will represent the racial and ethnic diversity of the Waiver population as well as have cross representation from the disability advocacy community. This Committee will assist in the development of educational and marketing materials.
Member Services:	The current Recipient Services Unit will be expanded to handle Waiver Member Services. This unit will answer member inquiries and address concerns, including formal grievances, of Waiver members. A Consumer Ombudsman will be designated within this unit. Member Services will draw from the staff of DSS, Division of Legal Services (DLS) to provide a hearing officer for grievances. Member services will also staff a hotline for Waiver members.
Contracts:	This individual will develop the Request for Proposals that will be used to solicit bids for the Waiver. In carrying out these functions, the contractor will work closely with DSS, Division of Budget and Finance (DBF), and the Division of Legal Services (DLS). In addition, the actual bid solicitation and awarding of contracts will take place through the Missouri Office of Administration (OA). OA is an independent state agency that oversees bids and purchasing for all state agencies. The contract officer will coordinate the writing, negotiating, and monitoring of contracts with DMS, DBF, DLS, and OA.
Network Development:	This unit will also work with a five-member team from the Department of Health to facilitate the development of primary care networks and managed care plans with sufficient capacity to administer the Waiver (see implementation below). This unit will handle all provider and plan inquiries, concerns and complaints. It will also be responsible for developing educational materials to inform providers of how The Waiver will be managed and the standards that plans and providers must meet.
Medicaid Working Group Pilot Project Director:	The Pilot Project Director will administer the voluntary, managed care program for the permanently and totally disabled in Central Missouri that will be included in the Waiver.
MIS/Data Collection:	The current MIS unit will collect and verify the electronic records and reports required of plans that become Waiver providers. It will direct these reports to the appropriate personnel and units listed above.

WAIVER IMPLEMENTATION

Formation of Managed Care Plans

All Waiver health plans must be either licensed pre-paid health plans, or federal or state qualified health maintenance organizations. They must also comply with State guidelines of nondiscrimination. (See Appendix 3A.)

The state is confident that by the second year of the Demonstration Project there will be sufficient managed care capacity to ensure that all Missourians eligible for the Waiver can be enrolled in qualified plans. Nearly two-thirds (64 percent) of the Waiver population lives in counties that already have at least three health plans licensed to provide managed care. (See Appendix 3B) In counties with fewer licensed plans, primarily rural, the Waiver will provide a market incentive for more plans to enter these areas. In addition, the Department of Health and the Division of Medical Services are actively working in rural areas to facilitate network development.

Community health centers:

The State will not ask for a waiver of federal 100 percent cost-reimbursement rules for FQHCs and RHCs. They may choose to become bidders and participants in the Waiver as pre-paid health plans.

Timeframe

The Missouri Department of Health has defined six regional health districts in Missouri. These will serve as the basis for the geographic- and population-based phase in of the Waiver. (See Map 1.) The phase in will take place first in those districts that have plans and network capacity to provide the covered services. In areas where networks are insufficient, the Division of Medical Services and the Department of Health will work with providers and plans to develop adequate capacity. The Department of Health has assembled a team to do this, and has begun a network development effort in the Southeast District. The Waiver is scheduled to be statewide by the end of the second year.

Currently, Jackson County (Kansas City) has a Medicaid Managed Care program for AFDC recipients that has operated for the past 10 years. The first phase of the Waiver will bring up managed care for Medicaid-eligibles in the St. Louis area. On July 1, 1995, Medicaid in the St. Louis metropolitan area — the counties of St. Charles, St. Louis, Jefferson, Franklin, and the City of St. Louis — will begin serving Medicaid-eligible Waiver members under a Medicaid Managed Care program that mirrors the Waiver design. Implementation of this has already begun; contracts with managed care plans will be competitively bid with the RFPs going out during the summer of 1994. Negotiations will take place in the fall of 1994, and enrollment will begin in the spring of 1995.

Year-1 target:

By the end of the first year of the Waiver phase in, the Waiver will be available to the majority of Missouri residents eligible for the Waiver, about 60 percent of those who qualify. (See Appendix 3B.)

In October, 1995, after bringing up the Waiver for Medicaid-eligibles in St. Louis, the Division will convert the managed care program in Jackson County to the Waiver program for the Medicaid population there. At the same time, enrollment will open in the St. Louis area and the Northwest district for all Medicaid-eligibles, newly-eligible children up to 200 percent of the poverty level, and adults up to 100 percent of the poverty level.

IMPLEMENTATION SCHEDULE

Medicaid Managed Care

Current:

Kansas City Medicaid Managed Care for AFDC recipients

July 1995 - October 1995:

St. Louis Mandatory enrollment in Medicaid Managed Care for Medicaid recipients eligible for the Waiver.

Waiver

Year 1: October, 1995 - October 1996

- Mandatory Waiver enrollment for Medicaid eligibles in Kansas City and Northwest Missouri.
- Voluntary enrollment for newly eligibles — children up to 200 percent FPL and adults up to 100 percent FPL — in Kansas City, Northwest Missouri and the St. Louis metropolitan area.

Year 2: October, 1996 - October 1997

- Mandatory Waiver enrollment in remainder of State for Medicaid eligibles and voluntary enrollment for children up to 200 percent FPL and adults up to 100 percent FPL.
- Voluntary enrollment throughout State for adults between 100 percent and 200 percent FPL.

Setting the Capitated Rate

Plans will compete in a negotiated bidding process in which plans will submit sealed bids. The bidding system will be geographically based, using health planning regions defined by the Missouri Department of Health. When feasible, preference will be given to those plans bidding on entire regions. All bids must be for the entire standard Waiver benefit package and all eligibility categories.

The State will construct confidential expected ranges for each cohort prior to bidding to ensure that bids are not excessively high or low. After the bids are received, the Waiver will negotiate with all bidders and will attempt to bring plans whose bids fall outside the State's predetermined ranges into the accepted range. Because the bidding system is geographically based, capitated rates may vary depending on the region served by each managed care plan.

The State will delay implementation of the Waiver in any area in which there is insufficient capacity to provide the Waiver services.

Contractual Agreements with Managed Care Plans

The managed care plans will be contractually required to institute monitoring procedures for ensuring access to specialists, timely appointment and waiting times, recipient education, and all services in the benefit packages. Plans must agree to the standards of quality established by the State and to participate in the ongoing quality assurance process.

Payment of the Rate

Plans will be paid a capitation rate specific to their benefit package through the MMIS system. A portion of the rate will be withheld until all areas of the contract are in compliance. Reconciliation will take place through the MMIS system.

Reinsurance/Stop Loss

A small percentage of each capitation payment will be reserved by the State of Missouri to fund a reinsurance pool. Plans will be able to access the reinsurance pool only after the cost of providing services to any one member has reached a specified limit. That limit will be determined after conducting actuarial analyses in each region. In addition, plans must notify the state when they foresee that a patient's condition may reach the specified limit.

Chapter 4

EVALUATION

The purpose of the Waiver is twofold: 1) To improve the health of those who turn to government-provided health care; and 2) To increase access to health coverage for low-income, uninsured Missouri residents. To hold the State accountable, an independent evaluation will be conducted to determine the extent to which Missouri achieves its objectives. Although other state demonstration projects have addressed broadly the effects of capitation and managed care on the delivery of Medicaid, Missouri's Waiver offers a unique opportunity to analyze the impact of:

- Outcome-driven managed care that utilizes a state-of-the-art quality assurance program.
- Competitive bidding and market dynamics.
- Integration of school-linked health services.
- A voluntary, fully capitated managed care program for the disabled.
- Using FUTURES/JOBS participants to educate and enroll members.
- Managing the care of individuals needing long-term behavioral health services.

This chapter presents a plan that could be used by an independent evaluator to analyze these and other issues. It is organized into the following sections:

"I just hope that one day, I can get off the system and help other people in need." –Medicaid recipient

1. Evaluation Objectives
2. Candidate Research Hypotheses
3. Data Sources
4. Methods for Data Collection and Analysis

EVALUATION OBJECTIVES FOR THE WAIVER

The Waiver is designed to test an innovative approach to providing quality health care services and improving access to primary and preventive health care while controlling health care costs. Through managed care, capitation, integration with schools, and outcome-based quality assurance, the State will create incentives for providers to replace fragmented delivery systems with primary care networks that increase patient access to family physicians and preventive care. By promoting consistent patient doctor relationships, the Waiver will lead to greater patient satisfaction, more informed medical

decision-making, and a more effective and efficient use of medical resources. In this way, the Waiver is expected to provide quality health care to all members without significantly increasing costs. An evaluation is necessary not only to gauge whether the Waiver achieves its objectives, but to gather information that can contribute to long-term health reform in the United States.

The evaluation would assess the impact of the Waiver on both participants and the health care system. To determine whether observed effects are due to the Waiver or other variables, both qualitative and quantitative data and information could be gathered. Five major research questions that may be explored through this demonstration are:

1. **Quality of Care and Health Status:** When compared to the traditional Medicaid program, does the Waiver produce positive improvements in the health of recipients and the quality of care they receive?
2. **Access to Health Care:** Does the Waiver result in increased access to health care, and primary care in particular, for Medicaid recipients and the previously uninsured?
3. **Reform of the Delivery System:** Does the Waiver improve the delivery system, leading to the development of coordinated networks of primary care?
4. **Utilization Patterns:** Does the design of the Waiver cause a shift in the types of services obtained by members prior to the Waiver?
5. **Public Policy and Planning:** Does the Waiver affect other areas of public policy in Missouri, such as the budgetary process and welfare reform?

CANDIDATE RESEARCH HYPOTHESES FOR THE WAIVER

The following pages will outline potential candidate hypotheses for each of the preceding research questions. As with the above questions, the following hypotheses are not intended to be definitive; rather they attempt to break down the research questions into their component parts and illustrate how they could be addressed by an independent evaluator.

1. Quality of Care and Health Status: When compared to the traditional Medicaid program, does the Waiver produce positive improvements in the health of recipients and the quality of care they receive?

The general health of the Waiver members, especially children, is expected to improve as they visit their primary care physicians and seek treatment earlier. As a result of enhanced access to care and the emphasis on preventive care, Waiver members also are expected to receive high quality care. The primary care provider should provide on-going education and consistent encouragement to Waiver members to reduce or eliminate high-risk health behaviors. To monitor the impact of the Waiver, Missouri will develop and implement a comprehensive, multi-dimensional approach to quality measurement, as detailed in Chapter 2.

In addition, an independent evaluator could measure the impact of many of the design elements of the Waiver on quality by answering the following questions:

- Do members show improved health in certain key outcome areas such as immunization rates for children, incidence of sexually transmitted diseases, and rates of births to mothers without adequate prenatal care?

- Do children enrolled in health plans that are linked to schools have better outcomes — as measured by immunization rates, for example — than those who are not?
- Do measures of continuity and coordination of care improve through the use of health plans particularly for those that integrate their services and develop links to schools?
- Does the use of school staff to help coordinate access to services not included in the standard benefit package result in better health outcomes?
- Does the use of a broad-based Quality of Care Advisory Council result in a more effective QA/QI program?
- What is the self-reported health status of previously uninsured individuals at the onset of coverage, after one year, two years, and three years of coverage?
- How does functional status of the enrolled population change over time?
- What impact does the pilot for the physically disabled have on the quality of their care, and measurements of continuity and coordination?

Candidate hypotheses include the following:

- Pregnancy outcomes of Waiver members will improve.
- The incidence of severe, untreated conditions will decrease.
- A greater proportion of enrolled children will receive EPSDT services, particularly those in plans that include schools.
- Managed care plans will provide the same or better quality care than the existing fee-for-service system.
- There will be an increase in age-appropriate immunizations of children members.
- The health status of previously uninsured individuals will improve.
- Participants in the pilot for the physically disabled will experience improved quality of care and better outcomes.
- Indicators of key children's health problems will improve.

2. Access to Health Care: Does the Waiver result in increased access to health care, and primary care in particular, for Medicaid recipients and the previously uninsured?

Coverage for the previously uninsured and increased access to primary care for both Medicaid eligibles and the newly eligible should result in greater utilization of primary care providers and increased access to the health care system. In particular the State expects competitively bid managed care to improve access for all the Waiver members. The State expects higher compliance with EPSDT requirements and a higher percentage of children who receive all of their immunizations.

Access could be assessed through the following questions:

- Does the project result in an increase in the number of primary care providers willing to serve this population?
- Does the project result in an increased willingness of low-income residents to apply for public health care?
- How does health care access change for members who were Medicaid eligible prior to the implementation of the Waiver?
- To what extent does the project improve access for the newly-covered population?
- Does the use of a health benefits manager, particularly JOBS/FUTURES enrollees or graduates, encourage enrollment in the Waiver?
- To what extent does the Waiver improve the delivery of primary and preventive care to children, as measured by compliance with the EPSDT periodicity schedule and prenatal care regimens?
- To what extent does the enrollment of schools as Medicaid providers and case managers for EPSDT services improve compliance?

- To what extent does the use of schools improve access to health services in general?
- What proportion of the newly eligible population choose to enroll?
- To what extent does the pilot for the physically disabled improve access for enrollees?
- Do Waiver members report improved access to care?

Hypotheses regarding access include the following:

- Members will report overall satisfaction with accessibility and availability of care.
- The use of a health benefits manager, particularly JOBS participants and graduates, will encourage enrollment.
- The use of managed care plans will significantly reduce the non-emergency use of the emergency room.
- The delivery of primary and preventive care, particularly compliance with the EPSDT periodicity schedule, will increase, especially for plans that contract with schools.
- Members will rely on their primary care provider for the majority of their health care needs.
- The proportion of pregnant women receiving recommended prenatal services will increase.
- Incidence of long hospital stays will be reduced since participants will seek care earlier.
- Members will report improvement in the accessibility and availability of care under the program, particularly for children enrolled in plans that have contracted with schools.
- The number of primary care physician visits will increase and the number of specialist visits will decrease.
- The number of primary care providers serving this population will increase.
- Participants in the pilot for the physically disabled will report increased accessibility and availability of care.

"As soon as they find out you're on Medicaid, they treat you like you don't matter, like you're not a person."

—Medicaid Recipient

3. Reform of the Delivery System: Does the Waiver improve the delivery system, leading to the development of coordinated networks of primary care?

For the Waiver to operate successfully, managed care providers will need to establish formal agreements with schools and coordinate wrap-around services that are provided to Medicaid-eligibles. In addition, rural areas as well as urban areas currently underserved by primary care physicians and managed care plans will require network development.

Service delivery reform could be measured through the following questions:

- What impact do provider reports and consumer guides have on changes in health care delivery?
- Will incorporating principles of managed competition through the use of competitively bid rates encourage efficiencies and innovation in the health care delivery system?
- What impact does the project have on provider willingness to organize into managed care plans?
- To what extent does the program attract and retain health plans?
- To what extent do plans establish formal agreements linking them with schools?
- What impact does the project have on total and per capita expenditures for the eligible population?
- Does the program increase administrative efficiency?

- To what extent does the project increase provider satisfaction by developing a relationship that provides a medical home to the Waiver members?
- What impact does the pilot for the disabled have on total and per capita expenditures for participants?

A better health system:

The State will influence the health delivery system by creating a large purchasing pool, using a competitive bidding process, defining a standard benefits package. These economic incentives combined with outcome-based quality assurance and the integration of health services with schools will improve the effectiveness of health systems in Missouri.

Candidate hypotheses regarding service delivery reform include:

- A competitive bidding process will result in rates that are more cost-effective than those set by the State using fee-for-service-equivalent data;
- Sufficient numbers of providers will participate in the program so that health care is available and accessible to all members.
- The Waiver will increase network capacity in rural areas;
- Practitioners emphasizing preventive and primary care will increase.
- Primary care providers will report an increase in patient volume; specialists will report a decrease in patients.
- There will be an increase in the number of managed care plans, and they will be offered over a broader geographic area.
- The level of charity care provided by hospitals in Missouri will decrease.
- Total Medicaid expenditures will rise initially as eligibility expands; however, the cost per member will increase at a much slower rate than for a comparable fee for service population.
- Providers and recipients will report overall satisfaction with the demonstration.
- The use of provider incentive payments will affect practice patterns to reflect an emphasis on primary and preventive care.
- The cost per participant in the pilot for the disabled will be lower than for a comparable fee-for-service population.

4. Utilization Patterns: Does the design of the Waiver cause a shift in the types of services obtained by members prior to the Waiver?

Emergency room visits should drop, while physician office visits increase. Three elements of the Waiver should change the care-seeking behavior of the Waiver members:

1. School linkages.
2. Informed decision-making through the use of consumer guidebooks.
3. Easier access to primary care.

The effect of the benefits plan design could be assessed through the following questions:

- What effect does member cost-sharing have on service utilization and compliance with treatment regimens?
- Does the co-payment for non-emergency use of the emergency room for newly eligibles affect use of the emergency room?

- Does the introduction of managed care and emphasis on primary and preventive care reduce the incidence of acute care provision and chronic conditions in the adult population?
- To what extent will the managed care system modify provider practices and promote emphasize on cost effective treatment modalities?
- Do consumer guides and access to information on providers change the utilization behavior of enrollees?
- To what extent does the use of managed care plans and assigned primary care providers reduce the utilization of the emergency room for non-emergent conditions?
- How do the health care utilization patterns of the formerly uninsured population compare to those enrollees who were Medicaid eligible prior to the implementation of this project?

Candidate hypotheses regarding utilization patterns include:

- The utilization rate of preventive health services and compliance will increase as a result of the absence of co-payments.
- To the degree primary and preventive services are used, chronic conditions in the adult population will decrease.
- Provider reports and consumer guides will be an effective and efficient method to assure public accountability and deliver high-quality care that produces positive outcomes.
- Publicly disseminated consumer guides will provide an incentive to plans and providers to offer a health care product that is responsive to the needs of the Waiver population.

5. Public Policy and Planning: Does the Waiver affect other areas of public policy in Missouri such as the budgetary process and welfare reform?

The Waiver will change the nature of government-provided health care. The Division of Medical Services will assume a significant role in the monitoring and oversight of care delivery, health status and health outcomes.

