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Ethical Issues: Access in Missouri
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Medicaid spending in Missouri has been growing at double-digit rates since 1998, expanding to cover almost one in five citizens and contributing to the state's growing budgetary problems. Medicaid expenditures increased by almost 50 percent between 2001 and 2005 (from $4.2 billion to $6.3 billion), predominantly due to increases in enrollment, as well as changes in case mix.[i] In an attempt to curb this growing financial burden 90,000 enrollees were cut from the Medicaid roles in 2005 resulting in a fierce debate as to the morality of eliminating health care access for many of the most vulnerable citizens, such as the elderly, dying, and disabled.[ii] This $600 million cut was not without real and devastating consequences both ethically and economically. It took about a year, but ultimately those chronically ill, now without coverage and therefore without providers, found their way to safety net institutions like University of Missouri Health Care, putting more uncollected debt in the hands of state institutions, and ultimately the taxpayers. It also meant that almost $380 million of annual federal payments to the state were lost.

In 2006 there was a call for action by both the governor and the legislature to undertake a complete overhaul of the Missouri Medicaid program. Ultimately, in the early morning hours of Friday May 18, 2007 the Missouri General Assembly sent SB 577, the massive Medicaid overhaul bill, to Governor Blunt for signing. The adopted version of the final bill was the 146-page product of a conference committee that was formed when separate bills passed by the House and Senate conflicted. The Senate plan emphasized the use of managed care but gave way to the House version, which focused more on increasing provider reimbursements as a mechanism to improve access to health care.[iii] The new program will emphasize wellness, prevention, and personal responsibility, and will increases access to healthcare for many Missourians.

The final version renames the state Medicaid program "**MO HealthNet**" and creates an 18-member MO HealthNet Oversight Committee (including four physicians) to design the new system. MO HealthNet activates many important services for the underserved in Missouri by:

- Reinstating dental care and optometric services.
- Restoring coverage for durable home medical equipment and hospice care.
- Extending coverage for children age18-21 in the foster care program.
- Providing coverage for cancer screening.

- Covering family planning services for 90,000 low-income and uninsured women.
- Expanding eligibility under the SCHIP program to include children whose parents do not have access to affordable health insurance and those with parents participating in the state's drug court program.
- Extending coverage to women with incomes at or below 185% of the federal poverty level.
- Extending coverage to several thousand disabled workers by allowing a "Ticket to Work" program that will allow those who are 100% disabled to go back to work and earn a little money but not lose eligibility for healthcare as a result.
- Creating a premium offset pilot project to subsidize health insurance premiums for low-income workers.

Every enrollee will be offered a choice of at least three options called "Health Improvement Plans." Among the required options are risk-bearing coordinated care plans (managed care), administrative services organization plans (managed fee-for-service), and coordinated fee-for-service plans (essentially the existing Medicaid Chronic Care Improvement Program).

A cornerstone of this MO HealthNet is the promotion and establishment of "health care homes." Currently, Federally Qualified Health Centers (FQHC) serve as health care homes for nearly 300,000 Missourians. MO HealthNet expands the number of providers available by assigning each participant to a health care professional, not just a site, where enrollees will receive a health risk assessment and a health care plan designed to coordinate care and head off emerging health problems. Other highlights of the bill:

- The Department of Social Services (DSS) is required to devise a plan to increase provider fees to Medicare's levels within four years.
- The state is required to create a pay-for-performance program, but it is to be developed and overseen by a special committee composed of 18 members, nine of which are physicians.
- DSS is required to promulgate rules governing the use of telemedicine in the new program.
- No aged, blind, or disabled persons shall be required to enroll in a managed care plan.
- All health improvement plans are required to meet quality targets, help enrollees remain in the least restrictive environment, and offer call centers and nurse help lines to enrollees.
- Repeal of the mandatory second medical opinion for surgery.
- Abandons the plan to issue debit cards to give enrollees enhanced access to care in return for healthy behavior.
- The new program is authorized to require copayments for most services, but any copay amount will be in addition to, and not in lieu of, payments made by the state to the provider.
- Allows state income tax deductions for long-term care insurance premiums, and provides other incentives for people to purchase those policies.

The new law goes into effect on August 28, 2007, but the first phase of implementation will not begin until July 1, 2008. Enrollment is to be completed by 2011.

The moral context of healthcare is primarily about patients and it is irrational to think that eliminating services for those who cannot afford to pay will eliminate the need for them. Illness, suffering, and death, and therefore the need for health care, cannot be legislated away or otherwise minimized through bureaucracy. The universal need for healthcare is an undeniable reality, though fiscal responsibility admittedly cannot be ignored. Constructive economic adjustments will also consider provisions that improve quality, enhance prevention, and encourage personal responsibility for one's own health and health care. Providers, organizations and society, must therefore find ways to provide access to everyone by aligning incentives with quality and personal responsibility. MO HealthNet is a good start and Missouri has taken a huge step forward in meeting these challenges, but much more remains to be done if we, as a society, are to effectively enable adequate and equitable healthcare for everyone.

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[i] Holohan J and Cohen M. *Cover Missouri Project: Report 4.* http://www.urban.org/url.cfm?ID=1001004. July 05, 2006
[ii] Morris F. *Debating Medicaid and Morality in Missouri*. NPR. May 30, 2007
[iii] Holloway T. *MSMA Legislative Report* Number 19. May 21, 2007