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HEALTH CARE AND HUMAN SERVICES POLICY, RESEARCH, AND CONSULTING - **WITH REAL-WORLD PERSPECTIVE**.

MO HealthNet Clinical Services Report

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About This Report

- Lewin is charged with conducting a review of selected areas of the MO HealthNet Clinical Services Program for potential short and longer-term cost-savings and areas in which operational effectiveness and efficiency could potentially be improved
- We used the following broad criteria to weigh which areas to recommend for more in-depth reviews:
  - Savings potential: Based on what we have learned so far about MO HealthNet
  - Current issues: Things that we have identified based on research we have conducted to date or we have heard from MO HealthNet staff
- Based on this criteria, MHN staff and Lewin identified the following areas for in-depth reviews:
  - Inpatient Hospital
  - Outpatient Hospital
  - CCIP (the current care coordination/management program – we also comment on care coordination/management more generally)
  - DME
  - Hospice

Big Picture Observations

- The Missouri Medicaid Program relies heavily on contractors to manage the $6 billion program, rather than building additional capacity in-house.
  - We believe managing such a large program, even with reliance on outside contractors, requires an investment in management resources to adequately define contractor requirements, implement changes, monitor performance, and evaluate impact. Our preliminary findings suggest more resources are needed in this area.
- A heavy dependence on provider taxes for state financing, combined with outdated reimbursement methodologies (e.g., per diem and percent of charges), inhibits opportunity for significant program efficiency improvements
  - In particular, institutional providers are incented to maximize services in the costliest settings and the perceived benefits of coordinated care models are diminished
- Significant care management opportunities exist for the Medicare dual-eligibles, but savings largely accrue to Medicare
  - Review of CCIP and hospice suggest MHN investment in managing benefits or service delivery would not benefit MHN; however, investigating shared savings approaches with CMS might be warranted
- Additional resources are needed to replicate the success exhibited by MHD's management of the pharmacy benefit in other clinical areas

MO HealthNet Clinical Services Strengths

- MO HealthNet has many strengths in the selected clinical areas of review, including:
  - CyberAccess continues to be enhanced and is increasingly used by Missouri providers to expand their knowledge base and facilitate efficient interaction with MO HealthNet
  - CCIP has innovative care management components, for example, connectivity between CyberAccess and CareConnection and health coaches in selected FQHCs and Truman Medical Center
  - SmartPA has extensive algorithm-based rules to maximize pre-certification in clinically-related areas, including DME
  - Inpatient hospital admissions are being given increased emphasis with the Inpatient Review Services contract transition

Clinical Focus Areas

- **Inpatient Hospital**
- **Outpatient Hospital**
- **Chronic Care Improvement Program (CCIP)**
- **Durable Medical Equipment (DME)**
- **Hospice**

Inpatient Cost Containment Programs

- Due to the high cost of hospital inpatient care, programs to reduce admissions and LOS have been a key strategy for payers in their cost containment efforts
- Inpatient hospital cost containment programs target several areas, including:
  - Precertification review programs to avoid unnecessary admissions and ensure appropriateness of inpatient level of care or procedure
  - Management of LOS and avoidance of readmissions
    - Precertification of elective admissions
    - Concurrent stay review to ensure that each inpatient day meets the inpatient level of care requirements
    - Discharge planning to ensure a safe transition to another level of care
  - Efforts to hold hospitals and primary care providers responsible for avoidable inpatient admissions and stays
    - Monitoring volume of admissions for ambulatory care sensitive conditions and incorporating financial incentives
    - Reducing or withholding payments for “never events” (serious and costly errors in the provision of health care services that should never happen) in hospital settings

MO HealthNet is doing some of these already, including expanding its pre-certification process

Summary Inpatient Statistics (excludes admissions for dual eligibles)

- Summary data show that utilization and spending have been fairly steady over the past several years

Type of Admission	Fee-For Service Admissions			Fee-For-Service Days			Amount Paid		
	CY2006	CY2007	CY2008	CY2006	CY2007	CY2008	CY2006	CY2007	CY2008
Medical/Surgical	55,171	54,428	54,361	282,624	281,494	285,320	$295,561,456	$305,188,136	$310,678,287
Behavioral Health	19,072	19,656	19,680	139,904	145,648	143,324	$111,266,226	$121,106,262	$122,109,145
Maternity	19,852	19,939	17,255	50,256	50,041	43,671	$41,762,149	$42,886,394	$37,426,762
Newborn	19,810	20,120	17,577	70,318	70,639	63,956	$75,130,353	$74,963,813	$67,961,309
Total	**113,905**	**114,143**	**108,873**	**543,102**	**547,822**	**536,271**	**$523,720,185**	**$544,144,605**	**$538,175,503**
Percentage of Total									
Medical/Surgical	48%	48%	50%	52%	51%	53%	56%	56%	58%
Behavioral Health	17%	17%	18%	26%	27%	27%	21%	22%	23%
Maternity	17%	17%	16%	9%	9%	8%	8%	8%	7%
Newborn	17%	18%	16%	13%	13%	12%	14%	14%	13%
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%

Type of Admission	Amount Paid Per Admission			Amount Paid Per Day			Average Length of Stay		
	CY2006	CY2007	CY2008	CY2006	CY2007	CY2008	CY2006	CY2007	CY2008
Medical/Surgical	$5,357	$5,607	$5,715	$1,046	$1,084	$1,089	5.12	5.17	5.25
Behavioral Health	$5,834	$6,161	$6,205	$795	$831	$852	7.34	7.41	7.28
Maternity	$2,104	$2,151	$2,169	$831	$857	$857	2.53	2.51	2.53
Newborn	$3,793	$3,726	$3,866	$1,068	$1,061	$1,063	3.55	3.51	3.64
Total	**$4,598**	**$4,767**	**$4,943**	**$964**	**$993**	**$1,004**	**4.77**	**4.80**	**4.93**

Source: Lewin tabulations of claims data from inpatient file by date of service. Payment amounts are based on claim payments only and do not include add-on payments such as Direct Medicaid payments or supplemental GME payments. Inpatient hospital payments from claims average approximately 35% of total inpatient hospital payments including add-ons.

