Introduction

In February 2019, McKinsey and Co. released a report on Missouri’s Medicaid system called “Rapid Response Review: Assessment of Missouri Medicaid Program,” with suggestions for ways to “transform” the system. Through this paper we colloquially refer to this review as “the McKinsey report.”

This “Rapid Response Review” was commissioned by the Governor and the Department of Social Services. We anticipate that the report will be used by members of the Administration and the Legislature to advocate for Missouri’s Medicaid System.

Should Missouri’s elected officials attempt to advance a major overhaul of the state’s Medicaid program, it will be essential that those who advocate on behalf of Missouri’s patients and consumers participate in the discussion. Missouri Health Care for All hopes that this summary of the report will help those who care about Missourians’ health care to understand the report, generate internal conversations, and prepare for upcoming public conversations.

The McKinsey report on “Medicaid Transformation” incorporates a number of ideas and excludes some important considerations. This summary outlines the “good, the bad, and the (invisible) ugly” parts.


Summary

This analysis is not intended to be exhaustive but to convey the overall trend of the ideas in the McKinsey report and what they might mean for Missouri’s Medicaid system and, most importantly, the Missourians who rely on Medicaid for their health care.

The report includes some important observations and good ideas, many of which have been suggested by advocates for years. The report also includes some very troubling suggestions, with insufficient evidence that the suggested changes would help, and not hurt, Medicaid participants.

Most concerning is the philosophical orientation of the report. In general, the report seems to blame the state’s budget woes on the Medicaid program, ignoring the impact of repeated tax cuts and the state’s refusal to expand Medicaid on the budget. Throughout the report, McKinsey recommends strategies which might raise corporate profits or cut state costs, but which could very well worsen health care access for vulnerable Missourians in the process.
Missouri needs a Medicaid program that is oriented primarily to meeting the health needs of low-income Missourians. Financial stability is an important consideration for the state, but cutting vulnerable children, adults, and families off of their health care is an unjust and immoral path to saving state dollars or raising corporate profits.

**Missouri Health Care for All**

Missouri Health Care for All is Missouri’s only statewide, non-partisan movement dedicated to the principle that every Missourian deserves quality, affordable health care.

In reviewing health policy proposals, our primary lens is the impact the proposed policy will have on real people in the state of Missouri. We pay particular attention to the anticipated impact on those with high medical needs and those who struggle most to access quality, affordable care, including communities of color, rural communities, low-income families, and people with disabilities.

Missouri Health Care for All believes deeply in the dignity and worth of all people, and we believe that health care is primarily a moral issue, not a political one.

**What is McKinsey and Company?**

McKinsey and Co. is a global management-consulting firm that pioneered applying accounting principles to general business operations. They’ve grown from a firm with a few dozen consultants to a very large organization with 27,000 employees worldwide. They advise corporations, individuals and government on everything from contracts to technology to public affairs.

McKinsey keeps a low public profile, so despite its massive size and influence, few in the general public are familiar with its operations. “The firm,” as it is known, generates $10 billion a year in revenues and is associated with a number of high profile controversies and failures, including Enron, the 2008 financial crisis, working with despotic governments to improve their image and increase their influence in western countries, and various conflict of interest scandals.

In the health care sector, McKinsey advised the maker of OxyContin, Purdue Pharma, to “turbo charge” sales of the opioid by pressuring doctors to prescribe more, to push for higher doses of OxyContin, on how to counter the “emotional” messages of mothers who have lost children to overdose, and how to bypass pharmacies with a direct mail order business.

Finally, McKinsey was hired on a controversial merger project by Centene that is currently the subject of a class action lawsuit.

**Context**

The McKinsey Report was not released in a vacuum. The following considerations factor into how to interpret the report and the intentions of those who commissioned and produced it.

- The Parson administration, in partnership with the Missouri Attorney General’s office, has launched a Medicaid Waste, Fraud and Abuse Task Force, despite extremely low levels of fraud in the program.
Over 70,000 Medicaid recipients have been recently dropped from the rolls because they did not return an eligibility form sent by conventional mail with a very short return deadline. Many did not learn they were no longer on Medicaid until they were denied services. Approximately 50,000 of those who have been dropped are children. Service providers have found that many, if not most, of the people who have dropped do, indeed, still qualify for the program.

MOHealthNet has made a budget request of $34 million dollars for undefined consultant and technical services related to the Medicaid program. No details about how this money will be spent have been made available.