Public policy development could be examined through the following questions:

- Does the Waiver's emphasis on quality assurance and outcome measurement increase the availability of accurate, detailed data for health care planning, redirection of resources, and further system reform?
- What impact does the introduction of the project have on Missouri's ability to more effectively plan and implement health care policy?
- What impact will the new payment system have on the State's budgetary process?
- Does the inclusion of new eligibles and the system of managed care impact welfare reform, education, and other significant public policy initiatives?
- What is the effect of the pilot for disabled persons on Missouri's other programs for the disabled?
- Does the expansion of the Waiver to the previously uninsured (and accompanying cost-sharing provisions) change legislative and public perceptions of government-provided health care?

Policy impact

The availability of health coverage to the previously uninsured could also impact other policy areas such as welfare reform and unemployment.

Hypotheses regarding public policy are presented below:

- The State will more accurately project health care spending.
- The State will have more accurate information on which to base health care and human services planning.
- Contracting with FUTURES/JOBES participants and graduates will provide them with meaningful work experience and could be used as a model for other programs.
- The availability of health coverage to low-income families who rely on public support will encourage their entry into the work force.
- The State, as a result of the demonstration, will redirect resources in the health and human services system to more efficient and effective practices and programs.
- The expansion of the Waiver to the working poor and cost-sharing will lessen negative perceptions previously associated with Medicaid.

DATA SOURCES

Data collection will begin early in the Waiver's implementation to ensure that adequate baseline information is available to monitor plans as well as for comparison during evaluation. Several data sources may be used to test the Waiver hypotheses. In addition to its current data gathering, the State will implement a quality assurance/quality improvement program for the demonstration (described in Chapter 2) that will collect additional information. While this information could be used in an evaluation, additional data sources can be designed by the independent evaluator. Responsibility for developing these data sources will be determined when the study design is finalized.

Potential data sources include:

- Case Study Interviews and Focus Groups
- Per Capita Data
- State MMIS
- HEDIS and provider reports required for Quality Assurance
- Demonstration Data Set
- Member Surveys
- Member Grievances
- Medical Records Analysis
- Plan and Provider Surveys
- Ongoing Program Monitoring
- Department of Health, Center for Health Statistics

Case Study Interviews and Focus Groups

Evaluation of the Waiver could be carried out through case study interviews and focus groups. This type of qualitative research provides in-depth, personal insight into the program and can help validate and understand quantitative data.

Key persons that should be interviewed include:

- Waiver members and Medicaid recipients not eligible.
- Waiver physicians and providers, as well as nonparticipating physicians and providers.
- Representatives and administrators of both participating and nonparticipating managed care plans.

- Provider associations and other provider groups.
- Advocacy and citizen/consumer groups.
- Administrative personnel and staff from the Division of Medical Services, the Department of Health, legislators, legislative staff, other State and local agencies or community service organizations that have contact with Waiver members.
- The Medical Care Advisory Committee.

The issues that could be addressed in these case study interviews include:

- Quality of care.
- Comparison to health care access prior to the Waiver.
- Program expectations.
- Effectiveness of outreach and enrollment strategies.
- Reasons for policy and operational decisions on the part of the State as well as among providers and plans.
- Changes in operations needed to accommodate the demonstration.
- Factors influencing plan formation (geographic variations and ability of plans to attract specialists in rural areas).
- Factors of the program influencing the plans' delivery systems.

Per Capita Data

Since an important feature of the proposed demonstration project is to improve access, quality, and appropriate utilization of services, ongoing per capita encounter and expenditure data is necessary. This data can help determine whether the program is indeed encouraging appropriate utilization of services and improving access to care. This data could also be used to determine the effects of the Waiver on utilization patterns. The two primary sources of per capita information will be:

1. Medicaid claims data from the state MMIS; and
2. A demonstration data set and data from the plans collected through provider reports.

State Medicaid Management Information System (MMIS)

The MMIS, which processes the current fee-for-service Medicaid program, is able to produce historical, per capita encounter and cost data for services. In addition, fee-for-service utilization and expenditure data can be obtained and summarized for each eligibility category, e.g., AFDC children. Initially this information will be used to set confidential capitation ranges. The historical fee-for-service data could be used for comparison with the Waiver utilization data to determine increased/decreased utilization, service delivery changes, and costs or savings.

Demonstration Data Set

Because the demonstration project will be implemented through managed care plans, the information currently available from the MMIS may not be available in its present format under the Waiver. Thus, a minimum data set will be defined with the cooperation of the plans to make sure necessary data is available for comparisons during the demonstration. At a minimum, health plans will be required to submit encounter data via electronic media on a monthly basis consistent with the formats of the HCFA 1500, UB 92 and NCPDP Version 3.2 or 3.C.

A minimum data set may include:

- Hospital services
- Surgeries
- Physician services
- Laboratory, x-ray services
- Durable medical equipment
- Other services
- Third party liability

In addition, each plan will be required to provide information on standard quality indicators — such as immunization rates, communicable disease outbreaks, low birth weights — adopted by the State. In addition, a measurement tool such SF-36 might be used as a format to collect data on functional outcomes. This information will be included in provider and HEDIS reports prepared by the plans and submitted periodically to the State. In the latter phases of the demonstration project, the State will publish this data in consumer guides.

Member Surveys

A member satisfaction survey will be conducted to evaluate satisfaction with the program providers and plans. The surveys will provide information for the quality assurance/quality improvement program. The survey could also be used to provide information on other program outcomes, such as changes in the participants' health status and behavior related to utilization of resources. The surveys will be computer-generated, and the data will be read by scanner and automatically recorded and tallied. A stratified, random sample could be used to select a representative population and to maintain the integrity of the survey in terms of confidence levels and potentials for survey bias. Members could respond to survey questions in the following areas:

- Enrollment/Disenrollment process:
 - Entry into the program
 - Maintenance of eligibility (re-certification)
 - Eligibility problem resolution
 - Disenrollment

Member input:

Member surveys will provide both qualitative and quantitative data that will help determine whether the Waiver is responding to the needs of members, whether they are being treated respectfully and whether their access to medical services is improved.

- Satisfaction with managed care plan and physician:
 - Overall satisfaction
 - Access to emergency, urgent, routine, and preventive care
 - Convenience (measured in travel time)
 - Difficulty in obtaining a primary care provider
 - Responsiveness in non-emergency visits (measured in waiting time with and without appointment)
 - Patient rapport and confidence
 - Availability of specialty care
 - Treatment by non-medical personnel (courtesy, respect, and support)
 - Treatment by medical personnel (courtesy, respect, and support)

- Grievances handled quickly and fairly
- Managed care plan requirements and procedures (complicated or difficult to understand)
- Cost considerations
- Referral problems
- Billing problems
- Quality of care
- Health status:
 - Current health status (self reported)
 - Any primary care visits (number of visits)
 - Any new health care needs detected (number of diagnoses/episodes)
 - Any emergency utilization (number of visits)
 - Any hospital inpatient days (number of days)

Extensive surveys should be conducted at the beginning of the demonstration, midway and toward the end of the demonstration. In addition, periodic surveys of members will be conducted to monitor quality. Current eligibles should be surveyed at the beginning of the demonstration to obtain information to provide a comparison between the current programs and the demonstration.

Member Grievances

Plans will be required to establish grievance procedures for members, and the State will provide an external review process for members who wish to file complaints with the State. General and plan-specific problems could be identified by collecting information regarding grievances brought in either venue and analyzing the bases for the grievances as well as the resolutions. In addition, reasons for transfers among plans and changes in primary care providers could be studied.

Medical Records Analysis

An analysis by the independent evaluator of a sample of patient medical records could be conducted to assess the health status of the participants and to evaluate the type, quality, and appropriateness of care provided in the program. The analysis would consist of evaluating the changes in health status on the basis of medical record documentation of encounters, including but not limited to preventive services, diagnoses (provisional, admitting, working, and discharge diagnoses), treatment, referrals, and outcomes.

Plan and Provider Surveys

Surveys of participating health plans and their providers could be conducted to assess their satisfaction with the program and to identify factors that led plans to participate. Surveys could also be used to obtain information on any changes that the plans may have implemented to comply with program requirements or to facilitate their taking on this population. They could assess such factors as altered reimbursement structure, operating environment, marketing, or an increased need for educational or outreach efforts. Before the start of the demonstrations, 100 percent of the plans could be surveyed to establish an initial benchmark. Thereafter, surveys could be conducted at intervals throughout the demonstration. The surveys could focus on the following areas:

- For the plans:
 - Cost effectiveness of program design
 - Quality of care
 - Business performance
 - Potential for further cost containment
 - Evidence of cost shifting

Provider perceptions:

In addition to improving the health-seeking behavior of members, the Waiver also seeks to increase the willingness of providers and health plans to serve low-income families. Therefore, gaining insight into the perceptions and responses of providers to the Waiver is essential in evaluating the full impact of the Waiver.

- For the service providers:
 - Satisfaction with program design
 - Quality of care/professional latitude
 - Satisfaction with and any changes to the referral system
 - Potential for improving or expanding program
 - Incentives to become involved or remain in the Waiver
- Factors affecting decision to participate:
 - Benefit package
 - Capitation rate
 - Length of contract
 - Potential increase in patient volume
 - Demonstration administration and reporting requirements
 - Potential reduction in amount of uncompensated care

Ongoing Program Monitoring

Data will be collected from the participating plans throughout the course of the demonstration project. This data will be used to augment the information obtained through other data collection methods. Monitoring data will include:

- Number of program eligibles;
- Utilization rates of major services; and
- Financial condition of the plans.

PROCEDURES FOR DATA COLLECTION AND ANALYSIS

Collection

Throughout the evaluation, the State will be challenged to obtain complete, accurate and meaningful data. Differences among plans, providers, and members may exist and will have to be reconciled. These differences may be the result of unique geographic considerations, availability/non-availability of secondary and tertiary care, or provider documentation of service encounters. Differences could be resolved by defining and requiring data collection and reporting according to specified standards. Where data may need to be encoded, nationally acknowledged standards such as ICD-9, DSM-3, and CPT-4 may be used.

Standard Demonstration Data Set

A standard demonstration data set will be established in connection with reporting requirements. Data elements will be well defined in order to eliminate classification and reporting difficulties by providers and plans. Rules for aggregating and collapsing data into required elements will be documented as well as the rules for summarizing data. Documentation relating to data collection and data reporting will be available to all participating plans.

Standard Reporting Formats

As discussed above, encounter data will be required of managed care plans at least monthly in a format consistent with the formats of the HCFA 1500, UB92 and NCPDP Version 2.2 or 3.C if and until the State determines that another standardized form is more appropriate.

Historical Comparisons

Evaluation of the effectiveness of the demonstration program involves comparing before and after measurements and/or conditions. Due to external factors, the baseline environment is likely to be different from the experimental environment, leading to different and/or incompatible data or responses. Therefore, some data transformations will be necessary to normalize all data. However, to minimize the need for normalization, baselines will be established at the outset of the demonstration project.

Comparative Analyses Among Plans

Given the standard definitions of the required data elements and the defined format requirements, cross-plan comparisons will be attempted. However, it is acknowledged at this time that for reasons stated above as well as other reasons, differences among providers, plans, and members might lead to situations where comparisons may not be appropriate. Unless standard treatment protocols are established, measuring the effectiveness of plans based on service utilization is tenuous. Consequently, for purposes of evaluating the effectiveness of the demonstration in this area, service evaluations will focus on final outcomes rather than the treatment process.

Surveys

Surveys will be employed to measure various aspects of the programs. The survey populations will be defined. However, random sampling with the usual techniques for eliminating statistical bias will be employed when the population is so large that a survey of 100 percent of the population is not feasible. As additional survey parameters, or language and other communication problems arise, they will be accommodated, rather than passed over. Anonymity of respondents will be required to encourage survey participation.

ANALYSIS

The following methodologies could be used to test the research hypotheses using the data sources as listed above:

- Case studies and surveys of plans, providers, and members.
- Ongoing comparisons of the program based on geography, participating plans, and selected populations.
- Ongoing comparisons to determine how Missouri's demonstration experience has changed the nature of Missouri's Medicaid program relative to other states' Medicaid programs.
- Comparisons of potential members through the development of baseline data at the time of initial enrollment and subsequent demonstration data.
- Comparisons of current eligibles, focusing on changes over time by comparing the experience under the existing programs with that under the Waiver.

The development of appropriate baseline data is required for each methodology. It is recommended that baseline information be developed for each:

- A state, or states, other than Missouri.
- Participating plans.
- County-specific information.
- Type of service and place of care.
- Eligibility and demographic group.

States selected for comparisons should to be similar to Missouri in terms of population, demographic characteristics, provider supply, and current Medicaid benefit provisions, among other factors. Hypotheses may be tested with multiple methodologies using a variety of data sources.

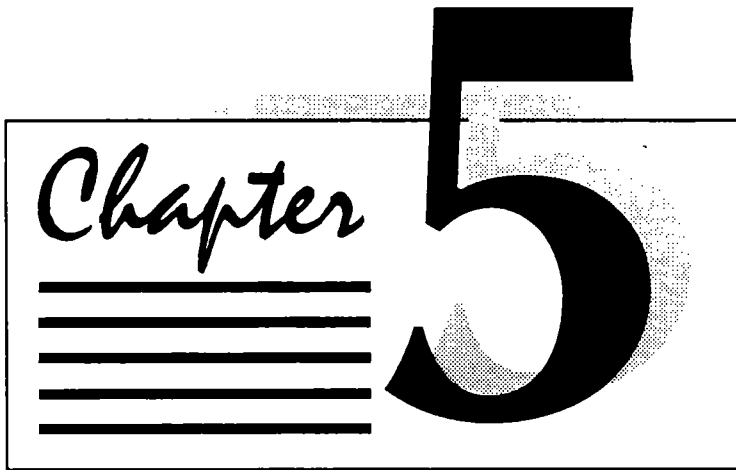
Program expenditures could be analyzed through a series of comparative analyses using expenditure data from MMIS and the Demonstration Data Set. Comparisons of the changes in service expenditures by eligibility and demographic group should be made using per capita data obtained from the MMIS and the Demonstration Data Set. The analyses may be supplemented by case studies and plan, provider and member surveys.

The impact of the Waiver on health services utilization is anticipated to be measured by analyzing MMIS data (claim files, eligibility files, provider files) and the Demonstration Data Set. Ongoing program monitoring efforts and program members survey data, supplemented by medical records review, would provide the basis for measuring changes in usual source of care.

Quality of care and health status outcomes are anticipated to be measured primarily through the quality assurance/quality improvement program, which includes standard quality indicators, functional outcomes, and patient satisfaction surveys. Before and after comparisons could be made on various factors. Medical records could be reviewed for specific “tracer conditions” to assess changes in health status and provider adherence to treatment protocol.

Patterns might be determined from MMIS data, the Demonstration Data Set, and member and survey data. The analyses used to test each project’s program and plan enrollment hypotheses would include state by state and plan-by-plan comparisons of potential member and member characteristics, a comparison of eligible and non-eligible self-reported health status, and a trend analysis of program enrollment using monitoring data.

The analysis of the impact of the demonstration on managed care plans would include an analysis of plan satisfaction with the program and changes in patient volume. The relevant data would be obtained primarily from MMIS data, the Demonstration Data Set, and survey responses.



COST AND CASELOAD ESTIMATES

The Missouri Waiver Demonstration Project will extend health care coverage to over half the medically uninsured population in the state, while saving an estimated \$262 million in federal expenditures by the end of federal fiscal year (FFY) 2000. This chapter will provide background information about the methods and data sources used to develop the proposed Waiver budget. The chapter is divided into the following sections:

1. Federal Financial Participation Under the Waiver
2. Baseline Cost of Service
3. Waiver Cost of Services
4. Administrative Costs: Baseline vs. The Waiver
5. Cost Summary

The following appendices detail the technical steps performed in the development of the cost estimates:

- Appendix 5.A: Existing Caseload
- Appendix 5.B: Expanded Caseload and Total Waiver Population
- Appendix 5.C: Calculation of Per Member Per Month (PMPM) Costs
- Appendix 5.D: Waiver Program Estimates

These appendices provide a step-by-step guide to the actual calculation of individual cost estimates discussed in this chapter.

FEDERAL FINANCIAL PARTICIPATION UNDER THE WAIVER

Under the waiver, federal financial participation (FFP) will change as a result of the expanded coverage to the uninsured, but the Waiver is projected to remain budget neutral in aggregate over the waiver years. The following describes the terms of financial participation:

For populations and services not affected by the Waiver Demonstration Project, FFP would continue at the regular matching rate for actual expenditures as reported on the HCFA 64. The populations and services largely unaffected by the waiver are:

Individuals meeting at least one of the following definitions

(Note: overlap exists among these groups):

- Aged
- Permanently and Totally Disabled
- Dual Medicare/Medicaid eligibles (including SLMBs/QMBs)
- Institutional Residents, including residents of:
 - ICF/MR's
 - Nursing Homes
 - Mental Health Institutions

For these groups, pharmacy benefits will be provided under a managed pharmacy program.

Services unaffected by the waiver are:

- Adult Dental
- Hearing Aid (Audiology)
- Personal Care
- Nursing Home Care
- Adult Day Care
- Respite Care
- Homemaker Chore
- Optical

For populations and services affected by the Waiver, FFP is requested for costs incurred for each individual determined eligible for the waiver program (including those currently eligible under the existing Title XIX program and those newly eligible based on the proposed expanded program eligibility). The amount of FFP will be determined in the following manner:

- 1) For the first year of the waiver, the regular federal matching share will be made according to actual per capita expenses detailed and estimated in this chapter.
- 2) The federal per capita share determined for the first year of the waiver would be determined for each subsequent year by the percentage indicated by the capitated rates awarded through competitive bidding.
- 3) The federal matching rate will continue to be adjusted according to existing procedures. Existing enhanced match rates for the family planning component of capitation will be applied proportionally.

The Waiver can achieve its dual goals of expanded coverage to a portion of the uninsured and overall cost savings through three mechanisms. First, the inherent efficiencies of a managed delivery system are expected to result in less inappropriate utilization of expensive treatments such as emergency room exams and hospitalization. This is accomplished by the financial incentives of

capitation and stringent monitoring of quality standards that encourage less expensive primary and preventive care. Second, the current Medicaid disproportionate share (DSH) program now pays for uncompensated care to uninsured individuals. A portion of this program's funding will be converted to explicit coverage through prepaid per capita payments, and an additional portion will be used for special payments to providers serving the Waiver target population not enrolled. Finally, those uninsured individuals above 100 percent of the federal poverty level (FPL) who choose to enroll in the Waiver will be asked to share in the cost of their health care coverage on a sliding scale basis.