Payment Per Admission Distribution, CY2008 (dual eligibles' admissions excluded)

Admissions

Paid Amount	Med/Surg	Behavioral	Maternity	Newborn	Total
< $1,000	6,041	1,007	2,166	1,971	11,185
$1,000 - $9,999	41,568	16,268	15,007	14,721	87,564
$10,000 - $49,999	6,306	2,301	79	699	9,385
$ 50,000 +	446	104	3	186	739
Total	54,361	19,680	17,255	17,577	108,873

% of Admissions

Paid Amount	Med/Surg	Behavioral	Maternity	Newborn	Total
< $1,000	11.1%	5.1%	12.6%	11.2%	10.3%
$1,000 - $9,999	76.5%	82.7%	87.0%	83.8%	80.4%
$10,000 - $49,999	11.6%	11.7%	0.5%	4.0%	8.6%
$ 50,000 +	0.8%	0.5%	0.0%	1.1%	0.7%
Total	100.0%	100.0%	100.0%	100.0%	100.0%

% of Dollars

Paid Amount	Med/Surg	Behavioral	Maternity	Newborn	Total
< $1,000	1.4%	0.6%	3.7%	2.2%	1.5%
$1,000 - $9,999	48.5%	58.5%	92.2%	48.5%	53.8%
$10,000 - $49,999	37.7%	30.3%	3.6%	22.4%	31.7%
$ 50,000 +	12.4%	10.6%	0.5%	26.8%	13.0%
Total	100.0%	100.0%	100.0%	100.0%	100.0%

Source: Lewin tabulations of claims data from inpatient file. Payment amounts are based on claim payments only and do not include add-on payments such as Direct Medicaid payments or supplemental GME payments. Inpatient hospital payments from claims average approximately 35% of total inpatient hospital payments including add-ons.

Approaches to Potential Cost Containment and Operational Efficiencies

	Short Term	Longer Term	Key Points
Decrease LOS		X	• Structure concurrent review and discharge planning • Complicated by reimbursement methodology
Decrease Avoidable Admissions		X	• Focused outreach to selected persons with multiple admissions to avoid subsequent health crises and minimize need for further admissions • Precertification of elective admissions • Evaluation and minimization of preventable admissions
Monitor and Maximize Contractor Performance		X	• Establish metrics for contract management and monitor them regularly • Strengthen financial incentives in contract
Restructure Reimbursement Methodology		X	• Per diem methodology does not incentivize hospitals to reduce LOS and move forward with discharge planning
Transition to Care Management	X	X	• Transition care management best practices • Increased emphasis on on-site health coaches
Monitor Inpatient Metrics	X	X	• Determine metrics for continuous review • Review metrics regularly
Coordinate Care Coordination Program and Inpatient Review Services		X	• Notify Inpatient Review Services contractor upon each care coordination program enrollee's precertification and/or admission

Decrease Length of Stay

(Note: A thorough assessment of the inpatient reimbursement model is being separately procured by DSS and is not part of the scope of this Lewin engagement)

Length of Stay Distribution, CY2008 Admissions (dual eligibles' admissions excluded)

- MO HealthNet average inpatient LOS was about 4.93 days in 2008
- The 2007 national average for Medicaid patients was 4.3 days, more than a half-day less than MO[1]
- Longer stays are most common among behavioral health patients; 64% stay at least 5 days

Length Of Stay	Med/Surg	Behavioral	Maternity	Newborn	Total
1	9,765	1,144	2,464	2,866	16,240
2 - 4	25,951	5,971	13,941	13,076	58,939
5 - 9	11,790	8,304	675	672	21,441
10 - 29	6,006	3,952	157	621	10,736
30+	849	309	18	342	1,518
Total	54,361	19,680	17,255	17,577	108,873
% Distribution	Med/Surg	Behavioral	Maternity	Newborn	Total
1	18%	6%	14%	16%	15%
2 - 4	48%	30%	81%	74%	54%
5 - 9	22%	42%	4%	4%	20%
10 - 29	11%	20%	1%	4%	10%
30+	2%	2%	0%	2%	1%
Total	100%	100%	100%	100%	100%

[1] Source: AHRQ, Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project, Nationwide Inpatient Sample, 1997-2007, accessed at : http://www.hcup-us.ahrq.gov/reports/factsandfigures/2007/exhibit5_2.jsp.

Techniques for Decreasing LOS

- Operational mechanisms to avoid unnecessarily long LOS include:
  - Notification of all admissions in real time – Contractor at time of analysis will implement concurrent review system 5/31/10 - Nurses can document and review case notes relative to continued hospital LOS online and providers can request LOS extensions through CyberAccess - Efficient and beneficial to the hospitals and contracted nurses know the most relevant information for decision making
  - Concurrent review of inpatient admissions within parameters:
    - Review LOS extension requests
    - High LOS diagnoses – Daily review and in-depth discharge planning
    - LOS exceeding established threshold – Daily in-depth discharge planning and medical director involvement
  - Comprehensive discharge planning, including coordination of:
    - Home care
    - Transportation
    - Rehabilitation (outpatient facilities and SNF)
    - Telemonitoring
    - DME and supplies
  - Care coordination case manager/health coach involvement with care coordination program admissions for continuity, discharge planning, and follow-up

Decrease Avoidable Admissions

(Note: Analyses in this section exclude dual eligibles and obstetrical/newborn admissions)

Summary Statistics By Individuals' Number of Admissions Across 2006-2008 Timeframe (dual eligibles, maternity, and newborn admissions excluded)

- More than 42,000 persons had two or more admissions across the three-year timeframe
- 15% of all admissions (totaling $190 million in expenditures) occurred *after* individuals' 5th admission
- 6% of all admissions (totaling $71 million) occurred *after* individuals' 10th admission
- 830 people had 15+ admissions and incurred $35 million in inpatient care ($42,203 per person) *after* the 15th admit