This “Medicaid Transformation” review, though compiled by McKinsey, only refers to the company in footnotes. There are no indications of the company’s involvement included in the report or on the DSS website. We believe it is important to keep the controversial nature of McKinsey’s business practices and its possible conflicts of interest top of mind when examining these recommendations.

The cost of the contract to produce the 115 page “rapid response review” was $2.7 million, the most expensive bid of all the responses to the State’s request for proposals.

The Good

The report provides good information and data on the internal processes and outcomes of the Medicaid program.

There are a number of valuable insights and good ideas in the report. It is important to note, however, that most of these ideas are not new and have been suggested by many advocates, providers, policymakers and departmental staff in Missouri for years.

Some of these valuable observations and insights are:

*Acute Care:*

- Recognition that Missouri’s Primary Care Health Homes (PCHH, pg. 24) and Community Mental Health Center Health Homes (CMHCHH, pg. 25) are national models of integrated, coordinated care, and are akin to “value based payment” models.

- The need for a better re-admissions policy (pg. 28).

- Remedy the low reimbursement rates for doctors, which make practical access for Medicaid recipients elusive (pg. 29, 39).

- A significant physician shortage problem in the state, especially in rural areas (pg. 36, 39).

- An emphasis on care coordination which, when done well, helps patients to avoid problems like “exacerbations and complications” (PEC, pg. 30), and improves tracking of outcomes for patients (pg. 35).
• Timely observations about the potential issues with “provider tax payments” (pg. 37) and “disproportionate share” payments (DSH, pg. 37).

• Addressing the low payment levels of rural and safety net providers, which could help them be more viable (pg. 39).

• Updating the durable medical equipment fee schedule and procurement list, which could include Medicaid coverage for equipment such as hearing aids (pg. 42).

**Long Term Care Services:**

• Changing the Medicaid institutional bias in favor of nursing homes and replacing it with a focus on home and community services.

• Updating/finishing the “rebalancing” initiatives designed to get more people living in the community, “aging in place,” and receiving services and supports to keep them out of nursing homes (pg. 53).

• The desperate need to improve the level of care assessment process for long term care services (pg. 50).

• Making the “no wrong door” system of being able to access services and supports from multiple points more consistent and less cumbersome for participants (pg. 49).

• Reforming how nursing homes are funded and building incentives/requirements to provide quality care (pg. 51).

• Getting people out of nursing homes who could live in the community with the proper mixture of services and supports, like “Money Follows the Person” (pg. 52, 56).

• Turning Money Follows the Person into a waiver service, in order to keep the program from expiring and shift more people out of institutions and into the community (pg. 52).

**Pharmacy**

• Improving Missouri’s rebate capture rate and addressing “grandfathering”, which may affect the state’s ability to access lower cost drugs (pg. 59, 60).

**Managed Care**

• A recognition that the reporting requirements for MCOs, methods for compiling data and public access to this data needs significant improvement (pg. 67).

**Program Integrity**

• Identifying people who are dually eligible for Medicare and Medicaid (pg. 74) and those who are eligible for Medicare (pg. 78).
- Improving data gathering and use (pg. 76).
- Better coordination of the various agencies responsible for fraud, waste, and abuse (FWA, pg. 75).

**Federal Reimbursement**

- Improving federal match for programs such as Alzheimer’s services, communicable diseases treatment, autism, crisis intervention, and emergency room enhancements (pg. 80).
- Leveraging federal program initiatives for substance use disorder/opioid use disorder (SUD/OUD) treatment, particularly in health homes (pg. 81, 82).

**MMIS**

- Recognition that the IT infrastructure of Missouri’s Medicaid program is antiquated, fractured, and requires modernizing (pg. 83-92).
- Moving more or all IS/IT services “in-house” rather than outsourcing to contractors (pg.92).

**Operations**

- A thorough explanation of problems with communication and integration of systems between Family Support Division and MOHealthNet (pg. 93).
- Integration of FSD and MHD systems responsible for handling communication with participants (pg. 99).
- Identification of staff intensive, repetitive tasks as a significant cause of errors in enrollment, disenrollment, delay in identifying and correcting mistakes, and other problems (pg. 99).
- Demonstration that the over reliance on call centers/live contacts, under-staffing, and the lack of viable alternatives (like robust online “self-service” options) due to problematic IT infrastructures are linked (pg. 100).
- Possible solutions to improve access, communication, and services, and to address the problem of high wait times at call centers (pg. 101, 102, 107)

**Implementation Considerations**

- An acknowledgement that not much in the report’s recommendations is new: “The assessment of the state’s Medicaid program revealed that the Departments responsible for the Medicaid program are aware of many of the opportunities identified...” (pg. 111)
The Bad

Despite the good observations and ideas contained in the report, there are many concerns about the report’s underlying assumptions and ill-advised recommendations.