Certification of Matching Funds

One of the two following procedures will be used to certify funds as state share match for the Waiver:

Method 1

Procedures currently in place to certify matching funds from local governments and other state agencies will continue under the Waiver. State and local government agencies will continue to provide certification statements and financial documentation for funds provided to hospitals and used for uncompensated acute care services. Although the amount of uncompensated care is expected to decrease under the Waiver, acute care services will continue to be provided to individuals in the Waiver target population who are not enrolled in the Waiver. To the extent these services are funded by local or state government agencies, they will remain eligible for federal support. The payment methodology for these services will be specified by the state prior to the commencement of the program.

Method 2

The Waiver managed care plans are likely to utilize existing locally-funded services to provide care to enrollees. Examples of these services are locally funded transportation networks, ambulance services and local and county health departments. The Waiver program design allows for plan flexibility in the coordination of services provided by both contracted providers and locally-funded providers. To the extent that these locally-funded services are used by Waiver enrollees, federal financial participation is requested. The certification process is described below:

- The plan will indicate if its service network includes any locally-funded providers that will deliver one or more services covered in the standard benefit package;
- The amount of non-federal subsidization per unit of service will be determined by the State, through conventional audit procedures and review of available revenue and cost information;
- The plan will be required to submit information through the existing encounter data reporting system to indicate every instance of a service provided by one of the designated locally-funded providers. This provider level encounter data is consistent with other reporting requirements under the Waiver;
- The State will submit a separate claim for FFP after every FFY for the services provided by locally-funded providers. The amount of this claim will be the product of the volume of services reported through encounter data and the subsidization cost per unit of service.

This procedure recognizes that the per-member, per-month (PMPM) payments to health plans (and corresponding FFP) are lower than would otherwise be experienced if locally-subsidized providers were not utilized. Thus, the year end claim is necessary to fully match the non-federal cost of delivering services to the Waiver enrollees. Services provided by locally-subsidized providers are subject to all the Waiver quality assurance standards and monitoring procedures.

BASELINE COST OF SERVICES

Expanded health care coverage to low-income individuals is a goal of the State of Missouri. House Bill 564 in 1993 expanded Medicaid coverage to 30,000 pregnant women, infants, and children in poverty. In addition the legislation mandated (subject to appropriation) 1902(r)(2) expansion in FY 1996. If the State does not obtain approval for the Waiver, state policy makers likely will pursue federally allowable expansions in Medicaid eligibility under Section 1902(r)(2). Therefore, the baseline program cost estimates include:

Current Medicaid Program. This includes all services and eligibility groups that are currently covered under the Medicaid program projected over the waiver years, FFY 1996 - FFY 2000; plus

1902(r)(2) Expansion Population. This refers to the population of uninsured children under age 19 with family income under 200 percent FPL projected over the waiver years.

The remainder of this section is divided into discussions regarding these two populations. Although the State has substantial information about the current Medicaid program cost, it was necessary to draw upon non-state data sources to estimate the cost of services associated with the 1902(r)(2) population.

Current Medicaid Program

The FY 1995 Medicaid program budget was used as the starting point for estimating what Missouri Medicaid expenditures would be in the absence of the Waiver. The FY 1995 total expenditures were projected forward across the waiver years using estimates developed by the U.S. Department of Health and Human Services for Missouri Medicaid growth rates without comprehensive health care reform (US HHS, 2/28/94). The composite inflation factor of 11.5 percent, which represents increases in both utilization and prices, was applied to all current Medicaid service categories. Exceptions to this inflation factor include:

- 0% DSH program growth due to the capped nature of this program;
- 3.3% State Medical growth based on historical data;
- 5% Mental Health Institution growth, and 2% ICF/MR growth based on historical trends.

The current DSH program in Missouri will be capped at \$620 million in FFY 96. DSH payments are currently provided to hospitals through three distinct payment methodologies: Per diem payments for all-cost/all-days, Medicare Medicaid Contractual Payments (MMCP), and the Uncompensated Care/Access to Care Incentive (UCACI)-Safety net program.

- (1) Per Diem payments — Hospitals that meet minimum federal and state criteria are designated second tier, first tier or first tier 10 percent DSH and receive enhanced per diem payments. In addition, first tier and first tier 10 percent hospitals are not subject to day limitations.
- (2) MMCP — Payments structured to reimburse hospitals for a portion of their uncompensated care are made to all hospitals except first tier 10 percent DSH.
- (3) UCACI-Safety Net — first tier 10 percent DSH facilities receive payments, funded by certified state and local government funds, based on the hospitals level of uncompensated care.

1902(r)(2) Expansion Population

The FY 1995 Medicaid program budget does not reflect the 1902(r)(2) expansion population and associated costs. The State anticipates that in FY 1996, under a 1902(r)(2) expansion, approximately 114,912 children under 200 percent FPL would become Medicaid eligible. The number of children who would gain coverage under this allowable eligibility expansion is based on the 1993 Current Population Survey (CPS) data file (which reflects 1992 data) released by the U.S. Census Bureau. Because the age classifications for children on the State's earlier analysis of the Current Population Survey (under 19 years of age) did not correspond to the 1902(r)(2) eligibility category of children in Missouri (under 21 years of age), an adjustment was made to the CPS data. In addition to an adjustment for age classifications, it was necessary to adjust the CPS data for the 1902(r)(2) population from the base year (1992) to the first year of the waiver (FFY 1996) and throughout the waiver years. The population under 200 percent FPL is expected to grow at the same rate as the overall population in Missouri compounded by the growth rate in the uninsured. See Appendix 5.B for the calculation of this population group.

Once the number of newly eligible children was estimated, the cost of providing services to this population was projected. The State had completed extensive analysis of the per member per month (PMPM) fee-for-service (FFS) cost of providing services to different eligibility groups during its evaluation of the Waiver. These FFS PMPM cost estimates were used as the basis for estimating the 1902(r)(2) service related costs. Because a PMPM unit of cost was used, it was also necessary to estimate the number of member months for the 1902(r)(2) expansion population. Using the number of new eligibles mentioned above, 114,912 children, in combination with the current average length of eligibility of children in the State's Medicaid for Children (MFC) program, the total number of months of eligibility, or member months, was calculated. Exhibit 5.1 summarizes the calculation of these members.

Exhibit 5.1
Baseline Program 1902(r)(2) Expansion Population

	Waiver Year 1: FFY 1996	Waiver Year 2: FFY 1997	Waiver Year 3: FFY 1998	Waiver Year 4: FFY 1999	Waiver Year 5: FFY 2000
Total Number of Children < 200% FPL (1)	114,912	118,719	122,653	126,717	130,915
Expected Presentation Rate by End of Waiver Year	70%	80%	90%	90%	90%
Expected Enrollment by End of Year	80,438	94,975	110,387	114,045	117,824

(1) 1902(r)(2) population are children under age 19 without health insurance.

The MFC fee-for-service PMPM cost of the current program was calculated and used as the basis for estimating the cost of the 1902(r)(2) population because of the similarity between the expanded and existing eligibility groups. To determine the PMPM costs throughout the waiver years, inflation factors were applied to base year payments. It was assumed that between the base year (SFY 1994) and FFY 1996 that costs would increase at the same rate that the average program costs have increased between SFY 1993 and SFY 1994, or 7.3 percent per year. The waiver year FFY 1996 PMPM cost was then inflated throughout the waiver years using the Medical Consumer Price Index of 5.6 percent per year. Exhibit 5.2 presents a summary of the total cost estimates.

Exhibit 5.2 Total Baseline Program Costs

	Waiver Year 1: FFY 1996	Waiver Year 2: FFY 1997	Waiver Year 3: FFY 1998	Waiver Year 4: FFY 1999	Waiver Year 5: FFY 2000	Totals Across Waiver Years
Existing Program Baseline Costs Excluding Disproportionate Share Payments	\$2,179,955,882	\$2,418,785,247	\$2,684,789,104	\$2,981,084,503	\$3,311,146,700	\$13,575,761,436
Total Disproportionate Share Payments	\$620,568,422	\$620,568,422	\$620,568,422	\$620,568,422	\$620,568,422	\$3,102,842,110
Expanded Program Costs, Children < 200% FPL, allowable under 1902(r)(2), (1),(2)	\$24,519,546	\$53,662,400	\$67,514,062	\$79,004,246	\$87,874,822	\$312,575,076
Administrative Costs	\$22,672,932	\$23,871,702	\$25,125,801	\$25,881,359	\$26,660,169	\$124,211,963
Total Program Costs	\$2,847,716,782	\$3,116,887,771	\$3,397,997,389	\$3,706,538,530	\$4,046,250,113	\$17,115,390,585

(1) Disproportionate Share monies included.

(2) Expanded program without waiver is expected to enroll without geographic phase-in but includes expected presentation rates. For calculation see Expanded Caseload Appendix, Exhibit 7.

COST OF SERVICES

The Waiver demonstration program will affect the:

Current Medicaid Program. This includes all services and eligibility groups that are currently covered under the Medicaid program projected over the waiver years, FFY 1996 - FFY 2000; plus

Uninsured Population. The Waiver is intended to offer access to all uninsured Missourians. The initial target group includes adults and children who have been uninsured at least six months and whose income is under 200 percent FPL. This expanded population will be eligible for the standard benefit package previously defined. However, adults in this group will not be eligible for the extended Medicaid wrap-around services not included under capitation (see Chapter 2).

As with the estimation process for the baseline program, the methodology for estimating the cost of the Waiver relied on numerous assumptions and data sources. Therefore, to clearly present this information the remainder of this section is divided into the following seven subsections:

- A. Current Medicaid Program Caseload
- B. Expanded Caseload
- C. Pilot Program for the Disabled
- D. PMPM Cost of Current Medicaid Caseload
- E. PMPM Cost of Expanded Medicaid Caseload
- F. Cost Sharing for the Expanded Caseload
- G. Enrollment Caps

Current Medicaid Program Caseload

The average monthly number of eligibles for SFY 1994 was used as the starting point for the estimate of the current Medicaid program caseload. The SFY 1994 data consists of six months of actual data and six months of projected data. A combination of historical and projected growth factors was used to inflate this caseload from SFY 1994 to the first year of the waiver, FFY 1996, and then throughout the waiver years (see Appendix 5.A).

Because of the comprehensive nature of the Waiver coverage, the demonstration project will affect the historical average length of stay for Medicaid eligibles. Currently, a portion of the Medicaid population becomes eligible and ineligible for Medicaid during the year because of the existing eligibility criteria. Yet, because the Waiver substantially raises the eligibility criteria, it is likely that more of this base population will remain eligible throughout the year without gaps in eligibility. Therefore, it was estimated that the length of eligibility for this population would rise to a point approximately halfway between existing lengths of eligibility and 12 months (the maximum annual length of eligibility). While there will always be some fluctuation in eligibility, a conservative approach was used so that the number of member months for this population under the Waiver would not be understated. With the increase in the income level to 200 percent FPL, the length of eligibility is expected to increase significantly. Exhibit 5.3 summarizes the total number of eligibles and member months represented by the current Medicaid population. Appendix 5.A provides a complete, detailed description of the estimation process for the existing caseload.

Exhibit 5.3
Total Existing Medicaid Eligibles and Member Months

	Waiver Year 1: FFY 1996	Waiver Year 2: FFY 1997	Waiver Year 3: FFY 1998	Waiver Year 4: FFY 1999	Waiver Year 5: FFY 2000
Existing Medicaid Population	446,787	468,756	492,454	518,051	545,738
Existing Medicaid Population Member Months (1)	6,196,372	6,494,128	6,815,031	7,161,364	7,535,653

(1) Elderly and Disabled populations are excluded.

The Waiver will not be implemented statewide in the program's first year. Instead, a geographic phase-in strategy will be employed that recognizes the state of provider network readiness in different regions. Phase-in of eligibility groups will occur over the first two years of the waiver, resulting in 57.9 percent of the target population eligible for the Waiver in the first year of the waiver and 100 percent by the end of the second year of the waiver. All eligibles that reside outside the Waiver geographic service areas during the phase-in of the managed care network will continue to be covered in the existing fee-for-service program. The accompanying map and supporting data (Appendix 5.E) indicates what areas will be converted in each of the program's first two years. Existing Medicaid eligibles, as well as new Waiver enrollees, will be converted to the new program simultaneously according to this plan. If network development occurs faster than anticipated, the geographic phase-in will be accelerated.

The calculated number of member months calculated above presupposes that all eligibles are enrolled in the Waiver for an expanded length of time. However, since participation in the Waiver is voluntary, estimates must be made about the presentation rate for the program. The existing population in those geographic areas phased-in during FY 1996 will all be enrolled by the implementation date of the program, because in the months immediately proceeding the implementation of the Waiver, current Medicaid recipients would choose or be assigned to one of the available health plans. This prior enrollment applies only to the existing population. As discussed below, the experience of Oregon was used as the basis for estimating the show rate of the expanded population.

Expanded Caseload

To determine the estimated caseload, or member months, for the expanded Medicaid caseload population, it was necessary to project the number of new eligibles and their length of eligibility under the Waiver. The first step was to determine the targeted uninsured population under 200 percent FPL. As with the 1902(r)(2) expansion, this information was extracted from the CPS data. The calendar 1992 base year uninsured population under 200 percent FPL was categorized into the following three population groups:

Children under 200% FPL	113,256
Adults under 100% FPL	95,819
Adults between 100-200% FPL	122,020

Besides income eligibility criteria, Waiver applicants also must have been medically uninsured for six months prior to enrollment.

The expanded population has been divided into these three groups to reflect not only differences in age (adults versus children) but to reflect the planned phase-in of new populations under the Waiver. All children under 200 percent FPL and adults under 100 percent FPL will be eligible for the Waiver the first year of the program. Adults between 100 percent and 200 percent FPL will become eligible in the second year of the program.

Under the Waiver, geographic phase-in of expanded eligibility groups will occur over the first two years of the waiver, resulting in 57.9 percent of the target population being eligible in the first year of the waiver, and 100 percent of expected members eligible by the end of the second year of the waiver. Only those uninsured Missourians residing in Waiver geographic service areas will be eligible to enroll in the Waiver program.

The next step in the expanded caseload calculation was the conversion of the number of eligibles to the number of member months. The new population is likely to have eligibility experience similar to that of the existing Medicaid population prior to the implementation of the Waiver. Therefore, using HCFA 2082 data, it was determined that under the existing eligibility criteria, 56.8 percent of the non-aged, non-disabled population are eligible for 12 months and that the remaining non-aged, non-disabled population has an average length of eligibility of 7.4 months. These percentages were used to calculate the number of member months of the expanded population. (This calculation was done separately for adults and children).

Missouri used enrollment data from the Oregon waiver to estimate the expected maximum enrollment of the expanded population of uninsured across the waiver years. The State of Oregon, in its waiver, assumed after the first year that 70 percent of the expanded population would be enrolled and that after the second year 90 percent of the expanded population would be enrolled. The Waiver enrollment, however, will be affected by premium cost sharing for the uninsured populations between 100-200 percent FPL, which will tend to reduce the rate at which people enroll in the Missouri waiver program. Because only those children at or above 100 percent FPL are affected by premium cost sharing, presentation rates are weighted by the number of eligibles above and below 100 percent FPL. Premium cost sharing is expected to result in 60 percent of children under 200 percent FPL to enroll at the end of first year, FFY 1996; 70 percent at the end of the second waiver year; and 80 percent in all remaining waiver years.

The population of uninsured adults between 100-200 percent FPL enrolled in FFY 1997 will also be affected by premium cost sharing. Consequently, enrollment rates should be significantly lower than the other waiver groups that are either partially impacted (i.e., children under 200 percent FPL)

or unaffected (i.e., adults under 100 percent FPL) by premium cost sharing. The show rate for this uninsured group is projected to be 50 percent after the first year; 60 percent after the second year; and 70 percent for FFY 1999 and FFY 2000. For the adult population under 100 percent FPL that begins enrollment in FFY 1996, projections for this expanded population suggest that 70 percent would enroll by the end of the first year; 80 percent by the end of the second year; and 90 percent for the three remaining waiver years.

These data and estimates are useful to project the maximum enrollment of the expanded population in any given year, but they do not address the rate at which enrollment is likely to occur. Based on the actual enrollment rate experienced in Oregon, approximately 29 percent of the expanded population expected to enroll by the end of the year would be enrolled within the first three months of the year. Therefore, instead of a linear enrollment experience over the waiver years, a curvilinear projection is used.

The estimates of caseload are trended forward across the waiver years using the projected annual growth in the Missouri population between 1990 and 2000, and the national annual growth of the uninsured population between 1990 and 1992. (The Missouri-specific annual growth rate in the uninsured population was not used due to possible data reliability problems between 1990 and 1992.)

Exhibits 5.4 and 5.5 present the total number of eligible and member months estimated under the Waiver program, first in table format and then graphically across the waiver years. Exhibit 5.6 compares the number of eligibles under the baseline Medicaid program (including the 1902(r)(2) children) with the Waiver program eligibles. Appendix 5.B presents the step-by-step technical process used to estimate the expanded caseload.

Exhibit 5.4 Expanded Population

NUMBER OF ELIGIBLES

	Waiver Year 1: FFY 1996	Waiver Year 2: FFY 1997	Waiver Year 3: FFY 1998	Waiver Year 4: FFY 1999	Waiver Year 5: FFY 2000
Children Under 21 years of age Under 200%FPL	45,611	91,970	108,677	112,278	115,999
Uninsured Adults Under 100% FPL	45,355	89,493	100,000	100,000	100,000
Uninsured Adults Between 100% to 200% FPL	0 (1)	71,227	88,304	100,000	100,000
Total Expanded Waiver	90,967	252,689	296,981	312,278	315,999

NUMBER OF MEMBER MONTHS

	Waiver Year 1: FFY 1996	Waiver Year 2: FFY 1997	Waiver Year 3: FFY 1998	Waiver Year 4: FFY 1999	Waiver Year 5: FFY 2000
Children Under 21 years of age Under 200% FPL	295,068	847,237	1,187,245	1,226,582	1,267,224
Uninsured Adults Under 100% FPL	293,413	829,796	1,051,828	1,051,828	1,051,828
Uninsured Adults Between 100% to 200% FPL	0 (1)	460,778	928,807	1,051,828	1,051,828
Total Expanded Waiver	588,480	2,137,812	3,167,879	3,330,238	3,370,879

(1) Phase-in of coverage for Adults between 100-200% FPL occurs in Year 2: FFY 1997 of the Waiver. Population enters program at the same presentation rate as the other populations that entered program in Year 1 of the waiver.