Total Med/Surg + Behavioral Admits, 2006 - 2008	Number of Persons	Number of Admits	Med/Surg $	Behavioral $	Total $, Med/Surg + Behavioral	# Persons With This Number of Admits or More	Number of Admits Above This Level	Percentage of Admits Above This Level	Estimated $ Above This Level	Probability Persons Reaching This Level Will Have At Least One More Admit	Probability Persons Reaching This Level Will Have At Least Three More Admits
1	57,283	57,283	$187,439,446	$69,604,545	$257,043,991	99,504	122,864	55.3%	$699,447,341	42%	14%
2	19,053	38,106	$159,688,739	$58,690,247	$218,378,985	42,221	80,643	36.3%	$459,089,171	55%	23%
3	8,758	26,274	$114,863,192	$45,479,532	$160,342,724	23,168	57,475	25.8%	$327,197,030	62%	29%
4	4,752	19,008	$85,526,280	$32,608,732	$118,135,012	14,410	43,065	19.4%	$245,162,942	67%	35%
5	2,826	14,130	$63,964,220	$27,085,649	$91,049,869	9,658	33,407	15.0%	$190,181,317	71%	39%
6	1,807	10,842	$49,349,487	$21,906,896	$71,256,383	6,832	26,575	12.0%	$151,287,709	74%	43%
7	1,213	8,491	$39,291,791	$16,269,514	$55,561,305	5,025	21,550	9.7%	$122,681,096	76%	46%
8	860	6,880	$31,953,086	$12,660,802	$44,613,888	3,812	17,738	8.0%	$100,979,920	77%	48%
9	640	5,760	$28,602,382	$9,496,318	$38,098,700	2,952	14,786	6.6%	$84,174,603	78%	50%
10	483	4,830	$21,527,603	$9,189,137	$30,716,739	2,312	12,474	5.6%	$71,012,714	79%	52%
11	350	3,850	$17,924,242	$7,068,772	$24,993,014	1,829	10,645	4.8%	$60,600,477	81%	54%
12	286	3,432	$16,187,269	$7,044,257	$23,231,526	1,479	9,166	4.1%	$52,180,739	81%	56%
13	203	2,639	$11,637,961	$4,873,478	$16,511,440	1,193	7,973	3.6%	$45,389,159	83%	59%
14	160	2,240	$9,936,086	$4,164,795	$14,100,881	990	6,983	3.1%	$39,753,229	84%	61%
15	125	1,875	$7,745,019	$3,282,887	$11,027,906	830	6,153	2.8%	$35,028,157	85%	63%
16	97	1,552	$8,390,910	$2,193,568	$10,584,478	705	5,448	2.4%	$31,014,692	86%	64%
17	82	1,394	$5,217,586	$2,159,722	$7,377,308	608	4,840	2.2%	$27,553,434	87%	64%
18	73	1,314	$4,301,828	$2,278,911	$6,580,739	526	4,314	1.9%	$24,558,991	86%	63%
19	63	1,197	$4,819,503	$1,881,820	$6,701,323	453	3,861	1.7%	$21,980,126	86%	65%
20	57	1,140	$4,508,951	$1,757,584	$6,266,535	390	3,471	1.6%	$19,759,911	85%	66%
21+	333	10,131	$38,552,298	$14,784,470	$53,336,767	333	3,138	1.4%	17,864,189	89%	67%
Total	145,017	222,368	$911,427,879	$354,481,634	$1,265,909,513						

Source: Lewin tabulations of claims data from inpatient file. Payment amounts are based on claim payments only and do not include add-on payments such as Direct Medicaid payments or supplemental GME payments. Inpatient hospital payments from claims average approximately 35% of total inpatient hospital payments including add-ons.

Heavy Inpatient Utilizers In Any Given Year Tend to Have Multiple Admissions Across Years

- Utilization patterns suggest significant care coordination and intervention opportunities for frequent users
  - 207 persons had 10 or more medical/surgical admissions during 2007. Looking forward, this subgroup experienced 1,189 med/surg admissions during 2008 (an average of 5.7 admissions per person) with these CY2008 admissions collectively costing $6.8 million
  - Similarly, 1,388 persons had 5 or more med/surg admissions during 2007; this subgroup experienced 4,076 med/surg admissions during 2008 (an average of 2.9 admissions per person) with these CY2008 admissions collectively costing $24.3 million
  - 4,557 persons had 3 or more med/surg admissions during 2007; this subgroup had 8,107 CY2008 med/surg admissions (an average of 1.8 per person) with these 2008 admissions collectively costing $47.4 million
- Further condition-specific analysis needed to identify potential targets for appropriate interventions

Persons With Multiple Admissions are Mostly Receiving Medical/Surgical Care

- 2,312 persons had 10+ admissions for med/surg and/or behavioral health during 2006-2008 timeframe, accounting for 35,594 admissions
  - 25,100 of these admissions (70.5%) were for med/surg services
  - 10,494 of these admissions (29.5%) were for behavioral health services
  - 48% of this subgroup of 2,312 persons had at least one behavioral health admission
  - 23% had 10+ behavioral health admissions

Case Example: Individual with 47 Admissions in 2008, 130 Admissions Across 2006–mid-2009

- This individual had at least one admission in 10 of 12 months during 2008
  - Went to two or more hospitals in each of those ten months; was admitted to four or more hospitals in six different months
  - Maximum days in between admissions was 41
  - 41 of the 47 admissions came within a week of the previous admission, 28 were within 1-2 days of the previous admission. Of the 41 re-admissions occurring within a week, only 6 went back to the same hospital
- Most commonly admitted for chest pain, followed by behavioral health diagnoses; behavioral health admissions increased greatly year over year
- Was on the CCIP roster in January 09 and July 09
- Is consistently a high user - 28 admissions in 2007 and 33 admissions in 2006; also had at least 22 admissions during first eight months of 2009 (more may have occurred that were not counted due to claims lag)
- Total claims cost associated with these admissions was $64,000 in 2006, $146,000 in 2007, $199,000 in 2008 and $84,000 as of mid-2009
  - These costs are prior to supplemental payment add-ons
- While this is clearly an extreme case, it is intriguing. Evaluating this individual and applying the appropriate form of case management would likely prove cost-effective.
  - At a minimum, very extensive interventions seem warranted for the highest users