The overall argument is weighted toward the language, structure and culture of managed care.

- While a “fee for service” (FFS) system without any coordination or integration of care is not ideal, McKinsey’s argument that it should be replaced by a value based payment (VBP) model (“payment for outcome”) is the carrot counterpart to the risk-based stick of managed care.

- The report assumes that since “many” other public and private payors are “migrating” toward VBP and abandoning FFS, then Missouri should too. McKinsey and Company cites its own research to argue that “…well-designed APMs (alternative payment models) improve the quality of care and can meaningfully reduce the cost of care if implemented across the full spending base.” (pg. 13)

- The argument for “transformation” is based mostly on cost containment for the state and payment incentives for providers. The report begins with an assumption that cutting costs in the Medicaid program is the primary goal in any program overhaul, rather than prioritizing patient care or seeking balanced solutions.

- While acknowledging that Medicaid already uses payment models (in both FFS and managed care context) to incentivize better integration, coordination and outcomes for care, McKinsey argues that Medicaid spending is out of control as state GR expenditures have risen across time (pg. 14).

The public health insurance programs (Medicaid and Medicare) consistently outperform private insurance on a cost per member basis. And while enrollment growth is mostly responsible for increased costs, Medicaid expansion (for example) is shown to save states money as well as improve health outcomes.

The report includes extensive detail about the problems of antiquated, fractured IT structures which:

1. make cross departmental communication difficult and inconsistent
2. require staff intensive, manual processes which increase enrollment and other processing errors
3. cause long call center wait times
4. encourage weak oversight
5. facilitate missed federal match opportunities

However, none of the IT issues are quantified with specific numbers to illustrate the costs of such dysfunction.

Since patient, program and performance data is scattered in various systems which are not integrated and cannot communicate across networks, and since the condition of the IT network is cited as a reason for lack of public transparency on Medicaid outcomes, it is very difficult to assess the accuracy of many of the report’s conclusions.
The report says Missouri can save up to $300 million if it implements all the managed care suggestions in the report, but gives no estimates on how much updating MMIS and improving operations would save, even though these two areas are consistently mentioned or alluded to in the report as reasons for problems, inefficiencies and errors in the current system.

There is no way to assess how McKinsey calculated the savings it quotes for each section in the executive summary, even though at the end of the report it emphasizes the need for a “detailed and objective fact base” (pg. 113).

Other Problematic Ideas:

**Acute Care**

- Tying nearly every outcome to “risk” or “incentives.” Value based payment (VBS) could be a good idea. It could also be a means to moving Missouri to a complete managed care system, contrary to data showing that access to health care suffers under managed care. (pg. 40)

- Recommending prior authorization requirements in a system which does not communicate well internally or externally, where providers already have difficulty getting paid and see Medicaid as too cumbersome, will lead to less access, not better access, to care. (pg. 38)

- Bundled payments/episode based models (pg. 40) are cited as being effective (especially when combined with population-based models, pg. 40), but no data or analysis is cited to support these claims. The assertion that other states and private payers are moving in this direction does not explain whether this would work well in Missouri, and under what conditions.

- Moving FFS and MCO participants and patients into one payment model (VBS) gives managed care companies even more leverage than they already have.

**Managed Care**

The report repeatedly privileges the interests of managed care companies over the interests of patients.

- Opt out/“day one eligibility” for managed care prioritizes the convenience of corporations over the affirmative choice of patients (pg. 65).

- The report implies that care coordination and management should be shifted away from health homes for patients who are enrolled in managed care Medicaid, despite evidence that health homes have a stronger track record in producing good patient outcomes (pg. 66).

- The report recommends increasing dependence upon automated algorithms to reward “high performing” MCOs with new enrollees (pg. 66). Oversight needs to be strengthened on many fronts; without both effective staff oversight and a modernized IT infrastructure, simply relying on algorithms is likely to lead to poor outcomes for consumers.