Exhibit 5.5

**Expanded Caseload
Enrollment of Uninsured into the Waiver Program**

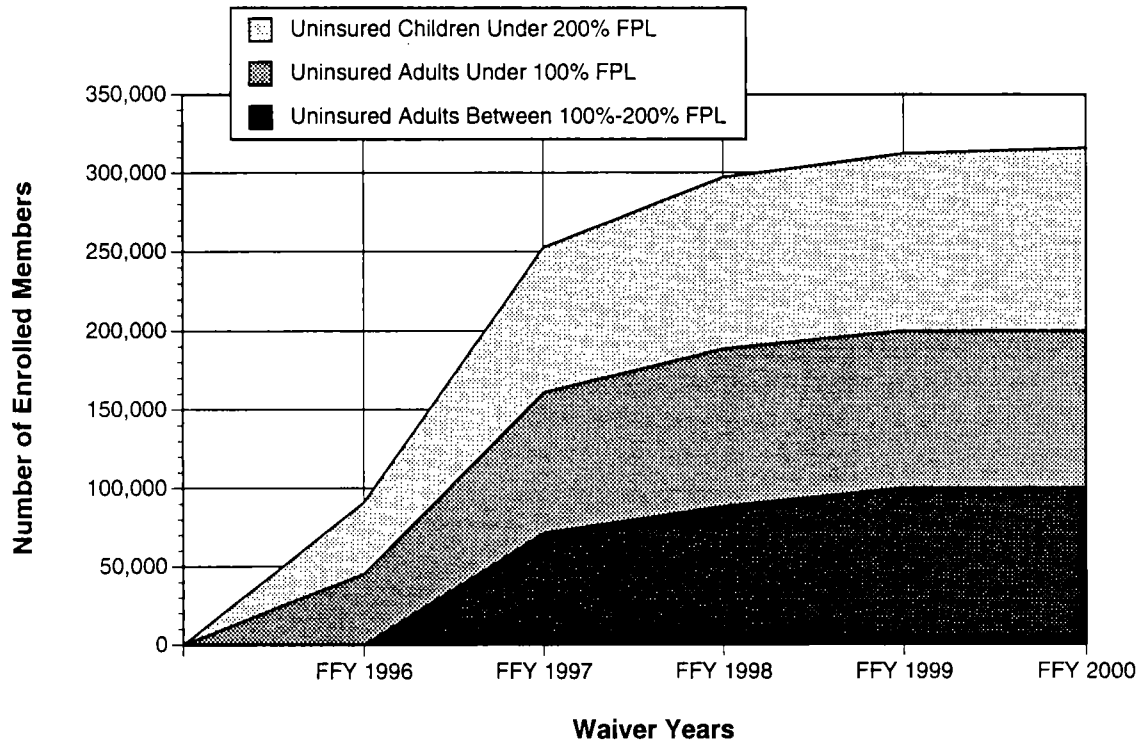
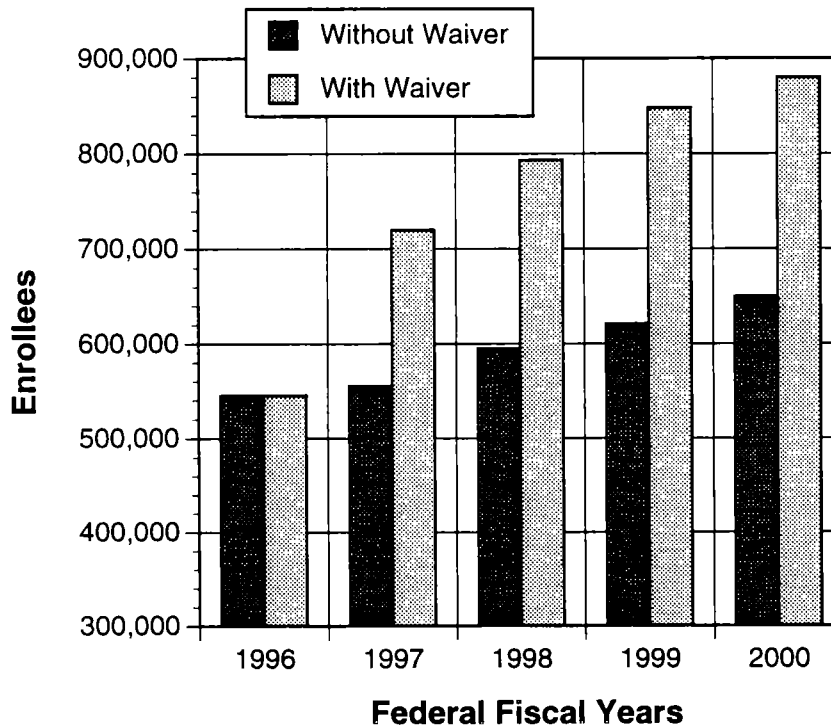


Exhibit 5.6

**Expanded Program
Number of Waiver Enrollees Vs. Baseline Program**



Pilot Program for the Disabled

The pilot program for the disabled (described in Chapter 2) will test the effects of placing the Waiver range of Medicaid covered services to this population into a capitated payment system. In addition to the incentives represented by prepaid reimbursement, the proposed service delivery model employs psychiatrists as care coordinators to further enhance efficiency. The pilot program will be available on a voluntary basis to the Medicaid disabled population in a ten county area. The costs and caseload projections for this pilot project are detailed in Appendix 5.C.

PMPM Cost of Current Medicaid Caseload

It must be stressed that actual PMPM rates paid by the Waiver will be determined by a competitive bidding process. However, to estimate the financial impact of the Waiver it was necessary to draw upon available data. Using program expenditure data specific to seven eligibility categories (Aged - Pharmacy only, AFDC, Disabled-Pharmacy only, Medicaid Pregnant Women, Medicaid for Children, Other FFP and Other State) for SFYs 1990 - 1994, historical PMPM costs were calculated. (PMPM cost estimates remain specific to eligibility groups throughout the waiver cost estimates.) This multi-year PMPM cost database was then used to evaluate the stability and quality of the cost data and resulting historical growth trends. Adjustments were made to account for annual cost variations caused by factors other than caseload, utilization and pricing variables. Adjustments were also made to reflect manual payments and recoupments not captured by the paid claims subsystem.

The SFY 1994 PMPM costs were used as the base year for the PMPM cost estimates. These base year costs were then inflated to the first year of the waiver by applying the average increase in payments between FFY 1993 and SFY 1994. The cost in the first year of the waiver were then trended from FFY 1996 throughout the remainder of the waiver years using the Medical Consumer Price Index. Exhibit 5.7 presents the PMPM costs, by eligibility group, for each year of the waiver.

Exhibit 5.7
Average Per Member Per Month Cost Estimates (1,2,3)

	Waiver Year 1: FFY 1996	Waiver Year 2: FFY 1997	Waiver Year 3: FFY 1998	Waiver Year 4: FFY 1999	Waiver Year 5: FFY 2000
Aged (Pharmacy Only)	\$136.27	\$144.03	\$152.24	\$160.92	\$170.09
AFDC	\$142.00	\$149.32	\$157.05	\$165.22	\$173.86
Disabled (Pharmacy Only)	\$117.63	\$124.34	\$131.42	\$138.92	\$146.83
Pregnant Women	647.51	\$679.29	\$712.88	\$748.39	\$785.93
Children	\$64.53	\$67.86	\$71.38	\$75.10	\$79.03
Other FFP	\$457.24	\$480.12	\$504.30	\$529.87	\$556.89
Other State	\$351.93	\$370.01	\$389.11	\$409.31	\$430.65
TOTALS (4)	\$150.82	\$158.53	\$166.67	\$175.29	\$184.39

(1) Includes \$1 PMPM transportation cost add-on (excluding Aged and Disabled).

(2) It was assumed that between the base year (SFY 1994) and the first year of the waiver (FFY 1996) that the PMPM costs would increase at the same rate as the average program costs have increased between SFY 1993 and SFY 1994:8.5%

(3) After the first year of the program it was assumed that PMPM costs would increase at the same rate as the Medical Consumer Price Index (CPI) for the five years of the waiver:5.7%(4)Totals exclude pharmacy only costs for the Aged and Disabled population categories.

These PMPM costs are the equivalent of FFS program expenditures, not anticipated managed care costs. To show the anticipated effect of the managed delivery system and capitated payment structure, a 5 percent reduction factor in year 1 and an additional 2.5 percent adjustment factor in year 2 will be applied to these PMPM costs. This is because managed care efficiencies and behavioral changes are anticipated to occur over a two year period. Also, ongoing cost increases are expected to be 2.8 percent lower than the present FFS system.

In the final section of this chapter represents the expected managed care savings under the Waiver. Appendices 5.C and 5.D contain the technical detail supporting these estimates.

Under the Waiver, DSH payments will be replaced by Special Payments for Essential Services (SPES). The SPES program in aggregate will be much smaller than comparable DSH payments under Medicaid without the waiver, as the previously uninsured enroll in the Waiver. In FFY 96, the SPES program is estimated to be \$485 million. Payments under the SPES program will continue for eligibles not enrolled in the Waiver and for the Medicaid not affected by the waiver. These and other components of the SPES program will be further reduced as more of the expanded population enroll in the Waiver.

PMPM Cost of Expanded Medicaid Caseload

The PMPM costs calculated for the existing Medicaid caseload were also used as the basis for estimating the PMPM costs of the expanded caseload. Costs for the expanded caseload consisting of children under 200 percent FPL were estimated based on the PMPM costs calculated for the Medicaid for Children eligibility group. The cost of the adult portion of the expanded population was estimated based on the AFDC PMPM cost. However, two additional adjustments were applied to these costs before they were used in conjunction with the expanded population.

The first adjustment was made to reflect the State's expectation that those in need of health care will have a greater show rate in the Waiver program. Therefore, PMPM costs were adjusted to reflect the increased risk stemming from adverse selection. The reasons for this are two-fold. First, the group's status as medically uninsured likely means the prevalence of pre-existing medical conditions precluding other insurance coverage is higher. Second, because participation is voluntary, those who are in greatest need are likely to sign up. To recognize this adverse selection, an adjustment to PMPM projections of 20.4 percent was made to children between 100-200 percent FPL and 10.8 percent to adults between 100-200 percent FPL. These adjustments were based on HCFA 2082 data for the State of Missouri. The cost per eligible was compared with the cost per recipient. The PMPM cost was then adjusted by the percentage difference between the cost per eligible and the cost per recipient. The percentage difference, however, was first adjusted downward by 5 percent (based on actuarial input) to reflect the potential better overall health status of the expanded population due to their higher socio-economic status.

The second adjustment was made to reflect differences in the potential collection of third party liability. The PMPM costs for the existing population reflects third party liability (TPL) collections from other insurance coverage (excluding Medicare). As a prerequisite for being included in the expanded caseload, an individual must not have any other insurance coverage. Therefore, the PMPM costs calculated for the existing population have been adjusted upward by a TPL factor to avoid any understatement of costs for this new population.

Projected PMPM costs for the expanded population are then adjusted for anticipated managed care savings (see previous section) and the resulting estimates are shown in Exhibit 5.8. These adjustments are presented in greater detail in Appendix 5.C.

Exhibit 5.8 Waiver Expanded Population per Member per Month Costs

	Waiver Year 1: FFY 1996	Waiver Year 2: FFY 1997	Waiver Year 3: FFY 1998	Waiver Year 4: FFY 1999	Waiver Year 5: FFY 2000
Children (under 21), < 200% FPL (1)	\$67.29	\$68.90	\$72.47	\$76.25	\$80.24
Uninsured Adults, < 100% FPL	\$134.90	\$138.12	\$145.27	\$152.83	\$160.82
Uninsured Adults, 100-200% FPL (1)	\$149.56	\$153.12	\$161.05	\$169.43	\$178.29

(1) Values reflect managed care savings and are adjusted for adverse risk selection for populations between 100-200% FPL.

Cost Sharing for the Expanded Caseload

Those individuals and families newly eligible for the Waiver (who would not otherwise be eligible under current Medicaid rules) will be asked to pay a portion of the cost of their health care coverage. Only those over 100 percent of the federal poverty level who choose to participate will pay a premium. The amount of this premium will be determined by using a sliding scale based upon the cost of coverage and family income. The estimated amount of cost sharing is shown in Appendix 5.D. These amounts, as with the PMPM costs, are estimates only and are subject to change based upon results of the bidding process.

Below 200 percent of poverty, the Waiver enrollees will pay, at the most, only three-fourths of the actual cost of their coverage. This sliding scale applies to both children (based on their family's income) and adults. Because the cost to cover children is expected to be substantially less than for adults, the cost sharing burden for children will also be less.

It will be the State's responsibility to collect cost sharing premiums. Funds collected from the Waiver expanded population via cost sharing are included in the Waiver budget as state match. Uninsured individuals whose income is at or above 200 percent of poverty will be permitted to "buy in" to the Waiver at the full cost of their premium. These funds will be used as an offset to the cost of coverage, so that there is no net effect (either state or federal) to the Waiver budget. The cost of collection is included in the premium.

Enrollment Caps for the Expanded Caseload

In order to assure fiscal predictability and integrity, enrollment caps will be applied to two subgroups in the Waiver expanded population. These caps are shown below:

Group	FFY 96	FFY 97	FFY 98 and beyond
Children	N/A	N/A	N/A
Adults < 100% FPL	50,000	100,000	100,000
Adults 100% - 200% FPL	N/A	75,000	100,000

These are estimated caps for planning purposes only, and may be adjusted over the life of the demonstration project to maximize coverage while still maintaining budgetary integrity at both the state and federal levels.

ADMINISTRATIVE COSTS: BASELINE VS. THE WAIVER

There are three components of waiver administrative costs: general Administration costs for: program management and eligibility determination; operation of the Medicaid Management Information System (MMIS); and Health Benefit Manager (HBM) costs for eligibility and enrollment activities required by the expanded population. A table showing the baseline and the Waiver administrative costs is located in Appendix 5.D.

ADMINISTRATION

Administration costs include the Personal Service and Expense/Equipment costs for the Division of Medical Services staff and the portion of Division of Family Services staff responsible for Medicaid eligibility determination. There is no difference in the Waiver and the baseline costs, since the baseline scenario still assumes gradual conversion to managed care under 1915(b) provisions. Planned staff changes are detailed in Chapter 3. An inflation increase of 2.5 percent per year was used for both scenarios.

MMIS

The MMIS is currently Medicaid's primary data processing resource. The role of the MMIS will change from that of a claims payment system to an information processor for oversight, monitoring and decision support as managed care is implemented. It is estimated that enhancements will be required to convert the MMIS to address the needs of managed care. These are projected to cost \$1 million and would be incurred with or without the Waiver, because they will be necessary to support 1915(b) expansion of managed care to St. Louis. Additionally, even without the waiver Missouri plans to implement a managed care program in St. Louis under 1915(b) provisions. Apart from this enhancement, base MMIS costs are expected to experience no growth over the five years of the waiver.

HBM

This expense refers to the costs of eligibility determination for the Waiver expanded population, and enrollments costs for both the Waiver expanded population and the current Medicaid population. Costs were based on current Missouri Department of Family Services eligibility/enrollment experience, and the average cost of processing an application for the Medicaid for Children category of eligibility. Baseline administrative costs also include the eligibility costs of the anticipated 1902(r)(2) expansion population.

COST SUMMARY

The effects of the Waiver program must be measured in terms of its impact on both public outlays (public expenditures by both the Federal government and the State of Missouri) and on the eligibles who will bear some of the costs associated with the program. Exhibit 5.9 summarizes the cost of the Waiver relative to the existing Missouri Medicaid program.

The overall trend in the financial impact tables is that of significant savings in the first two years of the waiver, with suppressed growth (as compared to the existing Medicaid program) throughout the waiver period. The reasons for the relatively large cost savings in the first two years of the Waiver implementation is a result of the following:

- Managed care will produce greater efficiencies and lower inappropriate utilization, resulting in one time savings in the Medicaid current population.

- Conversion of the current DSH program to explicit health care coverage, allowing the expanded population greater access to primary care instead of expensive treatment in later stages of the illness process.
- Greater efficiencies due to the conversion of the pharmacy benefit for the elderly and disabled to a statewide managed network.

The 1902(r)(2) population expansion included in the baseline scenario occurs with no geographic phase-in. Geographic phase-in of children under 200 percent FPL is used for the Waiver. Therefore, the expanded children's caseload is initially higher without the waiver.

In the remaining three years of the waiver, increases in the Waiver costs are anticipated. These trends are driven by caseload increases resulting from the geographic phase-in, coverage of new sub-groups in the expanded population, and increasing presentation rates under the waiver. As enrollment caps are triggered, these program cost increases are anticipated to slow. Both per capita cost increases and overall program expenditures are, nonetheless, expected to be significantly lower than without the Waiver.