Readmissions for Selected "Preventable" Conditions – Congestive Heart Failure

- Congestive heart failure (CHF) is one of the most common conditions that leads to "preventable" readmissions within 30 days of the previous admission
- In 2008, 1,006 persons accounted for 1,499 admissions with a primary diagnosis of CHF, totaling $7.2 million
  - 253 persons had 2 or more admissions, accounting for 746 total admissions
  - 237 of these admissions (32%) occurred within 30 days of the previous admission, with the readmissions totaling $1.3 million
- Many persons with multiple CHF admissions in 2008 also had multiple admissions for CHF in 2007
  - 52 persons of the 253 (21%) had multiple admissions in 2007
  - Of the 227 admissions for these 52 people, 98 were readmissions within 30 days of the previous admission

Readmissions for Selected "Preventable" Conditions – Respiratory Conditions

- Chronic obstructive pulmonary disease (COPD) and other respiratory conditions (e.g., asthma) also lead to "preventable" readmissions within 30 days of the previous admission
- In 2008, 2,186 persons accounted for 2,994 admissions with a primary diagnosis of COPD or related condition, totaling $10.2 million
  - 445 persons had 2 or more admissions, accounting for 1,253 total admissions
  - 288 of these admissions (23%) occurred within 30 days of the previous admission, with the readmissions totaling $1.1 million
- Many persons with multiple COPD and related admissions in 2008 also had multiple admissions for these conditions in 2007
  - 108 persons of the 445 (24%) had multiple admissions in 2007
  - Of the 392 admissions for these 108 people, 120 were readmissions within 30 days of the previous admission

Proactive Outreach to Persons with Multiple Admissions can Create a "Triple Win"

- Improve and stabilize the health status of high-need beneficiaries
- Achieve sizable and much-needed financial savings for MO HealthNet
- Redeploy some persons in clinical workforce toward preventing health crises (rather than treating health crises)

Some readmissions are best prevented through strong counseling and discharge planning during the prior admission

Modeling of Outreach Efforts and Inpatient Usage Reduction Scenarios

- Intriguing options exist regarding level of outreach for frequent inpatient users and point at which such outreach should be "triggered"
  - There seems to be a clear need for more intensive outreach than currently occurs under CCIP contract for many frequent inpatient users; table below shows costs of three different levels of outreach, all of which are far more intensive than CCIP model (involving face-to-face visits and ongoing case management)
- Initiating "low outreach" at 3rd admission runs risks of losing money rather than saving money, but offers highest savings potential
- Initiating outreach (any level) at 15th admission almost assures net savings, but at somewhat modest annual savings (<$5 million); however, ignoring persons until their 15th admission cannot be an optimal cost or quality of care management strategy
- While the savings a given intervention will achieve are difficult to estimate with accuracy in advance, the net savings can be calculated with a good degree of accuracy retrospectively

		NET ANNUAL SAVINGS (COST) AT LOW OUTREACH ($1,200 per person per year, roughly one home visit and 12 hours of other case mgmt)				NET ANNUAL SAVINGS (COST) AT MEDIUM OUTREACH ($2,400 per person per year, roughly four home visits and 18 hours of other case mgmt)				NET ANNUAL SAVINGS (COST) AT HIGH OUTREACH ($3,600 per person per year, roughly six home visits and 24 hrs of other case mgmt)			
Total Med/Surg + Behavioral Admits, 2006 - 2008	Number of Persons	Outreach Costs at $1,200 Per Person Per Year	Percentage Inpatient Reduction Needed For Breakeven	Net Savings At 30% Inpatient Reduction	Net Savings At 50% Inpatient Reduction	Outreach Costs at $2,400 Per Person Per Year	Percentage Inpatient Reduction Needed For Breakeven	Net Savings At 30% Inpatient Reduction	Net Savings At 50% Inpatient Reduction	Outreach Costs at $3,600 Per Person Per Year	Percentage Inpatient Reduction Needed For Breakeven	Net Savings At 30% Inpatient Reduction	Net Savings At 50% Inpatient Reduction
3	8,758	$27,801,600	25%	$4,918,103	$26,731,238	$55,603,200	51%	($22,883,497)	($1,070,362)	$83,404,800	76%	($50,685,097)	($28,871,962)
5	2,826	$11,589,600	18%	$7,428,532	$20,107,286	$23,179,200	37%	($4,161,068)	$8,517,686	$34,768,800	55%	($15,750,668)	($3,071,914)
10	483	$2,774,400	12%	$4,326,871	$9,061,052	$5,548,800	23%	$1,552,471	$6,286,652	$8,323,200	35%	($1,221,929)	$3,512,252
15	125	$996,000	9%	$2,506,816	$4,842,026	$1,992,000	17%	$1,510,816	$3,846,026	$2,988,000	26%	$514,816	$2,850,026
20	57	$468,000	7%	$1,507,991	$2,825,319	$936,000	14%	$1,039,991	$2,357,319	$1,404,000	21%	$571,991	$1,889,319

Source: Lewin tabulations of claims data from inpatient file. Payment amounts are based on claim payments only and do not include add-on payments such as Direct Medicaid payments or supplemental GME payments. Inpatient hospital payments from claims average approximately 35% of total inpatient hospital payments including add-ons. Factoring in the supplemental payments would substantially lower the percentage in admissions reduction needed for break-even and would substantially increase the savings achieved thereafter.