McKinsey suggests carving more services, such as pharmacy benefits, into managed care (pg. 69, 72), despite the fact that few of the performance benchmarks in current contracts are being met.
Finally, the report suggests moving aged, blind and disabled (ABD) populations into a managed care system (pg. 69, 72). All of the research cited to support this argument is published by McKinsey (two reports) and the Trump Administration. Meanwhile, the report ignores substantial evidence that managed care does an inadequate job of insuring services for people with complex, acute, medical and mental health needs. Enrolling dual eligibles in managed care is another “popular” trend identified by the report.

The report implies that the “popularity” of including ABD and dual-eligible populations in managed care in other states is a good reason for Missouri to follow suit. The writers suggest that these trends “...may be due to a belief that managed care models present opportunities to improve care management and thus improve quality, outcomes and experience for this population, while increasing the efficiency of the program by better managing medical cost trends over time.” However, no actual evidence or analysis is offered to support this belief, beyond a report also written by McKinsey. It should be noted that at least one managed care company is among McKinsey’s clientele.

*Operations*

The report makes workforce recommendations without addressing the need for more state staff and better pay (pg. 104). Call center triage and online options (pg. 108) mean little if you don’t have IS/IT infrastructure and enough staff capacity to handle participant needs.

It’s also important to remember that not all areas of the state have the same access to high speed internet and many people access the web on mobile devices or by “tethering” a laptop to a smartphone. These connections may be slow, intermediate and cost the participant “per minute.”

**The Invisible Ugliness**

This report addresses many issues with MOHealthNet and offers many recommendations. But what it does not say or address is just as important.

*A few examples:*

- Though the report mentions looking for ways to “capture” more “federal funding” (pg. 79), it never mentions the most obvious way to do so: Expand Medicaid. Closing the state’s Coverage Gap by expanding Medicaid would draw down more federal dollars, bolster rural health care access, keep hospitals from closing, and improve access to care.

- McKinsey cites in the beginning of the report how much Medicaid costs and how those expenses will take up a greater share of general revenue over time if cost containment strategies (like the ones recommended in the report) aren’t implemented (pg. 11-14). However, the report completely ignores the fact that Missouri’s budget woes are worsened by tax cuts and tax incentives implemented nearly every year by the General Assembly. Even when a tax cut said to be intended to cut $15 million actually costs the state over $100 million, there is no urgency to correct the error. The whole tone of the report regarding Medicaid costs reflects the talking points of partisans who blame safety net program participants for ballooning deficits, rather than the tax cuts they habitually pass.
• The report assumes that public health insurance programs should be run and managed like private business. Government is not a business, and therefore using bottom line thinking to assess and solve problems in a civic, public policy, health care, and legislative context imposes an ill-fitting framework on our deliberations.

• We cannot know if McKinsey has any conflicts of interest because we don’t know who all their current clients are. Missouri-based Centene hired McKinsey as recently as 2018.

• Nearly all of the major recommendations for “transformation” can be found in other reports on McKinsey’s website. It’s fair to question whether Missouri is getting tailored recommendations for our state or cookie cutter solutions.

• Though many of the ideas related to bringing down pharmacy costs and reversing institutional bias in favor of nursing homes are valuable, it should also be noted that pharmacy and nursing homes are usually foremost in other states in winning carve outs from managed care. Many of these recommendations would undermine their ability (along with hospitals and HCBS providers and vendors) to effectively mount opposition to shifting all services to managed care.

• Many of the ideas and problems identified in this report have been talked about in Missouri for a long time. It’s unfortunate that these good ideas are gaining some traction only after an outside consultant is paid $2.7 million to mention them.

• There is emphasis throughout the report on “risk” and equating all incentives with increased payments or tying more money with specific outcomes. However “realistic” or “pragmatic” this is assumed to be, it does nothing to give patient and recipient stakeholders true power because the system is focused on profits, not people.

The issues mentioned above are all within the scope of the report because all of these points, in some way, directly relate to the subject matter of Medicaid “transformation.”

Conclusions

The core mission of Medicaid is to provide comprehensive health coverage to low-income people so they can get the health care services they need.

Notwithstanding the good ideas contained in the report, the report privileges profits, cutting state costs, and partisan ideology over any substantial consideration of how to make Medicaid work best for the people who use it. Moreover, the report tries to sell the “Show Me State” on substantial program changes without adequate independent evidence to support its suggestions.

Medicaid is a lifesaving program for those who participate in it. Any attempts to radically remake it must engage community stakeholders and focus on the impact changes will have on the Missourians served.

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