Exhibit 5.9 Cost of the Waiver Compared to the Existing Baseline Medicaid Program

Total Baseline Medicaid Program Costs

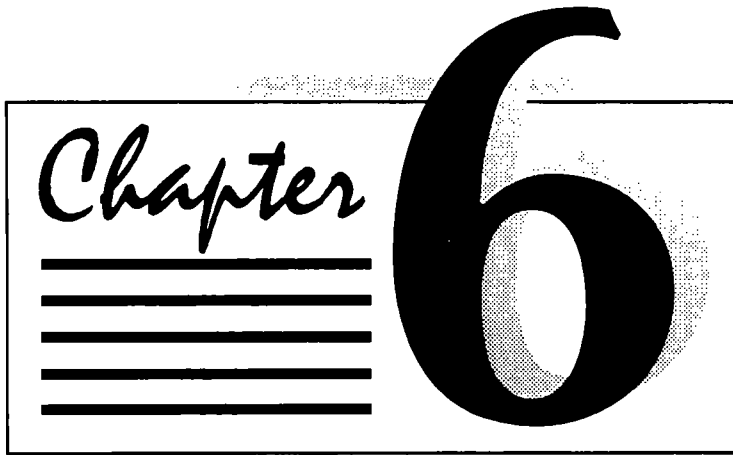
	Waiver Year 1: FFY 1996	Waiver Year 2: FFY 1997	Waiver Year 3: FFY 1998	Waiver Year 4: FFY 1999	Waiver Year 5: FFY 2000	Totals Across Waiver Years
Total Program Costs	\$2,847,716,782	\$3,116,887,771	\$3,397,997,389	\$3,706,538,530	\$4,046,250,113	\$17,115,390,585
Federal Obligation	\$1,693,970,980	\$1,855,100,548	\$2,023,518,328	\$2,208,425,754	\$2,412,076,073	\$10,193,091,683

Total Medicaid Program Costs under the Waiver

	Waiver Year 1: FFY 1996	Waiver Year 2: FFY 1997	Waiver Year 3: FFY 1998	Waiver Year 4: FFY 1999	Waiver Year 5: FFY 2000	Totals Across Waiver Years
Total Program Costs	\$2,702,685,803	\$2,994,633,435	\$3,340,453,018	\$3,610,975,780	\$3,885,979,525	\$16,534,727,562
Federal Obligation	\$1,622,349,106	\$1,798,485,668	\$2,006,360,337	\$2,169,021,730	\$2,334,390,341	\$9,930,607,182

Financial Impact of Waiver Program

	Waiver Year 1: FFY 1996	Waiver Year 2: FFY 1997	Waiver Year 3: FFY 1998	Waiver Year 4: FFY 1999	Waiver Year 5: FFY 2000	Totals Across Waiver Years
Total Program Savings	\$145,030,979	\$122,254,336	\$57,544,371	\$95,562,750	\$160,270,588	\$580,663,023
Federal FFP Savings	\$71,621,874	\$56,614,880	\$17,157,991	\$39,404,024	\$77,685,733	\$262,484,502



WAIVERS REQUESTED

In order for the State of Missouri to implement the Waiver, it requests the following waivers of statutory and regulatory requirements.

Eligibility

Section 1902(a)(10)(A) of the Social Security Act (the "Act") require States to provide medical assistance to certain categories of Medicaid recipients in addition to those either receiving or deemed to be receiving medical assistance on the basis of certain welfare categories under the Social Security Act. That section also allows States to extend coverage to optional categories of individuals. The State of Missouri requests a waiver of Section 1902(a)(10)(A) and the implementing regulations at 42 C.F.R. Part 435 in order to extend coverage under the Waiver to uninsured individuals in the State regardless of whether they satisfy the optional or mandatory categories for Medicaid eligibility.

Amount, Duration, and Scope of Services

Section 1902(a)(10)(B) of the Act and 42 C.F.R. § 440.230-250 require that the amount, duration, and scope of services be equally available to all recipients within an eligibility category, and also be equally available to categorically eligible recipients and medically needy recipients. Missouri's demonstration project will provide a basic managed health care benefits package to all categorical Medicaid recipients and the uninsured population at or below 200 percent of the federal poverty level. Missouri will continue to use a fee-for-service approach for non-enrolled individuals, including dual eligibles, individuals in long term care facilities (ICF/MRs, IMDs, and nursing facilities), and all individuals with disabilities who do not participate in the pilot project for the permanently and totally disabled. Benefits will be administered differently for project participation in the managed care groups, as opposed to recipients in the fee-for-service program. In order to account for any differences in amount, duration, or scope of services for recipients who will be enrolled in managed care as opposed to the fee-for-service plan, Missouri requests that these provisions be waived.

Uniformity

Section 1902(a)(1) of the Act and 42 C.F.R. § 431.50 require that the state Medicaid plan be in effect for all services and all eligible recipients in all political subdivisions of the State. The type of managed care plans available under the demonstration may vary by geographical area of the State. Moreover, there will no longer be uniformity in benefits, because the fee-for-service population (e.g., those in long term care facilities) may receive benefits in a different manner than the demonstration project participants.

Income Limitations

Sections 1902(1) and 1903(f) of the Act, and 42 C.F.R. § 435.100 et. seq., prohibit payments under Medicaid to States that implement eligibility standards in excess of the maximums allowed by regulations. Missouri requests a waiver to expand eligibility for managed care coverage to individuals with incomes at or below 200 percent of the federal poverty level. The expanded eligibility will not result in cost increases, because of the offsetting savings from other aspects of the demonstration. No request is made to waive income limitations for individuals who are eligible due to a determination of categorical eligibility.

Eligibility Standards

Section 1902(a)(17) of the Act and 42 C.F.R. Subparts G and H require the State to take into account income or resources of individuals who are not receiving assistance under Aid to Families with Dependent Children ("AFDC") who might otherwise become eligible for assistance under AFDC. In Missouri, persons who are ineligible for AFDC cash payments will be eligible for the managed care demonstration if their income is at or below 200 percent of the federal poverty level. They will be subject to asset limits of \$100,000, excluding a homestead. The State seeks to waive the standards for taking into account any other assets of the waiver eligible population. No request is made to waive income limitations for individuals who are eligible due to a determination of categorical eligibility.

Freedom of Choice

Section 1902(a)(23) of the Act and 42 C.F.R. § 431.51 require a state plan to pay for medical assistance from any institution, agency, community pharmacy, or person qualified to perform the delivery of services. The demonstration will allow participants to choose among available plans and practitioners every year, but will restrict each participant to a single health plan or practitioner that will render or arrange for all or most care for the one-year period, except that a participant may change plans for cause. To the extent this is seen as a limitation on freedom of choice, a waiver is appropriate and necessary.

Capitation Contract Requirements

Section 1903(m)(1)(A), (2)(A), and (2)(C) of the Act, and 42 C.F.R. § 434, prohibit payments to States that contract for comprehensive services on a prepaid or other risk basis unless such contracts are with entities that: (a) meet federal Health Maintenance Organization "HMO" requirements or state HMO requirements; (b) maintain an enrollment composition of no more than 75 percent Medicare and Medicaid enrollees (except in cases of public HMOs, and federally qualified community health centers who received grants exceeding \$100,000 during the preceding two years); (c) allow Medicaid members to disenroll at will on a monthly basis; and (d) have received prior approval from HCFA before the effective date of the contract. The State requests a waiver of §§ 1903(m)(1)(A) and (2)(A)(i) (42 C.F.R. §§ 434.20 and 434.21) because the demonstration provides for contracts with fully capitated health plans that include organizations that may not be state or federally qualified HMOs or federally qualified community health centers (exempt under § 1903(m)(1)(A) and (2)(B)).

The State requests a waiver of § 1903(m)(2)(A)(ii) (42 C.F.R. § 434.20, 21, and 26) in order to allow contracts with plans that are not federally qualified HMOs and federally qualified community health centers (not exempt under § 1903(m)(2)(G)) to operate without being restricted by the 75 percent enrollment composition rule. The State also requests a waiver of § 1903(m)(2)(A)(v) (42 C.F.R. § 434.27) in order to lock in participants for an initial period of six months. The lock-in would apply to all service areas without regard to whether alternative plans are available in the same service area. Participants will be allowed to change their selection of their health plan every year after enrollment. The State also requests a waiver of § 1903(m)(2)(A)(iii) (42 C.F.R. § 434.71) in order to permit coverage of individuals not meeting Medicaid eligibility requirements and to permit the state to establish capitation rates in the manner specified in this application. A waiver is also requested of 42 C.F.R. §§ 434.6, 14, 23, 25, 40, 53, 59, 65, 70, 71 and 72 to the extent that these provisions contain detailed requirements that may be construed as inconsistent with the intent of the demonstration.

Erroneous Payments

Section 1903(u) of the Act permits HCFA to withhold federal financial participation for a State's erroneous excess payments for medical assistance. Specifically, the Secretary may reduce FFP where erroneous payments exceed three percent of total medical assistance expenditures. Missouri requests a waiver of this requirement to the extent that benefits provided under the Waiver to the uninsured who would not otherwise be eligible for Medicaid could be deemed to constitute erroneous payments.

Payment for Drugs

Sections 1902(a)(54) and 1927 of the Act set forth a detailed program for manufacturer rebates and limitations on coverage of drugs under Medicaid. The goal of the section is to reduce costs and limit overutilization of prescription drugs authorized under Medicaid. The Waiver will reduce costs even further by allowing health plans to manage costs through establishment of their own formularies and by limiting the authorized formulary based on cost, therapeutic equivalent, and clinical efficacy. Missouri therefore requests a waiver of Section 1927 (and any implementing regulations) in order to establish more stringent controls.

In addition, Missouri requests a waiver that will allow it to control costs by exempting drug sales to the Waiver health plans from the best price calculation.

Upper Payment Limits for Capitation Contract Requirements

42 C.F.R. § 447.361 prohibits payment on a capitation basis to be made to a contractor where capitation payments exceed the costs of Medicaid "on a fee-for-service basis, to an actuarially equivalent non-enrolled population group." The State requests a waiver because there will be no "actuarially equivalent non-enrolled" group, in light of the fact that the waiver will extend to non-Medicaid populations.

There will be an overall cost limit on the waiver program; this is a technical waiver that will not impact on that limit.

Utilization and Quality of Care Review

Missouri requests a waiver from Sections 1903(g), 1903(i), 1902(a)(26), (30), (31) of the Act, and related regulations, to account for any minor technical differences that may exist between the Waiver's stringent utilization and quality of care review procedures and the federal requirements. The State specifically requests a waiver of medical necessity reviews for those Medicaid recipients enrolled in the Waiver. In a managed care program such as the Waiver, the health plans assume the responsibility for confining services to what is medically necessary, and the capitation payment approach gives them substantial incentive to confine care to what is medically necessary. State review would be redundant, intrusive, and unnecessary. There are other safeguards in the program to insure that the health plans provide care that is medically necessary; the requested waiver would not impact those safeguards. No waiver of quality of care requirements is sought.

Institutions for Mental Diseases

Sections 1902(a)(10), 1905(a)(1), 1905(a)(14), 1905(a)(16), 1905(h), and 1905(i) of the Act, and implementing regulations, limit coverage for inpatient psychiatric care to individuals ages 21 and under, or 65 and over. Missouri seeks a waiver of these requirements in order to enable it to provide a full range of appropriate services to non-elderly adults requiring inpatient psychiatric care and alcohol and other drug treatment. Missouri requests a waiver of these sections to the extent necessary to provide inpatient psychiatric and substance abuse treatment for the Waiver members between 22 and 64.

Disproportionate Share Hospital Payments

Section 1902(a)(13) of the Act and implementing regulations provide for payment to hospitals that takes into account the situation of hospitals that serve a disproportionate number of low income patients. Under the Waiver, the State will no longer pay hospitals directly for the population covered by the Waiver capitation. Rather, hospitals will be paid by the health care plans. Missouri seeks a waiver of this section to enable the State to satisfy the obligation to disproportionate share hospitals through the capitation amount paid to the health plans in accordance with the terms of the waiver program.

Hospice Care

Sections 1902(a)(10), 1902(a)(13)(D), 1905(a)(18), and 1905(o) of the Act, and implementing regulations, allow States to cover hospice care under Medicaid. Section 1905(o) appears to call for a choice by Medicaid eligibles of either receiving hospice care or other care related to the condition giving rise to the diagnosis of a terminal illness. Under a capitated system, there is no reason to require a managed care organization to force this choice. There may well be circumstances in which some services pertaining to the terminal illness will be appropriate even for an individual in hospice care. Since all of the services will be covered by a single capitation, there is no cost impact in granting the waiver.

Citizenship Declaration

Section 1137(d), incorporated into the Medicaid program by section 1902(a)(46), requires that all applicants submit written declarations of their citizenship or alienage status, and that the state obtain documentation of the applicant's alien status and verify that documentation with the Immigration and Naturalization Service. Missouri seeks to rely upon written declarations of citizenship status, and to employ verification only when necessary. Since section 1137(d) appears to make documentation and verification mandatory for every alien, the State has requested a waiver to avoid strict compliance with these requirement. Missouri does intend to require verification in every case where there is reason to question the applicant's declaration of United States and Missouri citizenship or of legal alien status. Thus, relieving the State from the necessity of documentation and verification in every alien case should not pose any significant risk of unauthorized persons becoming part of the program.

Finally, the State requests that HCFA grant any other waiver that HCFA deems to be required in order to implement the demonstration as described in this document. For example, HCFA may deem that additional waiver authority is required to allow reimbursement for services to persons who would not otherwise be eligible for Medicaid (i.e., non-aged, non-disabled single adults, childless couples, and others who do not meet "categorical requirements"). Section 1115(a)(2) provides authority for the expanded eligibility by allowing for reimbursement of the costs of services to individuals who would not otherwise be eligible for Medicaid as expenditures under the State's Title XIX Plan.

The APPENDIX

II = A, DEVELOPMENT PROCESS

Development of this planning document was a complex task that required expertise from many disciplines. Many thousands of hours of hard work, productive meetings (internal & external) and negotiations took place to develop the final product. In an effort to be as inclusive as possible, numerous committees and sub committees were formed. Some of these committees focused on specific areas, while others were responsible for overall coordination and development of the waiver.

Each committee and group played a significant part in the waiver development process. Their input and continued focus created is this proposal that will greatly benefit the citizens of the state of Missouri. Although the waiver application has been submitted, their work doesn't stop now. Missouri will continue this inclusive process and utilize their valuable input and expertise throughout the implementation stages as well.

The members and responsibilities of each committee or group are outlined below.

- Exhibit 1 Organizational chart used for quick reference to committee structure.
- Exhibit 2 Executive Steering Committee - This committee was specially formed for the waiver and consists of cabinet level state officials who are continuously involved in the waiver process. They reviewed all materials and made the final recommendations to the Governor.
- Exhibit 3 Staff Working Group - This group consists of key internal state staff, external health policy professionals and consumer advocates familiar with the Medicaid program and health care in general. They played a crucial role in analysis of policy development and the development of recommendations.
- Exhibit 4 Technical Advisory Group - This group's technical advice and assistance in the process was essential for sound program development.
- Exhibit 5 Medical Advisory Committee (MAC) - This standing committee meets all state and federal regulations for such committees (State Statute at Section 208.195, RSMo.) The committee represents many different medical specialties in this process. Their role was to review and approve staff working group recommendations.

- Exhibits 6-20 Medical Advisory Committee (MAC), Sub Committees - These sub committees consist entirely of members of a single specialty whose professional expertise supports Medicaid policy decisions. They are a channel of communication between the provider community and the Medicaid program. Chairs of each sub committee are appointed to the MAC.
- Exhibit 21 Medicaid Consumer Advisory Group - Medicaid consumers from around the state reviewed the design of the waiver and made recommendations regarding how to make the program responsive to their needs. Many of their recommendations were incorporated into the waiver.
- Exhibit 22 Interest Groups - This group from across the entire state was made up of advocates, health care organizations, doctors, providers, insurers, hospitals, etc. Although they only met formally several times, there were considerable informal discussions, phone calls and meetings.
- Exhibit 23 Missouri Consumer Health Care Watch Committee - This recently formed group is a committee of advocates and consumers interested in the waiver process. This group reviewed all waiver documents and provided input and suggestions for change. Their extensive assistance, especially in the quality assurance and consumer protection areas, was instrumental in the development of the waiver.
- Exhibit 24 Providers and Organizations - This is a list of providers, advocates and the general public that met concerning the St. Louis managed care development.
- Exhibit 25 St. Louis Metropolitan Health Care Planning Committee - A new committee was established to guide the implementation of Medicaid managed care in the St. Louis metropolitan area. The committee consists of business and civic leaders, elected officials, executives of the St. Louis health care provider community and state officials. Advisory groups representing the various sectors of the health care community in St. Louis provided input and recommendations to the Executive Committee.
- Exhibit 26 Focus Groups - Numerous Medicaid consumers and uninsured working poor were interviewed in small group settings to assess the similarities and differences among them with regard to health care. Both groups placed health care at the top of their personal agenda for action. These groups provided insight into the needs and concerns of the uninsured and Medicaid recipients.

WAIVER RELATED MEETINGS

December '93	Senate Appropriations Committee
January 11	Senate Waiver Subcommittee
January 18	Waiver organizational meeting - ESC, SWG, TAG
January 19	St. Louis Metropolitan Health Care Planning Committee
January 24	Office of Administration - Budget & Planning
January 24	Department of Health Budget Office
January 26	Staff Working Group
February 1	HCFA Regional Office
February 3	Subcommittee of Staff Working Group
February 4	Delta Dental
February 9	Staff Working Group
February 16	St. Louis Metropolitan Health Care Planning Committee
February 17	Staff Working Group
February 18	Staff Working Group
February 18	Technical Advisory Group
February 21	SWG meeting with consultants
February 24	HCFA Regional Office
March 1	KBIA radio interview, St. Louis Business Journal Interview
March 2	Missouri Pharmacy Association
March 2	Department of Mental Health
March 2	Ambulatory Health Care Centers Advisory Committee
March 3	Missouri State Medical Association
March 7	Missouri Hospital Association, St. Louis Regional Health Center, Truman Medical Center, University of Missouri Hospital & Clinics
March 10	St. Louis Children's Hospital Physicians Grand Rounds
March 11	Northwest Agenda
March 14	Local Investment Commission (LINC)
March 16	St. Louis Metropolitan Health Care Planning Committee

March	18	Finance Subcommittee of Staff Working Group
March	25	Missouri Consumer Health Care Watch
March	25	Department of Mental Health
March	28	Department of Elementary & Secondary Education
March	28	Head Injury Advisory Council
March	28	Missouri Coalition of Community Mental Health Centers
March	29	Staff Working Group and The Consultants
March	30	Technical Advisory Group
March	31	Department of Insurance
April	4	Vision Services Plan
April	5	Finance Subcommittee of Staff Working Group
April	5	Missouri Assoc. of Alcohol & Drug Abuse Programs
April	8	Bootheel Comprehensive Health Care Coord. Council
April	11	American Association of Retired Persons
April	12	Consumer Advocacy Reps., Health Watch, and MAC
April	12	Missouri Consumer Health Care Watch
April	13	Joint Committee On Health Care
April	15	Missouri Hospital Association
April	18	Department of Mental Health
April	18	Missouri Consumer Health Care Watch
April	18	Managed Care Organization Mtg.
April	19	Department of Mental Health
April	19	Springfield Chamber of Commerce
April	22	Staff Working Group
April	25	Medical Advisory Committee (MAC) and Technical Advisory Group (TAG)
April	26	Pharmacy Subcommittee; MAC
April	27	Missouri Optometry Association
April	27	Hospital Advisory Mtg.
April	28	Missouri Consumer Health Care Watch
April	29	Missouri Hospital Association

April	29	HCFA Regional Office
April	29	Health Link
May	1,2	Focus Groups
May	2	Managed Care Organization Mtg.
May	9	St. Louis Planning Committee, HMO Subcommittee
May	17	Department of Health Budget Office
May	20	Missouri Hospital Association-Northeast Council
May	23	Planned Parenthood
May	24	Medicaid Consumer Advisory Group
May	31	Bootheel Comprehensive Health Care Coalition
May	31	Hospital Advisory Mtg.
June	1	Ambulatory Health Care Centers Advisory Committee
June	2	Missouri Alliance For Home Care Task Force
June	6	Medicaid Consumer Advisory Group
June	7	Missouri Consolidated Health Care
June	8	Department of Mental Health
June	9	Local Investment Commission (LINC)
June	9	Missouri Hospital Association - Northwest Council
June	10	Missouri Legislative Black Caucus
June	10	Missouri Hospital Association - Southwest Council
June	13	Managed Care Organization Mtg.
June	15	St. Louis Metropolitan Health Care Planning Committee
June	15	Missouri Hospital Association - Central Council
June	16	Local Health Department Administrators
June	24	Missouri Hospital Association - St. Louis Children's Hospital, Children's Mercy, Cardinal Glennon Hospital
June	27	Department of Health Executive Staff
June	27	Missouri Public Health Association
June	28	HCFA Regional Office Briefing

II = A, EXHIBIT I

MEDICAID WAIVER WORKING GROUPS

Executive Steering Committee

Robert Bartman, Commissioner
Dept. of Elem. & Sec. Education

Donna Checkett, Director
Div. of Medical Services

Don Howard, Director
Div. of Aging

Ilalyn Irwin, Director
Policy Development

Coleen Kivlahan, Director
Dept. of Health

Keith Schafer, Director
Dept. of Mental Health

Carmen Schulze, Director
Div. of Family Services

Gary Stangler, Director
Dept. of Social Services

Mark Ward, Dep. Comm.
Div. of Planning & Budget

Technical Advisory Group

Kaiser Permanente
Pharmaceutical Manufacturers Assoc.
Missouri Pharmaceutical Assoc.
Missouri Retailers Assoc.
Heartland Coalition for Primary Health Care
Missouri Assoc. of Osteopathic Physicians and Surgeons
Missouri Hospital Assoc.
Missouri State Coalition of Community Health Centers
Missouri Nurses Assoc.
Missouri Family Health Council
Missouri Alliance for Home Care
Health Midwest
Missouri Podiatry Assoc.
Missouri State Medical Assoc.
Missouri Dental Assoc.
Missouri Optometric Assoc.