Recommended Action Steps For Persons With High Volume of Inpatient Admissions

- MO HealthNet needs to flag admissions in real time to support outreach initiatives
- Once someone has their 3rd med/surg/psych admission within a 24-month window of time, arrange for outreach meeting with this person and/or with significant others during that admission if possible (or as soon as possible post-discharge). For persons amenable to the outreach program, strive to:
  - Establish a relationship between patient, family and the MO HealthNet care coordinator
  - Identify factors leading to this and prior admissions (medical and non-medical)
  - Develop plan for more stable management of health condition(s) to avoid future health crises including self management of system exacerbation
  - Conduct low-level (telephonic) ongoing outreach to track health status, provide coaching; encourage patient/family to contact PCP or care coordinator early for advice on increased symptoms
- Create an enhanced outreach approach for persons with higher number of admissions, involving home visits and more frequent phone interaction
- Track financial performance of each outreach program, assess net savings programs and modify program as appropriate

Overview of MO HealthNet's Pre-Certification Process

- Inpatient hospital admissions must be certified as medically necessary and appropriate as inpatient services by an outside contractor
  - All enrolled hospitals subject to this admission certification requirement
  - Requirement is not enforced, however, as payment is still made for admissions that were not pre-certified
- MO HealthNet contracted with a vendor from 2005-2009 to conduct inpatient pre-certification and continued stay reviews
  - In the process of transitioning to a new vendor for inpatient pre-certification and continued stay reviews
  - Contract begins in late December 2009
- Have faced challenges with the program as structured, including:
  - Very manual review process, with most requests received via mail or fax
  - Vendor has a review backlog due to staffing issues
  - Providers have sometimes encountered long telephone hold times
  - Timeliness of reviews has been a challenge

Pre-Certification Program Enhancements in Progress

- MO HealthNet released an RFI to gather information on potential bidders in an effort to improve the process
  - No responders offered greater sophistication than Missouri's existing model
  - In the meantime contractor at time of analysis had acquired nurse case managers and enhanced CyberAccess capabilities
- MO HealthNet also received CMS approval to add the hospital pre-certification component to its existing Clinical Management Services & System For Pharmacy and Prior Authorization (CMSP) contract
  - CMS approval facilitated enhancement without significant additional cost
  - Achieved increased Federal Financial Participation from 50% to 75% due to use of professional services
- Contractor's new capabilities met MO HealthNet's needs to enhance the pre-cert program quickly and enhance its electronic capability
- Goals of the revised transition and the use of the new automated SmartPA:
  - Improve cost and quality management activities by extending CyberAccess web capabilities
  - Better enable providers to submit inpatient certification requests
  - Improve MO HealthNet response time regarding prior approval decisions
- Phased implementation began September 23, 2009

Pre-Certification Program Enhancements in Progress (continued)

- Contractor at time of analysis will provide clinical personnel to manually review and make decisions for requests not adjudicated by the SmartPA rules engine
- Types of services to be provided:
  - Prior authorization reviews
  - Admission certification reviews
  - Continued stay reviews
  - Psychiatric certification of need reviews
  - Specialty pediatric hospital post-payment reviews
  - General consultation and focused studies
- Phased implementation is underway
- Phase I: Go Live 12/01/09
  - Transition of manual prior authorization and concurrent stay review to contractor scheduled for 12/28/09
  - Requests taken by phone, fax, or secure email
- Phase II: Go Live 02/10/10
  - Deployment of contractor's Integrated Care Management System (ICMS) in support of the inpatient review function by the contractor staff
  - Full clinical decision captured and stored in ICMS application
  - Requests taken by phone, fax, or secure email

Pre-Certification Program Enhancements in Progress (continued)

- Phase III: Go Live 03/20/10
  - Deployment of SmartPA for web precertification request and auto-determination
  - Manual nurse review used for those not processed by SmartPA and appeals
  - Requests taken by web, phone, fax, or secure email
- Phase IV: Go Live 03/31/10
  - Deployment of medication reconciliation and discharge summary via CyberAccess
  - Providers able to access documents on line
- Phase V: Go Live 05/31/10
  - Deployment of electronic concurrent utilization review via CyberAccess
  - Nurses able to document and view case notes relative to continued inpatient stay
  - Providers to request LOS extensions via CyberAccess

MO HealthNet Pre-Certification Process – Implementation and Monitoring Considerations

- Implementation timeframe appears very aggressive
  - Does not allow for time to review and evaluate progress by phase and adjust policies and procedures where indicated; MO HealthNet needs to determine, for example:
    - What metrics to track, e.g., call volume, approvals, denials, estimated cost savings, provider complaints, provider compliance, requests for LOS extensions, etc.
    - Reports to be provided to MO HealthNet and timeframe for each
    - What triggers will require action, and what actions must occur (and by whom) based on those triggers
  - Have not yet developed strong monitoring and evaluation methods, although we understand MO HealthNet staff have been discussing with contractor at time of analysis
  - Does not address level of effort required of MO HealthNet staff to monitor contractor
    - Staff already stretched thin and should be given enough time and resources to closely monitor implementation

MO HealthNet Pre-certification Process – Implementation and Monitoring Considerations (continued)

- Operational considerations
  - Focus on selected areas first, then evaluate progress
  - Target high volume hospitals to build infrastructure, including discharge setting preparedness (e.g., home care, rehabilitation facilities, long-term care transition)
  - Coordinate this program with care coordination program; ensure that potential care coordination enrollees get immediate referral to care coordination program
- Provider education/buy-in
  - MO HealthNet staff have met with Missouri Hospital Association (MHA) staff to explain goals; an MHA staff person serves as an ongoing liaison
  - MO HealthNet may not yet have engaged enough individual providers (e.g., high-volume hospitals) to determine how best to implement
  - MO HealthNet needs greater input and buy-in from the hospitals for its enhanced program

Monitor and Maximize Current Contract Performance

Monitoring and Maximizing Current Contract Performance

- Consider more strongly tying contractor profitability under the care coordination contract to MO HealthNet savings levels
- Develop a work plan for implementation and monitoring purposes and to establish key performance dates and activities against which to measure performance
- Establish key indicators (including savings) for contract management, including:
  - Admissions and avoidable admissions
  - LOS and avoidable days
  - Readmissions in 30, 60, and 90 days
  - Cases referred to care coordination program
  - Cases involving transition care management
  - Denial rates (admissions and days) (aggregate, trends: by procedure/by facility)
  - Cases pre-certified on line/manually
  - LOS extensions on line/manually
- Require periodic reporting and performance reviews
- Perform outlier case reviews