External Data Support

DSS, Research & Evaluation; UMC, Business and Public Administration;
OA, Budget & Planning; DOH, State Center for Health Statistics; Show-Me Health

Staff Working Group

Donna Checkett, Chair

Eligibility	Services	Internal Management	Finance
Greg Vadner, Chair Janel Luck, Co- Chair Dianne Drainer Beth Griffin Marian Hartung	Allen Daugird, Chair Marva Lubker, Co-Chair Judith Widdicombe Collette Croze Dan Longo	Gary Bailey, Chair Pam Leyhe, Co- Chair Joel Schnedler	Tim Hull, Chair Robert Frank, Co- Chair Jim Uffmann

EXHIBIT 2

EXECUTIVE STEERING COMMITTEE

Robert Bartman, Ed.D., Commissioner
Department of Elementary and
Secondary Education
P.O. Box 480
Jefferson City, MO 65101
Phone: 751-4446
Fax: 526-4404

Carmen Schulze, Director
Division of Family Services
P.O. Box 88
Jefferson City, MO 65101
Phone: 751-4247
Fax: 751-8949

Donna Checkett, Director
Division of Medical Services
615 Howerton Court
Jefferson City, MO 65109
Phone: 751-6922
Fax: 751-6564

Gary J. Stangler, Director
Department of Social Services
P.O. Box 1527
Jefferson City, MO 65102
Phone: 751-4815
Fax: 751-3203

Don Howard, Director
Division of Aging
615 Howerton Court
Jefferson City, MO 65109
Phone: 751-3082
Fax: 751-8687

Mark Ward, Deputy Commissioner
Division of Planning and Budget
Office of Administration
Jefferson City, MO 65109
Phone: 751-2345
Fax: 751-9347

Ilalyn Irwin, Director
Policy Development
Office of the Governor
State Capitol Building
Jefferson City, MO 65101
Phone: 751-3283
Fax: 751-1495

Coleen Kivlahan, M.D., M.S.P.H.
Director, Department of Health
1738 East Elm
Jefferson City, MO 65101
Phone: 751-6001
Fax: 751-6041

Keith Schafer, Ed.D., Director
Department of Mental Health
1706 East Elm
Jefferson City, MO 65101
Phone: 751-4122
Fax: 751-8224

I = A, EXHIBIT 3

STAFF WORKING GROUP

Gary B. Bailey, Principal Assistant
Division of Medical Services
615 Howerton Court
Jefferson City, MO 65109
Phone: 751-6922
Fax: 751-6564

Donna Checkett, M.A., Director
Division of Medical Services
615 Howerton Court
Jefferson City, MO 65109
Phone: 751-6922
Fax: 751-6564

Colette Croze, Deputy Director
Office of Departmental Affairs
Department of Mental Health
1706 East Elm
Jefferson City, MO 65102
Fax: 751-8069
Phone: 751-6714

Allen J. Daugird, M.D., M.B.A.
Univ. of MO-Columbia
Associate Professor of Clinical
Family and Community Medicine
School of Medicine
M245 Health Sciences Center
Columbia, MO 65212
Phone: 314/882-5602
Fax: 314/882-9096

M. Dianne Drainer, Manager
Research and Evaluation Unit
Broadway State Office Building
First Floor
Jefferson City, MO 65102
Phone: 751-3060
Fax: 526-3574

Judi Widdicombe, RN
Health Policy Institute
225 E. Capitol
Jefferson City, MO 65101
Phone: 726-4856 or 635-8137 (JC)
Fax: 636-8197

Dr. Robert G. Frank
University of Missouri-Columbia
2R01 Rusk Rehabilitation Center
Columbia, MO 65212
Phone: 882-6928
Fax: 884-4540

Tim Hull, M.P.H., Fiscal Administrator
Division of Medical Services
615 Howerton Court
Jefferson City, MO 65109
Phone: 751-6922
Fax: 751-6564

Daniel R. Longo, Sc.D
Associate Professor
Department of Family Medicine
MA306/DC032.00 Medical Sciences
Building
Columbia, MO 65212
Phone: 882-4992
Fax: 884-6172

Greg Vadner, Deputy Director
Income Maintenance
Division of Family Services
Division of Family Services
615 Howerton Court
Jefferson City, MO 65109
Phone: 751-3124
Fax: 526-4837

Jim Uffmann, C.P.A., Deputy Director
Division of Medical Services
615 Howerton Court
Jefferson City, MO 65109
Phone: 751-8994
Fax: 751-6564

Joel F. Schnedler, CDP Deputy Director
Division of Medical Services
615 Howerton Court
Jefferson City, MO 65109
Phone: 751-7996
Fax: 751-6564

Janel Luck, Income Maintenance
Division of Family Services
615 Howerton Court
Jefferson City, MO 65109
Phone: 751-3507
Fax: 526-4837

Pam Leyhe, M.A., Mngt. Services Adm.
Division of Medical Services
615 Howerton Court
Jefferson City, MO 65109
Phone: 751-6926
Fax: 751-6564

Marian Hartung
Lutheran Family & Children Services
4625 Lindell Blvd., Suite 501
St. Louis, MO 63108
Phone: 314-361-2121
Fax: 314-644-5437

John Twiehous, Ph.D., Director
Division of Comprehensive Psychiatric Svcs.
Dept. of Mental Health
1706 East Elm
Jefferson City, MO 65102
Phone: 751-1260
Fax: 751-7815

Jerry Simon, Asst. to the Director
Division of Aging
P.O. Box 1337
Jefferson City, MO 65102
Phone: (314) 751-3082
Fax: (314) 751-8687

Anne S. Deaton, Ed.D.
Deputy Director, Alternative Serv.
Division of Aging
615 Howerton Court
Jefferson City, MO 65109
Phone: (314) 751-3082
Fax: (314) 751-08687

Gary Moll, Director Voc. Rehab.
2401 E. McCarty
Jefferson City, MO
Phone: (314) 751-3251

Marva Lubker, R.N., Deputy Director
Division of Medical Services
615 Howerton Court
Jefferson City, MO 65109
Phone: 751-3277
Fax: 751-6564

Beth Griffin
Citizens for Missouri's Children
2717 Sutton Blvd., Ste. 200
St. Louis, MO 63143
Phone: 314-647-2003
Fax: 314-644-5437

Joann Leykam, J.D., Director
Div. of Mental Retardation
and Developmental Disabilities
Dept. of Mental Health
1706 East Elm
Jefferson City, MO 65102
Phone: 751-8215
Fax: 751-9207

Jim Nunnelly
Anti-Drug Prgm. Administrator
Jackson County Court House
Prosecutor's Office
415 East 12th Street
Kansas City, MO 64106
Phone: 816-881-3814
Fax: 816-881-3843

Robin J. Rust, M.P.A., Policy
Division of Medical Services
P.O. Box 6500
Jefferson City, MO 65102
Phone: (314) 751-3277
Fax: (314) 751-6564

Jim Cook, Ph.D.
Alternative Services Administrator
Division of Aging
P.O. Box 1337
Jefferson City, MO 65102
Phone: (314) 751-3082
Fax: (314) 751-8687

Leslie Jordon
225 East Capitol
Jefferson City, MO 65101
Phone: (314) 634-7772
Phone: 726-4856 or 635-8137 (JC)

Mary Schantz
Missouri Alliance for Home Care
431 E. McCarty
Jefferson City, MO 65101
Fax: (314) 634-4374

AD HOC MEMBERS

David C. Aguillard, M.A., Special Projects
Department of Social Services
P.O. Box 1527
Jefferson City, MO 65102
Phone: 751-4815
Fax: 751-3203

Billie Waite, J.D., Legal Counsel
Division of Medical Services
615 Howerton Court
Jefferson City, MO 65109
Phone: 751-6922
Fax: 751-6564

Tim Wynes, J.D., Director
Division of Legal Services
P.O. Box 1527
Jefferson City, MO 65109
Phone: 751-3229
Fax: 751-8365

Deborah Goldammer
OA-Division of Budget and Planning
Room 124, State Capitol Building
Jefferson City, MO 65101
Phone: 751-9320
Fax: 751-9347

Jim Burns, C.P.A., Deputy Director
Division of Budget and Finance
Broadway State Office Building
221 W. High
Jefferson City, MO 65101
Phone: 751-2170
Fax: 751-7598

Dan C. Shimkus, M.Ed. Spec. Projects
Division of Medical Services
615 Howerton Court
Jefferson City, MO 65109
Phone: 526-5735
Fax: 751-6564

II = A, EXHIBIT 4

TECHNICAL ADVISORY GROUP

Bonnie Bowles
Associate Executive Director
MO Association of Osteopathic
Physicians and Surgeons
1423 Randy Lane
P.O. Box 748
Jefferson City, MO 65102
Phone: (314) 634-3415
Fax: (314) 634-5635

Charles Bowman
Executive Director
Missouri Hospital Assn.
4713 Highway 50 West
P.O. Box 60
Jefferson City, MO 65102
Phone: (314) 893-3700
Fax: (314) 893-2809

Kathy Carter, Executive Dir.
MO Coalition of Community
Mental Health Centers
915 Southwest Blvd.
Jefferson City, MO 65101
Phone: (314) 634-4626
Fax: (314) 634-8858

Cheryl Dillard, President
Kaiser Permanente
10561 Barkley, Ste. 200
Overland Park, KS 66212
Phone: (913) 967-4600
Fax: (913) 642-0209

Belinda Heimericks, M.S.(N)
Executive Director
Missouri Nurses Association
206 East Dunklin
P.O. Box 325
Jefferson City, MO 65102
Phone: (314) 636-4623
Fax: (314) 636-9576

Lon Lowrey, Gov. Affairs
Pharm. Mfg. Assoc.
16606 Jamestown Forest Dr.
Florissant, MO 63034
Phone: (314) 355-9631
Fax: (314) 355-9635

George Oestreich, CEO
MO Pharmaceutical Assn.
410 Madison Street
Jefferson City, MO 65101
Phone: (314) 636-7522 ex 222
Fax: (314) 636-7485

David Overfelt
Missouri Retailers Assn.
200 Madison
P.O. Box 1336
Jefferson City, MO 65102
Phone: (314) 636-5128
Fax: (314) 636-6846

Benjamin Pettus, Jr., CEO
Heartland Coalition for Primary Health Care
514 East Capitol Ave., Ste. A
Jefferson City, MO 65101
Phone: (314) 636-4222
Fax: (314) 636-4585

Mary Schantz
MO Alliance for Home Care
431 E. McCarty
Jefferson City, MO 65101
Phone: (314) 634-7772
Fax: (314) 634-4374

Barry Seward, Senior VP
Health Midwest
2304 East Meyer Blvd.
Suite A-11
Kansas City, MO 64132
Phone: (816) 276-9169
Fax: (816) 276-9200

Bill Spencer, Executive Dir.
Missouri Podiatry Assn.
215 E. Capitol
P.O. Box 717
Jefferson City, MO 65101
Phone: (314) 635-2245
Fax: (314) 634-2406

Patrick Mills
MO State Medical Association
113 Madison Street
P.O. Box 1028
Jefferson City, MO 65102
Phone: (314) 636-5151
Fax: (14) 636-8552

Roger Weis, Executive Dir.
MO Dental Association
230 W. McCarty Street
P.O. Box 1707
Jefferson City, MO 65101
Phone: (314) 634-3436
Fax: (314) 635-0764

Zoe Lyle, Exec. Director
MO Optometric Assn.
417 East High Street
Jefferson City, MO 65101
Phone: (314) 635-6151
Fax: (314) 635-7989

Sue Hilton, Executive Dir.
Missouri Family Health Council 1909
Southridge Dr.
Jefferson City, MO 65109
Phone: (314) 636-4060
Fax: (314) 636-2045

Peter DeSimone
Executive Secretary
Missouri Assoc. for Social Welfare
308 East High Street
Jefferson City, MO 65101
Phone: (314) 634-2901
Fax: (314) 635-1648

E. Frank Ellis, President
Swope Parkway Health Ctr.
4900 Swope Parkway
Kansas City, MO 64130
Phone: (816) 923-5800
Fax: (816) 923-9210

Paul Dow, Executive Director
Missouri Child Care Assn.
P.O. Box 1583
Jefferson City, MO 65102
Phone: (314) 635-7226
Fax: (314) 635-9848

Del Snoberger
Partners HMO
1 City Place Dr. Ste. 670
St. Louis, MO 63141
Phone: (314) 994-2439
Fax: (314) 994-2260

Rebecca Gavin
MO-SPAN
8744 Wornall Rd.
Kansas City, MO 64114
Phone: (816) 361-7531

II = A, EXHIBIT 5

MEDICAL ADVISORY COMMITTEE

Honorable J. B. (Jet) Banks
Missouri Senate
State Capitol Building, Room 319
Jefferson City, MO 65101
314-751-4650

Honorable Thomas MacDonnell
Missouri House of Representative
State Capitol Building, Room 134
Jefferson City, MO 65101
314-751-5702

Honorable Pat Kelley
House of Representatives
State Capitol Building, Room 204
Jefferson City, MO 65101
314-751-1456

Colleen Kivlahan, M.D.
Missouri Department of Health
P.O. Box 570
Jefferson City, MO 65102
314-751-6001

Ron Barnes, Director
Visiting Nurse Association of
Central Missouri, Inc.
1809 Vandiver Drive, Suite 100
Columbia, MO 65202
314-474-6000
FAX: 314-474-6400

Matthew Brauss, R.N.
3650 Upton
St. Louis, MO 63116
314-481-3345 (Home)

Sessions Cole, M.D.
St. Louis Children's Hospital
400 South Kingshighway
St. Louis, MO 63110
314-454-6148 (Office)
314-862-3405 (Home)

Dan Couch, Deputy Executive Director
Truman Medical Center West
2301 Holmes
Kansas City, MO 64108
816-556-3149 (Office)
FAX: 816-556-3769

Robert F. Gouy
United Medical Mart
11833 New Halls Ferry Road
Florissant, MO 63033
314-838-3100 (Office)
314-653-0097 (Home)

Jonathan G. Hanson, D.D.S.
Oral and Maxillofacial Surgery
1407 Southwest Boulevard
Jefferson City, MO 65101
314-635-7216 (Office)

Michael H. Ledbetter, D.O.
Dogwood Medical Center
Route 1, Box 27C
Osage Beach, MO 65065
314-348-0209 (Office)
314-346-4235 (Home)

Michael Nichols, O.D.
500 Keene, Suite 103
Columbia, MO 65201
314-874-2030 (Office)

Tom Beetem, R. Ph.
Lake View Hills Subdivision
Jefferson City, MO 65101
314-636-7187 (Home)

David L. Ruecker
Mark Twain Manor
8182 Maryland Avenue, Suite. 207
Clayton, MO 63105

Dan Vallee
Rock Township Ambulance Dist.
P.O. Box 21
Arnold, MO 63010
314-296-5066 (Office)
314-789-2464 (Home)

Phil Melugin, Director
In-Home Services
Oxford Health Care
3660 S. National
Springfield, MO 65807
417-883-7500 (Office)
417-886-8697 (Home)

Stanley Peterson, M.D.
3231 South National
Springfield, MO 65807
417-883-7422 (Office)

Erma M. Cunningham
931 Country Ridge Drive
Jefferson City, MO 65109
314-761-4263

||=A, EXHIBIT 6

ALTERNATIVE CARE SUBCOMMITTEE

Larry Christy
Services for Older Americans
1210 Oklahoma Avenue, Box 308
Trenton, MO 64683
(816) 0-359-5318 H-359-4218

Nancy Huff
St. John's Regional Home Care
1235 Cherokee
P.O. Box 4086
Springfield, MO 65808
800-525-9137 H-(417) 485-8371

Phil Melugin, Director
In-Home Services
Oxford Health Care
3660 S. National
Springfield, MO 65807
(417) 883-7500 (H) 886-8697

Annie Pope, Project Director
American Red Cross
5615 Pershing
St. Louis, MO 63112
(314) O-454-3941 H-725-7922

||=A, EXHIBIT 7

AMBULANCE SUBCOMMITTEE

Bob Dietrich, Vice President
Gateway Medical Transport Service
P.O. Box 2680
6942 Gravois Avenue
St. Louis, MO 63116
(314) O-351-4702 H-789-2148

Bruce A. Grotewiel, Ambulance Director
Jefferson City Ambulance Service
Charles E. Still Osteopathic Hospital
1125 Madison
Jefferson City, MO 65101
(314) O-635-7100/Ext. 1331 H-893-6192

Howard V. Phillips
Saline County Ambulance Director
P.O. Box 37, 233 West Morgan
Marshall, MO 65340
(816) O-886-3317 H-886-7566

Eugene Richardson
Lifeguard Emergency Medical Services
517 South Hancock
Sedalia, MO 65301
(816) O-827-2937 H-826-6621

John A. Sharp, Executive Director
Metropolitan Ambulance Services Trust
5835 Troost Avenue
Kansas City, MO 64110
(816) O-765-7195 H-361-1700

Dan Vallee, Administrator (Chair)
Rock Township Ambulance District
P.O. Box 21
Arnold, MO 63010
(314) O-296-5066 H-789-2464

I = A, EXHIBIT 8

AMBULANCE SUBCOMMITTEE

Nancy Cossey, LSCSW
Social Services Supervisor
The Visiting Nurse Association
Home Health Services of Greater Kansas City
527 West 39th Street
Kansas City, MO 64111
816-531-1200 (Office)
816-333-4772 (Home)

Patrick E. Cullen
414 Beam Street
Willard, MO 65781
417-742-4817 (Home)

Erma M. Cunningham
931 Country Ridge Drive
Jefferson City, MO 65109
314-761-4263

Alice Kitchen, LMSW
Director of Social Services
Children's Mercy Hospital
Twenty-Fourth at Gillham Road
Kansas City, MO 64108-9898
816-234-3670 (Office) 816-361-9394

Tammy Poirrier
3820 Fairview
St. Louis, MO 63116
314-638-1089 (Office)

Eva-Maria Williams, ACSW
Truman Medical Center-West
Department of Social Services
2301 Holmes
Kansas City, MO 64108
816-556-3000 (Office/page)
816-361-5259 (Home)

J. Keith Willis, M.S.S.W./A.C.S.W.
Department of Mental Health
P.O. Box 104791
Jefferson City, MO 65110
314-751-3070 (Office) 314-893-8248

EX-OFFICIO MEMBERS:

Effie Day and Jim Smith
Legal Aid of Western Missouri
1005 Grand Avenue
600 Lathrop Building
Kansas City, MO 64106
816- 474-6750

William V. Brell, D.D.S.
1531 East Sunshine, Suite E10
Springfield, MO 65804
(417) O-883-5866

John N. Dane, D.D.S.
Dental Department
Truman Medical Center-East
7900 Lee's Summit Rd.
Kansas City, MO 64139
(816) O-373-4415 ext. 1169 H-525-5218

Ronnie Drake, D.D.S.
1717 Biddle
St. Louis, MO 63106
(314) O-622-3874 H-721-6017

Jonathan G. Hanson, D.D.S.
(Interim Chair)
1407 Southwest Boulevard
Jefferson City, MO 65101
(314) 635-7216

Kenneth S. Powell, D.D.S.
3403 North Union Boulevard
St. Louis, MO 63115
(314) O-381-1556 H-314-432-1122
(Chairman of Social Services Committee,
Missouri Dental Association)

Ronald A. Smith, D.D.S.
General Dentistry
6607 Independence Avenue
Kansas City, MO 64125
(816) O-241-8233 (913) H-897-5418

Arthur Shinn, Pharm.D., FASCP
Vice President, Clinical Services
Managed Prescription Services, Inc.
515 N. 6th St., Suite 1100
St. Louis, MO 63101
(314) 259-4213
FAX# (314) 436-1592

Theresa Prosser, Pharm.D.
Assistant Professor of Clinical Pharmacy
St. Louis College of Pharmacy
4588 Parkview Place
St. Louis, MO 63110
(314) 367-8700

Harvey H. Haynes, P.D.
President, Kansas City Nursing Services, Inc.
7605 N. Chestnut
Gladstone, MO 64119
(816) 436-7475 (K.C. Nursing Serv.-Phar-
macy)
Fax# (816) 436-4375

Valerie Walker, M.D.
West-End Medical Center, Inc.
504 North Euclid Ave., Suite A
St. Louis, MO 63108
(314) 367-4044

Donald Miller, M.D.
Internal Medicine, Inc.
200 St. Mary's Medical Plaza, Suite 302
Jefferson City, MO 65101
(314) 636-7183

Samuel Brayfield, D.O.
Dogwood Medical Center
Rt. 4, Box 27-C
Osage Beach, MO 65065
(314) 348-0209

A. Michael Dykstra, D.O.
Dykstra Clinic
Rt. B, Box 287
Canton, MO 63435
(314) 288-5949

Muriel M. Leighter, R.N., MSN, CPHQ
9755 Winner Road
Independence, MO 64052
(816) 836-8100, Ext. 6324 (Indep. Reg.)

Ronald Graham, Pharm.D.
Government Relations Manager
CIBA-GEIGY Corporation
1311 Granite Creek Drive
Blue Springs, MO 64015
(816) 228-5741

Randall Huss, M.D. (Interim Chairman)
Rolla Family Practice
910 W. 10th St.
Rolla, MO 65401
(314) 364-4226

David Rush, Pharm.D.
Professor, Clinical Pharmacy and Medicine
University of Missouri - Kansas City
and Clinical Pharmacist
Truman Medical Center-East
7900 Lee's Summit Road
Kansas City, MO 64139
(816) 373-4415, ext. 2063

John W. Newcomer, M.D.
Assistant Professor of Psychiatry
Washington University
School of Medicine
4940 Children's Place
St. Louis, MO 63110
(314) 362-2440

II = A, EXHIBIT II DUR REGIONAL COMMITTEE

(KANSAS CITY REGION)

Sheila L. Schmidt, R.Ph.
5221 N. Kensington
Kansas City, MO 64119
(816) 471-3000

Bonnie S. Grabowski, R.Ph., MBA
Pharmacy Manager
North Kansas City Hospital
2800 Hospital Drive
North Kansas City, MO 64116
(816) 691-1974

Karen McWay, Pharm.D.
Department of Pharmacy
Children's Mercy Hospital
24th at Gillham Road
Kansas City, MO 64108
(816) 234-3059

Keith Perkins, Pharm.D.
V.A. Medical Center - Pharmacy
4801 East Linwood Blvd.
Kansas City, MO 64128
(816) 861-4700 ext. 3635

Mary L. Rardin, M.D.
Swope Parkway Health Center
4900 Swope Parkway
Kansas City, MO 64130
(816) 923-9210

Pamela Pascal Rush, Pharm.D.
22009 East R.D., Mize Road
Independence, MO 64057
(816) 229-7749

Carleton J. Lindgren, M.D.
12805 E. 38th Street
Independence, MO 64055
(816) 461-8368 (home)
Children & Family Mental Health Center
(816) 525-1919

W. Jack Stelmach, M.D.
Vice President of Medical Affairs
Baptist Medical Center
6601 Rockhill Road
Kansas City, MO 64131
(816) 276-7501 FAX: 926-2272

(COLUMBIA REGION)

Frances Hedrick, M.D.
Holts Summit Family Health Center
165 West Simon Blvd., P.O. Box 427
Holts Summit, MO
(314) 896-8301

Randaye Stowers, R.Ph.
4701 N. Wyatt Lane (home)
Columbia, MO 65202
(314) 445-3708
(Columbia Wal-Mart Pharmacy)

Tim Cacek, Pharm.D.
Department of Pharmacy
Boone Hospital Center
1600 E. Carpenter
Columbia, MO 65201
(314) 875-6436
(314) 875-8326 (direct page)

John W. Reuter, R.Ph.
Director of Pharmacy
Still Regional Medical Center
1125 Madison St.
Jefferson City, MO 65102
(314) 635-7100 Ext. 1280

Thomas M. Pursel, Jr., R.Ph.
707 Ridgeview Drive (home)
Washington, MO 63090
(314) 239-2693 (h)
(314) 239-8777 (w)
(314) 569-6733 (FAX)

(KIRKSVILLE REGION)

Robert Theobald, Ph.D.
Department of Pharmacology, KCOM
800 W. Jefferson
Kirksville, MO 63501
(816) 616-2316

Jay Warner, R.Ph.
Warner's Drug
108 South 17th St.
Unionville, MO 63565
(816) 947-2484

G. Neill McKee, R.Ph., Owner
Clark County Pharmacy, Inc.
150 W. Main
Kahoka, MO 63445
(816) 727-2902

Ed Powers, R.Ph., Owner
Macon Pharmacy Old Hwy. 36 E.
Macon, MO 63552
(816) 385-2147

Karla Dwyer, R.Ph.
Elliott Pharmacy
N. Hwy. 63
Kirksville, MO 63501
(816) 665-9871

(ST. LOUIS REGION)

Terry Seaton, Pharm.D.
Assistant Professor
Division of Pharmacy Practice
Saint Louis College of Pharmacy
4588 Parkview Place
St. Louis, MO 63110
(314) 569-6072

Duane A. Wesche, R.Ph.
Wesche's Pharmacies
4429 Bridgeside Court
Bridgeton, MO 63044
(314) 429-5533 (Overland store)
962-8899 (Webster Groves store)
298-9907 (home)

Jeffrey Elbl, Pharm.D.
Clinical Coordinator of Pharmacy/IV Services
Jefferson Memorial Hospital
P.O. Box 350
Crystal City, MO 63019-0350
(314) 933-1340

Randolph Beckner, Pharm.D.
Pharmacy Manager
Barnes Hospital
One Barnes Hospital Plaza
St. Louis, MO 63110
(314) 362-5371

Sandra Ind Connell, R.Ph.
1909 Cherokee Trail
Florissant, MO 63031
(314) 838-3557

Mitchell Champagne, P.D.
Assistant Director Pharmacy Services
St. Joseph Health enter
300 First Capital Dr.
St. Charles, MO 63301

Dorothy (Sara) Hancock, R.Ph.
Jewish Hospital
Pharmacy Department
216 S. Kingshighway
St. Louis, MO 63110
(314) 454-7335

(CAPE GIRARDEAU REGION)

Yee Way Ting, Pharm.D.
Department of Pharmacy
Saint Francis Medical Center
211 Saint Francis Drive
Cape Girardeau, MO 63701
(314) 335-1251

Kenneth Michel, P.D., FASCP
2033 Schweitzer
Poplar Bluff, MO 63901
(314) 785-7624

Rhonda K. Rubenacker, R.Ph.
Pharmacist Service, Inc.
P.O. Box 25
Perryville, MO 63775
(314) 547-8820

Clarence J. Ritter, M.D.
14 Doctors' Park
Cape Girardeau, MO 63701
(314) 334-9641

Jeffrey L. Dryden, D.O.
1115 Alaska Ave., Suite 113
West Plains, MO 65775
(417) 257-6721

(SPRINGFIELD REGION)

Kurt Grady, Pharm.D.
Assistant Director of Pharmacy
Lester E. Cox Medical Centers
3801 South National Ave.
Springfield, MO 65807
(417) 885-6283

Kenneth F. Scott, Jr., M.D.
Hospital Dr.
Clinton, MO 64735
(816) 885-8007

Diane M. McClaskey, R.Ph.
3229 W. Katella Court
Springfield, MO 65807
(417) 866-5983

Michael A. Vinehout, R.Ph.
Rt. 4, Box 4220
(home address-works at Stanley's Phcy)
Marshfield, MO 65706
(417) 468-7230

Joel N. Cohen, M.D.
3150 South National
Springfield, MO 65807
(417) 887-4270

Louis J. Metz, R.Ph.
3535 E. Mentor
Rogersville, MO 65742
(417) 869-1837 (work)
(417) 886-3870 (home)

||=A, EXHIBIT 12

DURABLE MEDICAL EQUIPMENT

Kathleen A. Brown
Buy Home Care
111 Schumate Chapel Road
Jefferson City, MO 65109
(314) O-634-6001 H-893-5550

Robert F. Gouy (Interim Chair)
United Medical Mart
11833 New Halls Ferry Road
Florissant, MO 63033
(314) O-838-3100 H-653-0097

Ted J. Hammer
2510 Hampton Ave.
St. Louis, MO 63139
(314) O-647-1617 H-842-3811

Curtis E. Jackson
928 South Western
Mexico, MO 65265
(314) 636-2442 H-581-7519

William Rubin
Procure Medical Supply
622 Collins Avenue
Festus, MO 63028
(314) O-937-7607 H-469-1662

Byron Whitaker, C.P.O.
Certified Orthotics and Prosthetic Assoc.
14301 West 96th Terrace
Lenexa, KS 66215
(913) O-492-3223 H-631-9068

||=A, EXHIBIT 13

HEARING AID SUBCOMMITTEE

Ervin Dock
2050 South National, Suite 100
Springfield, MO 65804
(417) O-886-1960 H-883-0620

Deborah Galley
1613 NE Ridgeway
Lee's Summit, MO 64063
(816) O-478-4040 H-525-0613

Jacqueline Hartman
Clinical Audiologist and Speech
Pathologist
Midwest Head and Neck Surgery, Inc.
Suite 118, 9701 Landmark Parkway Drive
St. Louis, MO 63127
(314) O-843-3828 H-458-0658
Ans. Serv. 576-9195

||=A, EXHIBIT 14

HOME HEALTH SUBCOMMITTEE

Ron Barnes, Director (Chair)
Visiting Nurse Association
of Central Mo., Inc.
1809 Vandiver Drive, Suite 100
Columbia, MO 65202
(314) 474-6000 Fax: 314/474-6400

Beverly A. Hollander, R.N., MA
Admin. Director of Home Care Services
Incarnate Word Hospital Home Health
3545 Lafayette Avenue
St. Louis, MO 63104
(314) 865-6500 (H) 481-1017
Fax: 314/865-6807

Karen Johnson, Rehabilitative
Services Director
Visiting Nurse Association
of Greater Kansas City
527 West 39th Street
Kansas City, MO 64111
(816) 531-1200, Ext. 7780
H-792-0755 Fax: 913/722-2385

Faye Royale Larkins, RN, MPH
Home Health & Hospice
Barnes Home Health & Hospice
One Barnes Hospital Plaza
St. Louis, MO 63110
(314) 362-0200 Fax: 314/362-0910

Delores "Dee" Morarity, R.N.
Missouri River Home Health & Hospice
1440 Aaron Court
Jefferson City, Missouri 65101
(314) 635-5643 (H) 636-5381
Fax: 635-6552

M. Joan Schmidt, Director
St. John's Mercy
1701 Heritage Hills Drive
Washington, MO 63090
(314) 239-8625 Fax: 314/239-8649

II = A, EXHIBIT 15 HOSPICE SUBCOMMITTEE

Matthew E. Brauss, R.N., President
Beacon of Hope Hospice
12660 Lamplighter Square
St. Louis, MO 63128
(314) O-664-1505 H-481-3345

Donita Hopke, Patient Care Coordinator
Regional Hospice of Central Missouri
404 Keene Street
Columbia, MO 65201
(314) O-875-9600 H-594-2284

Judith Mange
Chief Operating Officer
Professional Physical Therapy, Inc.
1023 Executive Parkway, Suite 4A
St. Louis, MO 63141
(314) O-469-0011 H-962-9115

Carol Peltier, Executive Director
Kansas City Hospice
6601 Winchester Avenue, Suite 250
Kansas City, MO 64133
(816) O-737-0677 (913) H-541-8574

Adell Peterson, R.N.
Consultant Community Health Nurse
Bureau of Home Health Licensing
and Certification
Missouri Department of Health
P.O. Box 570
Jefferson City, MO 65102
(314) O-751-6336 (417) H-993-4735

Debbie Schoenlaub
Director of Home Care Services
Heartland Health System, Inc.
416 North Seventh
St. Joseph, MO 64501
(816) O-271-7190 H-364-6843

Rick Williams, Executive Director
The Hospice of Southwest Missouri, Inc.
Kickapoo Plaza, 3653 South Avenue
Springfield, MO 65807
(417) O-882-0453 H-886-7023

$\parallel = A$, EXHIBIT 16 PHYSICIAN SUBCOMMITTEE

Fred E. Bodenhamer, O.D.
 124 East Dunklin Street
 Jefferson City, MO 65101
 (314) O-635-2020 H-636-3882

Sessions Cole, M.D., Director
 Division of Newborn Medicine
 St. Louis Children's Hospital
 One Children's Place
 St. Louis, MO 63110
 (314) O-454-6148 H-862-3405

Michael H. Ledbetter, D.O.
 Dogwood Medical Center
 Route 4, Box 27C
 Osage Beach, MO 65065
 (314) O-348-0209 H-346-4235

Wilbur T. Hill, D.O.
 Liberty Family Medical Services, Inc.
 Seaport—Clipper Building
 38 Westwoods Drive
 Liberty, MO 64068
 (816) O-781-4244 H-781-5234

$\parallel = A$, EXHIBIT 17 ROSTER - PRIOR AUTHORIZATION SUBCOMMITTEE

Henry D. Petry, D.O.
 Laurie Clinic
 P. O. Box 1277
 Laurie, MO 65038
 (314) 374-5263

Fred E. Bodenhamer, O.D.
 124 E. Dunklin
 Jefferson City, MO 65101
 (314) 635-2020

James R. Ennis, D.O.
 Route #1, P.O. Box 217
 Holts Summit, MO 65043
 (314) 896-5115

Robert C. Kimbrough, III, M.D.
 Ferrell-Duncan Clinic, Inc.
 1001 E. Primrose
 P.O. Box 9007
 Springfield, MO 65808-9007
 (417) 881-1100

Barbara R. Cole, M.D.
 Dept. of Pediatrics
 Washington University School of Medicine
 Campus Box 8116
 400 S. Kingshighway
 St. Louis, MO 63110
 (314) 454-6000

Douglas Beal, M.D.
 University Physicians
 Green Meadows Child Health Clinic
 3217 S. Providence -
 Columbia, MO 65203
 (314) 882-4730 or (314) 882-3713