Monitoring and Maximizing Current Contract Performance (continued)

- Online capabilities should lead to reduced payments for nurse reviews
  - Unless nurses' roles are redirected elsewhere (e.g., for enhanced discharge management)
- Establish feedback loops
  - Hospital
    - Cooperation/compliance
    - Outliers in meeting discharge expectations
    - Poor results in discharge planning
    - Readmission outliers
    - Never events
  - Primary care
    - Potentially avoidable hospital admissions for complications of chronic disease
    - Identified access issues leading to inpatient admissions
    - Excessive ER use by member panel

Restructure Reimbursement Methodology

(Note: A thorough assessment of the inpatient reimbursement model is being separately procured by DSS and is not part of the scope of this Lewin engagement)

MO HealthNet Relies Heavily on Per Diem Payment Model that Most States have Abandoned

- Under per diem methodology, hospitals' incentives are to maximize length of stay, especially among lower cost patients
- Only 7 states entirely use prospective per diems (AK, AZ, FL, LA, MS, MO, NV)
  - The majority of states employ prospective payments using DRGs for at least some, if not all, of their inpatient services
- None of Missouri's border states exclusively follow the per diem model
  - Iowa, Kentucky, and Oklahoma: Prospective payment/discharge using DRGs
  - Kansas: DRGs or the percentage of charge for specific hospitals and services
  - Nebraska: Prospective payment/discharge using DRG and peer groups, cost based payment for critical access hospitals, prospective cost based per diem for psych and rehab hospitals/units
  - Illinois: DRGs or prospective per diems for psych and rehab hospitals/units, or facility-specific per diem for other specialty hospitals/units
  - Arkansas: Follows a cost-based payment model for pediatric, teaching, and critical access hospitals. Cost-based payments with daily caps are made for other acute hospitals, while rehab hospitals receive a prospective per diem rate
  - Tennessee: All beneficiaries enrolled in capitated MCOs
- While reimbursement model analyses are not within this engagement's scope, alternatives to existing per diem approach warrant close consideration
  - Any review must account for impact on, and necessary changes to, direct payments system and provider tax

Source: Kaiser Family Foundation Online Medicaid Benefits database, http://medicaidbenefits.kff.org/

Monitor Inpatient Metrics by Hospital and Intervene if Necessary

(Note: Analyses in this section exclude dual eligibles and obstetrical/newborn admissions)

A Few Hospitals Account for a Large Share of MO HealthNet's Fee-For-Service Admissions

	CY2008 Admissions				
Hospital Name	Med/Surg	Behavioral	Med/Surg + Behavioral	Estimated Average Persons Hospitalized On Any Given Day	Rank
BARNES-JEWISH HOSPITAL	4,719	385	5,104	75.6	1
TRUMAN MEDICAL CENTER HOSPIT	2,922	447	3,369	50.9	2
L E COX MEDICAL CENTER	2,018	1,085	3,103	50.7	3
ST JOHNS REGIONAL	2,680	407	3,087	46.7	4
POPLAR BLUFF REGIONAL MEDICA	2,045	766	2,811	44.7	5
DEPAUL HEALTH CENTER	1,003	1,253	2,256	39.4	6
ST JOHNS REGIONAL	1,224	950	2,174	36.6	7
UNIVERSITY OF MO-COLUMBIA	2,347	43	2,390	34.6	8
ST LOUIS UNIVERSITY HOSPITAL	1,660	354	2,014	30.9	9
HEARTLAND REGIONAL MEDICAL C	1,504	386	1,890	29.3	10
ST ALEXIUS HOSPITAL	548	1,030	1,578	28.4	11
TWIN RIVERS REGIONAL MEDICAL	1,168	555	1,723	27.9	12
SSM ST JOSEPH HEALTH CENTER	388	1,102	1,490	27.6	13
ST JOHNS MERCY	989	579	1,568	25.8	14
LAKELAND REGIONAL HOSPITAL		1,112	1,112	22.2	15
ST ANTHONY'S MEDICAL CENTER	725	571	1,296	21.8	16
FREEMAN HEALTH SYSTEM	1,026	341	1,367	21.6	17
CHRISTIAN HOSPITAL NORTHEAST	1,040	278	1,318	20.5	18
SSM ST MARYS HEALTH CENTER	1,021	222	1,243	19.1	19
PHELPS COUNTY REGIONAL	715	397	1,112	18.2	20
Top 20 Subtotal	29,742	12,263	42,005		
All Other Hospitals	24,619	7,417	32,036		
Total, All Hospitals	**54,361**	**19,680**	**74,041**		
Top 10 Hospitals' Share of Total Volume	41%	31%	38%		
Top 20 Hospitals' Share of Total Volume	55%	62%	57%		

Working More Closely with (and at) the High Volume Facilities Seems Worthwhile

- On an average day, the top 10 facilities are collectively serving more than 400 hospitalized MO HealthNet persons (counting only fee-for-service admissions, excluding dual eligibles and maternity/newborn care)
- This volume level makes viable on-site staff placement to:
  - Interact with selected patients (e.g., those with recent prior admissions) and their significant others during hospitalization to better understand circumstances that led to current admission and begin plan of attack for better health stability going forward
  - Coordinate specific discharge planning steps (directly or through care coordination program)
  - Provide phone follow-up upon discharge and either continued case management/care coordination or hand-off where warranted
- These services could be provided directly by MO HealthNet, or through:
  - Contracts with the hospitals themselves (e.g., Truman Medical Center pilot initiative)
  - Contracting with external care coordination organization(s), such as a care coordination program expansion
  - Latter approach avoids relying on hospitals to lower admission volume and/or LOS; although many hospital-sponsored managed care programs have proven effective at reducing inpatient volume
- Annual cost of placing one outreach worker at all 10 facilities would be roughly $500,000-$750,000
  - CY2008 costs for med/surg and behavioral health admissions across these facilities totaled more than $150 million – prior to factoring in supplemental payments not captured on the claims files
  - Thus, outreach effort would need to lower costs by less than 0.5 percent for this service to break even. A significant return on investment is clearly possible