David B. Elias, M.D.
 Green Meadows Internal Medicine Clinic
 3217 S. Providence
 Columbia, MO 65203
 (314) 882-2424

Kevin G. Moores, Pharm. D.
Drug Information Service
Truman Medical Center
2301 Holmes
Kansas City, MO 64108-2677
(816) 556-4125

Gene Forrester, R.Ph.
3390 Country Hill Ct.
Columbia, MO 65203
(314) 442-6105

Ed Wood, R.Ph.
Wood Drug
10702 Manchester Road
Kirkwood, MO 63122
(314) 965-3811

II = A. EXHIBIT 18

ROSTER - PHARMACY SUBCOMMITTEE

Bill Fitzpatrick, R.Ph.
Interlock Pharmacy Systems
Weldon Parkway
St. Louis, MO 63146
(314) 567-6690

Phillip Bangert, R.Ph.
Bangert Pharmacy, Ltd.
13300 New Halls Ferry
Florissant, MO 63033
(314) 831-3313

Jerry Callahan, R.Ph.
Pharmacy Group Manager
National Supermarkets
P.O. Box 7123
St. Louis, MO 63177
(314) 731-5511 ext 280

Tom Beetem, R.Ph.
G.A. Fischer Drug/
Healthcare Prescriptions
510 Ellis Blvd.
Jefferson City, MO 65101
(314) 636-8119

William Groth, R.Ph.
Pharmacy Supervisor
Walgreens
440 N. Highway 67
Florissant, MO 63031
(314) 837-5521

Craig Leonard, R.Ph.
Lee's Summit Pharmacy
615 W. 3rd St.
Lee's Summit, MO 64063
(816) 524-3335

II = A, EXHIBIT 19

BONE MARROW TRANSPLANT ADVISORY GROUP

Nasrollah Hakami, M.D. (Chairman)
Professor of Child Health
Director, Pediatric Hematology/Oncology
Department of Child Health
University of Missouri Hospital and Clinics
1 Hospital Drive, 7th Floor North
Columbia, MO 65212
(314) 882-4929
FAX (314) 884-4277

Dr. Michael Perry
Ellis Fischel Cancer Center
115 Business Loop 70W, Room 524
Columbia, MO 65203
ATTN: Patty Moore
(314) 882-4979
FAX (314) 875-2284

Dr. Arnold Freeman, Chief
Section of Hematology/Oncology
Children's Mercy Hospital
24th at Gillham Road
Kansas City, MO 64108
(816) 234-3118

Dr. Christopher Sirridge
University of Missouri
School of Medicine
2411 Holmes
Kansas City, MO 64108
(816) 235-1910

Dr. Gary Spitzer
St. Louis University Hospital
3635 Vista at Grand Street
St. Louis, MO 63104
(314) 577-8854
FAX (314) 773-1167

Dr. Randy A. Brown
Washington University
School of Medicine
4960 Audubon Avenue
St. Louis, MO 63110
(314) 362-7766
FAX (314) 362-7086

Dennis O'Connor, M.D.
Hematology/Oncology Department
Cardinal Glennon Children's Hospital
1465 South Grand Boulevard
St. Louis, MO 63104
(314) 577-5638
FAX (314) 268-6411

Dr. Donna Wall
St. Louis Children's Hospital
400 South Kingshighway
St. Louis, MO 63110
(314) 454-6018
FAX (314) 454-2780

II = A, EXHIBIT 20

TRANSPLANT ADVISORY GROUP

Jack Codd, M.D. (Heart)
Depaul Health Center
12303 Depaul Drive
Bridgeton, Missouri 63044
(314) 298-0018

Leslie W. Miller, M.D. (Heart)
St. Louis University Hospital
1325 South Grand Boulevard
St. Louis, Missouri 63104
(314) 577-8894

Thomas S. Helling, M.D. (Kidney)
Paul W. Nelson, M.D. (Kidney)
St. Luke's Hospital
4320 Wornell Road, Suite 308
Kansas City, MO 64111
(816) 753-7460

Mr. Karl Kruse, Director
Missouri Kidney Foundation
114 Lewis Hall
Columbia, MO 65212
(314) 882-2506

Gilbert Ross, M.D. (Kidney)
Univ. of Mo Med. Center
807 Stadium Road
Columbia, MO 65212
(314) 882-1151

Nasrollah Hakami, M.D.
Professor of Child Health
Director of Pediatric
Hematology/Oncology
Department of Child Health
Univ. of Mo Hospital & Clinics
1 Hospital Drive, 7th Floor North
Columbia, MO 65212
(314) 362-5000
(Bone Marrow)

Douglas Hanto, M.D. (Liver)
1 Barnes Hospital Plaza
Suite 5108, Quenny Tower
St. Louis, MO 63110
(314) 362-7320

Hamner H. Hannah III, M.D.
Menorah Medical Center (Heart)
4949 Medical Center
Kansas City, MO 64110
(816) 276-8250

Ms. Carmen Kock
Director of Education
Midwest Organ Bank
4006 Central
Kansas City, MO 64111
(816) 531-3763

Mr. Dean Kappel, Director
Mid-America Transplant Assn.
1139 Olivette Executive Parkway
St. Louis, MO 63132
(314) 991-1661

James S. Carter, M.D. (Heart)
Cardiac and Thoracic Surgeon
Mo. Cardiovascular & Thoracic Surgeons
1701 E. Broadway
Columbia, MO 65201
(314) 876-1720

Michael Pasque, M.D. (Heart)
Barnes Hospital
4949 Barnes Hospital Plaza
St. Louis, MO 63110
(314) 362-5000

I=A, EXHIBIT 21

MEDICAID CONSUMER ADVISORY GROUP

Area 1

Donetta Ideaho
Marshall, Missouri

Melody Logan
Moberly, Missouri

Area 2

Sherry McAllister
St. Peters, Missouri

Lisa Armistead
Fulton, Missouri

Area 3

Kelly Crews
Fredericktown, Missouri

Lorna Hill
Sikeston, Missouri

Area 4

Samantha Haney
Buffalo, Missouri

Jacinda Jones
Springfield, Missouri

Jackson County

Debra Fell
Kansas City, Missouri

Shanel Guyton
Kansas City, Missouri

St. Louis City

Robin Wyllie
St. Louis, Missouri

Patricia Payette
St. Louis, Missouri

St. Louis County

Anita Carterq
St. Louis, Missouri

Phoelica McKenzie
St. Louis, Missouri

Alternate

Cheryl Isiah
St. Louis, Missouri

I = A, EXHIBIT 22

INTEREST GROUPS

Dr. Fred Hamburg
Pediatric Assoc. of Springfield
1000 E. Primrose, Ste. 560
Springfield, MO 65807
Phone: 417/882-1600
Fax: 417/882-1684

Lou DeFeo
Missouri Catholic Conference
600 Clark
Jefferson City, MO 65101
Phone (314) 635-6254

Mary Dunn, Executive Dir.
Southeast MO Business Group on Health
24 South Sheridan
Cape Girardeau, MO 63701

Marilyn Sanford, PT, Ph.D.
MO Physical Therapy Curricula
University of MO-Columbia
121 Lewis Hall
Columbia, MO 65211

Cindy Newport
MO Hospice Organization
1625 West 92nd Street
Kansas City, MO 64114
Phone: (816) 363-2600
Fax: (816) 523-0068

Russell Doumas
MO Assn. of Rehab Facilities
P.O. Box 251
Boonville, MO 65233
MO Coalition for Mentally Ill
208 B East High
Jefferson City, MO 65101

Fred Potter
Missouri Rehabilitation Assn.
2900 Rock Creek Pkwy., Suite 170
Kansas City, MO 64117

Rev. Bob Barker, Chairman
ADA State Advisory Council
Dept. of Mental Health
P.O. Box 687
Jefferson City, MO 65102

Nancy Dykstra
Missouri Habilitation Assn.
401 E. Locust
Columbia, MO 65203

Kay Conklin, Director
MO Planning Council for
Developmentally Disabled
P.O. Box 687
Jefferson City, MO 65102

Jim Tuscher
Paraquad
5100 Oakland Avenue, Suite 100
St. Louis, MO 63110
Phone: (314) 534-5100
Fax: (314) 534-0055

Patti Van Tuinen, Pres.
MO Public Health Assn.
323 Monroe
Jefferson City, MO 65101

Missouri Head Injury Assn.
3632A West Truman Blvd.
Jefferson City, MO 65101

MO Ophthalmological Society
113 Madison Street
Jefferson City, MO 65101

Missouri Optometric Assn.
417 East High Street
Jefferson City, MO 65101

Robert Edmonds, M.D.
MO Chapter, American Academy
of Pediatrics
14256 Cobble Hill
Chesterfield, MO 63017

Alpha Fowler Bryan, M.D.
St. Louis County Health Dept.
121 S. Meramec
Clayton, MO 63105

Richard Gram
Grace Hill Neighborhood Health Center
2600 Hadley
St. Louis, MO 63106

James B. Gwinner
MO Assn. of Osteopathic,
Physicians and Surgeons
P.O. Box 748
Jefferson City, MO 65101

William L. Kincaid, M.D.
Director, St. Louis City
Dept. of Health
P.O. Box 14702, 9th Floor
St. Louis, MO 63103

Curtis Long
Assn. Industries of Missouri
411 Jefferson
Jefferson City, MO 65101

Duke McVey, President
Missouri AFL-CIO
208 Madison Street
Jefferson City, MO 65101

Crystal Williams-Havegik
MO Assn. for Planned Parenthood
P.O. Box 395
Jefferson City, MO 65102

Phyllis Rozanski
Citizens for MO's Children
2717 Sutton Blvd., Ste. 200
St. Louis, MO 63143

Rick Rother
MO Physical Therapy Assn.
411 East Broadway
Columbia, MO 65201

Mary Schantz
MO Alliance for Home Care
431 East McCarty
Jefferson City, MO 65101

Gordon Smith, President
Ozarks Area Business Group on Health
1211 S. Glenstone, Ste. 501
Springfield, MO 63804
App. 1A-Exhibit 22 cont.

James C. Stutz
Executive Director
St. Louis Area Business Health Coalition
1030 Woodcrest Terrace Dr.
Suite 130
St. Louis, MO 63141

Susan Vaughn
Missouri Head Injury
Advisory Council P.O. 809
Jefferson City, MO 65102

Janie Vestal, M.D.
Missouri Perinatal Assn.
1443 North Robberson
Springfield, MO 65802

Sheelah Yawitz
16100 Chesterfield Village
Chesterfield, MO 63017

Tommy Kuhbach
MO Assn. for Social Welfare
P.O. Box 942
Columbia, MO 65205

Candice Hawkins
Gov.'s Comm. on Employment of People
3315 W. Truman Blvd.
Jefferson City, MO 65102

Gordon Garrett, Executive Vice President
St. Louis Metropolitan Medical Society
3839 Lindell Blvd.
St. Louis, MO 63108-5225

Dr. Thomas Brandt
Professional Foot Care
1007 Southwest Blvd.
Jefferson City, MO 65101
Phone: (314) 635-1241
Fax: (314) 636-4137

Brent DeRossett, Assistant Administrator
Citizens Memorial Hospital
1500 North Oakland
Bolivar, MO 65513-3099
Phone: (417) 326-6000
Fax: (417) 326-0338

Elaine Doyle, RN
Family Care Associates
701 West High
Jefferson City, MO 65101
Phone: (314) 636-3313

Delilah Pennington, MS, R.N.
Department of Health
Bureaus of Primary Care and
and Community Health Nursing
P.O. Box 570
Jefferson City, MO 65102
Phone: (314) 751-6169

Elaine West, Exec. Director
MO Association for Community Action
2410 Hyde Park Rd., Ste. B
Jefferson City, MO 65109
Phone: (314) 634-2969
Fax: (314) 636-9440

Anne S. Deaton, Ed.D.
Deputy Director, Alternative Services
Division of Aging
615 Howerton Court
Jefferson City, MO 65109
Phone: (314) 751-3082
Fax: (314) 751-8687

Joe Hopkins
Delta Dental
8390 Delmar Blvd.
St. Louis, MO 63124
Phone: (314) 993-0101 x200#
Recep: (314) 993-9090

Deborah L. Origer, Exec. Dir.
Prudential Insurance Co. of America
Westview Place, Suite 500
12312 Olive Blvd.
St. Louis, MO 63141
Phone: (314) 542-4580
Fax: (314) 542-4585

Al Schubert, VP
Managed Care Vision Services Plan
231 S. Bemiston Ave., Suite 1000
St. Louis, MO 63105-1914
Phone: (314) 727-6616
(800) 544-1415
Fax: (314) 727-6424

Sherri L. Wheeler
Senior Account Manager Public Policy
Schering Laboratories
5313 N. MacArthur Blvd., #1039
Irving, TX 75038
Phone: (214) 580-0098
(800) 544-5420 x8203
Fax: (214) 580-8635

Bonnie Pinet
Medicaid Biller
Still Regional Medical Center
P.O. Box 1128
Jefferson City, MO 65101

Donna Dittrich
Missouri Statewide Parent
Advisory Network
1124 Bliss Drive
St. Louis, MO 63137
Phone: (314) 388-3180

Jay Yalowitz
150 N. Michigan Ave Ste 2500
Chicago, IL 60601
Phone: (312) 750-6017
Fax: (312) 750-8600

Fred Brown, Pres. & CEO
Barnes-Jewish-Christian Health Services
4444 Forest Park Avenue
St. Louis, MO 63108

Ilene Lensmeyer
MO Planning Council for the
Developmentally Disabled
Dept. of Mental Health
1706 East Elm
Jefferson City, MO 65101
Phone: (314) 751-8677
App. 1A-Exhibit 22 cont.

Dr. Charles Rice, M.D.
Department of Surgery
University of Illinois
820 Southwood
Chicago, IL 60612
Phone: (312) 996-5219

Mike Miller
Collins Rental, Inc.
Old Hwy. 6 West
Kirksville, MO 63501
Phone: (800) 654-1652
Fax: (16-665-9312

Kimberly Stern
Center for Health Policy Studies
9700 Patuken Woods
Columbia, Maryland 21046

Daphne Genyk
Mercy Health Plan
200 Stevens Drive, Suite 350
Philadelphia, PA 19113

Fred Fey, Director Strategic Planning
Healthcare USA
8705 Perimeter Park Blvd., Suite 4
Jacksonville, FL 32216
Phone: (904) 646-0090

Robert M. Fry, Parent Advocate
Mid-MOMental Health Center
1883 B Waterfront Drive, N.
Columbia, MO 65202
Phone: (314) 449-2511 x-250

Joan M. Mills
6821 Crisp Avenue
Raytown, MO 64133
Phone (816) 353-4106

Debra Pappas, Exec. Dir.
Alliance for the Mentally Ill
of Greater Kansas City
1005 Grand Avenue, Suite 520
Kansas City, MO 64106
Phone: (816) 472-0030

Lorraine W. Smitt
Department of Mental Health
1706 East Elm
Jefferson City, MO 65102
Phone: (314) 751-4122

Kay Conklin
Missouri Planning Council
P.O. Box 687
Jefferson City, MO 65102

Joann Noll
Show-Me Choices
1270 Bridle Road
Webster Groves, MO 63119

Wes Buffington
Missouri Association of
County Developmental Disabilities Services
309 N. Jefferson, Suite 223
Springfield, MO 65806

Mimi Barrow
Missouri Association of Private
Residential Resources
1240 Dautel Lane
St. Louis, MO 63146

Steve Graff
Missouri Association of Support Providers
175 W. Slater
Marshall, MO 65340

Wanda Fraser
9731 State Rd. "y"
Dittmer, MO 63023

Joel D. Ferber
Legal Serv. of Eastern MO
P.O. Box 4999A
Field Station
625 N. Euclid
St. Louis, MO 63108
Phone: (314) 367-1700

Barbara Belcher
Gov.Affairs Merck
6033 West 158th Street
Overland Park, KS 66223
Phone: (413) 897-3915
Fax: (913) 897-2826

R. Jerry Morales, Executive Assistant
Community Health-In-Partnerships Services
2401 N. Grant
St. Louis, MO 63106
Phone: 314-652-9231

Thomas R. Bates
4090 Overall Road
Farmington, MO 63640

Marisa Richardson
316 Mill Street
Park Hills, MO 63601

Martha M. Pratte
813 W. Rollins Street
Moberly, MO 65270

Jan Asher, Activity Aide
Southeast Missouri Mental Health Center
Community Psychiatric Rehabilitation Center
1010 W. Columbia Street
Farmington, MO 63640-2997
Phone: (314) 756-0662

Monica Anthony
DMH
P.O. Box 687
Jefferson City, MO 65101

Keith Williams
P.O. Box 104146
Jefferson City, MO 65110

William E. Johnson
711 E. Jackson
Mexico, MO 65265

Tom Wallace
Eli Lilly
Suite 960
15301 Dallas Parkway
Dallas, TX 75248

Martha Sposito
Independence Regional Health Ctr.
1509 W. Truman Rd. Ste. 507
Independence, MO 64050

Madeleine Hawn
Gateway Home
11756 Borman Dr. Suite 135
St. Louis, MO 63146
(314) 997-1734

Teddy Costello
Gateway Homes
11756 Borman Dr.
St. Louis, MO 63146

Kay Green
DMH - MR/DD
1706 East Elm
Jefferson City, MO 65101

Fordyce Mitchel
DMH - MR/DD
1706 East Elm
Jefferson City, MO 65101

Sandra Dahlberg
SLARC
1816 Lackland Hills
St. Louis, MO 63146

E. Frank Ellis
Swope Parkway Health Ctr.
4900 Swope Parkway
Kansas City, MO 64130

Pamela Clyde
Delta Dental
8390 Delmar
St. Louis, MO 63124
Phone: (314) 993-9090

Steve Gaal
Delta Dental
8390 Delmar
St. Louis, MO 63124
Phone: (314) 993-9090

Dale Herrick
United Cerebral Palsy Assn.
106 E. 31st Terrace
Kansas City, MO 64111
Phone: (816) 531-4189

Robyn Kaufman
Boone Co. Group Homes & Family Support
1900 N. Providence, Ste 311
Columbia, MO 65202

Arlene Maminta
Boone Co. Group Homes & Family Support
1900 N. Providence, Ste 311
Columbia, MO 65202
Phone: (314) 874-1995