Transition to Care Management

Post-Discharge Transitions to Step-Down Services

- Expand network capacity and enhance transition processes for ease of discharge to settings such as:
  - Home and community-based care
  - Rehabilitation services
  - Long-term care
- Identify dual eligibles at admission in order to prepare for transition to Medicaid covered care
- Institute transition care/discharge management program for patients identified as high risk for readmission based on:
  - Past history
  - High risk diagnosis (including serious mental illness and NICU discharges)
  - Multiple comorbidities
  - Lack of support upon discharge

Post-Discharge Transitions to Step-Down Services (continued)

- Elements of transition care management best practices:
  - Medical home is identified for continuity of care, with follow-up appointment scheduled and occurring
  - Discharge summary is shared with and available to medical home, transition setting if applicable, and other key outpatient providers
    - Will become available in CyberAccess next year
    - Contractor at time of analysis should follow up with care coordination program enrollees at high risk for readmission to ensure discharge instructions are followed through
  - Medication reconciliation occurs
    - Will be available in CyberAccess next year
    - Contractor at time of analysis should follow up with care coordination program enrollees at high risk for readmission to ensure medication reconciliation follow-through
  - Follow up occurs

Coordinate Care Coordination Program and Inpatient Review Services

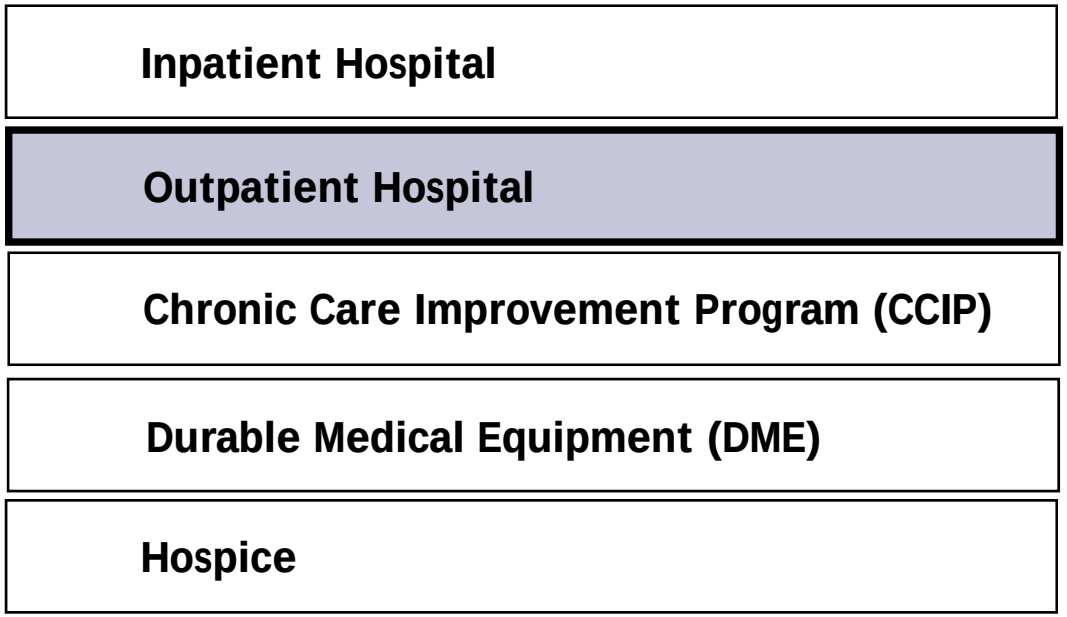
Most Persons With a Large Number of Inpatient Admissions Are Enrolled in the Care Coordination Program

- 2,312 persons had 10 or more admissions (across medical/surgical and behavioral health admission types) during the three-year period 2006-2008
  - These persons had 35,594 admissions, an average of 15.4 per person and 16% of statewide med/surg and behavioral health admissions
  - 1,647 of these individuals (71%) have been enrolled in the care coordination initiative at some point in time

Coordinate Care Coordination Program and Inpatient Review Services

- Inpatient services contractor should notify care coordination contractor of care coordinated enrollees upon precertification and notification of admission
- Care management and coordination contractor to include discharge planning/transition management for FFS population
- Determine if the Truman Medical Center pilot should be expanded to additional high volume hospitals

Clinical Focus Areas



Outpatient Hospital Claims Costs Have Increased Sharply in Recent Years

Service Category	Amount Paid			% Cost Increase		
	CY06	CY07	CY08	2006-2007	2007-2008	Average Annual Increase, 2006-2008
Outpatient Hospital	$278,250,849	$354,552,443	$385,080,822	27.4%	8.6%	17.6%
Inpatient Hospital	$523,720,185	$544,144,605	$538,175,503	3.9%	-1.1%	1.4%
Total Hospital	$801,971,034	$898,697,048	$923,256,325	12.1%	2.7%	7.3%

- Total fee-for-service costs increased 38.4% from 2006-2008, an average increase of 17.6% per year
- CY2008 outpatient hospital costs exceeded CY2006 by more than $100 million
- Some outpatient pharmacy costs were moved to the "pharmacy" category of service to garner rebates; all non-pharmacy outpatient hospital costs increased 44% from 2006-2008
  - By comparison, inpatient hospital costs increased only 3% from 2006-2008, although the 2008 increase in fee-for-service costs would have been larger had a managed care expansion not taken place
  - Outpatient hospital costs were 53% of inpatient costs during 2006, but were 72% of inpatient costs as of 2008
- Overall increases from 2007-2008 were below 10%, but were still quite steep (12.5%) if the pharmacy category is excluded (during 2008, some outpatient hospital pharmacy services were re-classified as "pharmacy" for rebate maximization purposes, driving a 32% "reduction" in outpatient pharmacy expenditures in that year)

Costs and Trends by Type of Outpatient Hospital Service

Type of Outpatient Hospital Service	# Claims			Amount Paid			% Cost Increase		
	CY06	CY07	CY08	CY06	CY07	CY08	2006-2007	2007-2008	Average Annual Increase, 2006-2008
Diagnostic Services	2,056,104	2,462,124	2,493,844	$100,017,636	$122,873,137	$133,550,886	22.9%	8.7%	15.6%
Outpatient Surgery (including medical/surgical supplies)	264,898	301,153	266,597	$64,706,325	$83,924,382	$96,206,149	29.7%	14.6%	21.9%
Emergency Room	330,655	391,966	383,387	$47,979,346	$64,601,168	$75,498,065	34.6%	16.9%	25.4%
Clinic	269,033	315,799	323,168	$13,759,560	$18,463,748	$22,186,149	34.2%	20.2%	27.0%
Pharmacy	378,802	450,407	342,768	$24,846,850	$30,969,613	$21,054,997	24.6%	-32.0%	-7.9%
Radiation Therapy	27,456	32,709	35,843	$7,137,227	$9,054,310	$10,131,996	26.9%	11.9%	19.1%
Cardiology	22,353	26,634	27,812	$4,656,734	$6,187,586	$7,103,972	32.9%	14.8%	23.5%
Treatment/Observation Room	36,851	38,101	34,265	$5,917,839	$6,764,373	$7,095,376	14.3%	4.9%	9.5%
All Other	203,060	232,881	224,897	$9,229,332	$11,714,126	$12,253,232	26.9%	4.6%	15.2%
TOTAL	**3,589,212**	**4,251,774**	**4,132,581**	**$278,250,849**	**$354,552,443**	**$385,080,822**	**27.4%**	**8.6%**	**17.6%**

- 80% of outpatient hospital costs occur in three broad categories: diagnostic services (35%), outpatient surgery (25%), and ER services (20%)
- Clinic services costs increased most sharply from 2006-2008 (27% per year), followed closely by ER services (25% per year)

Distribution of Diagnostic Services by Subcategory

	# Claims			Amount Paid				
Revenue Code Group	CY06	CY07	CY08	CY06	CY07	CY08	Average Annual Increase Cost , 2006-2008	Average Cost Per Claim, 2008
CT scan	69,417	86,262	89,517	$29,206,632	$37,241,856	$41,961,023	19.9%	$469
laboratory	1,570,864	1,889,060	1,918,598	$18,630,493	$23,224,287	$24,064,657	13.7%	$13
radiology - diagnostic	207,861	249,099	249,988	$16,760,797	$21,405,540	$23,299,303	17.9%	$93
MRI	19,296	18,646	18,212	$13,097,729	$12,744,312	$13,649,157	2.1%	$749
other imaging services	71,770	86,550	85,140	$9,463,524	$12,393,212	$13,166,500	18.0%	$155
nuclear medicine	14,223	16,214	16,880	$3,828,367	$4,442,571	$4,938,202	13.6%	$293
other diagnostic services	22,619	23,529	20,161	$3,108,938	$3,972,223	$4,202,052	16.3%	$208
EKG/ECG	46,705	54,977	58,299	$2,471,628	$3,091,091	$3,492,527	18.9%	$60
EEG	4,518	5,439	5,245	$1,717,208	$2,208,178	$2,485,517	20.3%	$474
laboratory - pathological	28,831	32,348	31,804	$1,732,319	$2,149,868	$2,291,948	15.0%	$72
All Diagnostic Services	2,056,104	2,462,124	2,493,844	$100,017,636	$122,873,137	$133,550,886	15.6%	$54

- CT scans are the costliest subgroup of diagnostic services, accounting for $42 million in CY2008 expenditures and $469 per claim. The claims volume of CT scans increased 29% from 2006-2008; the increase from 2007-2008 was only 3.8%.
- MRI exams had by far the lowest average annual expenditure increase (2.1% from 2006-2008) among the diagnostic services subgroups. The average cost per claim for MRI exams, $749 in 2008, was the highest among the diagnostic subgroups.
  - The volume of MRI claims decreased 5.6% from 2006-2008, whereas claims volume across all other diagnostic services increased 21.5%. This suggests that MO HealthNet's MRI prior authorization program could have had a significant impact on MRI usage and costs

Approaches for Potential Cost Containment and Operational Efficiencies

	Short Term	Longer Term	Key Points
Targeted ER Programs to Minimize Inappropriate Usage		X	• Identification of heavy ER users from claims data • Focus on ER diversion best practices
Prior Authorization Program for Outpatient Hospital Services	X		• While providers are required to seek pre-certification for certain procedures, not all do so • Impact of prior authorization cannot be easily measured
Revision of Outpatient Reimbursement Methodology	X	X	• Move away from percent-of-charges reimbursement
Shifting Routine Physician Care from Outpatient Hospital Setting to Less Costly Office/Clinic Settings		X	• Identify conditions and procedures that may be more appropriately addressed in a different outpatient setting (e.g. free-standing outpatient clinic) • Redirect procedures to ambulatory care settings as appropriate

Targeted ER Programs to Minimize Inappropriate Usage

Emergency Room "Frequent Fliers" Abound in MO HealthNet Population: 40,000 Persons Had At Least Three ER Visits During CY2008

- MO HealthNet Fee-For-Service Program, Dual Eligibles Excluded

Number of ER Visits During CY2008 (only selected rows shown after 10th visit)	Number of ER Users Reaching Exactly This Level	Number of ER Users Reaching At Least This Level	Percent of ER Users Reaching At Least This Level	Total ER Visits For Persons Reaching Exactly This Level	Total ER Visits After This Visit Level Is Reached	Percentage of Total ER Visits Occurring After This Visit Level Is Reached
1	91,940	166,002	100.0%	91,940	206,956	55.5%
2	34,387	74,062	44.6%	68,774	132,894	35.6%
3	15,955	39,675	23.9%	47,865	93,219	25.0%
4	8,422	23,720	14.3%	33,688	69,499	18.6%
5	4,862	15,298	9.2%	24,310	54,201	14.5%
6	2,906	10,436	6.3%	17,436	43,765	11.7%
7	1,906	7,530	4.5%	13,342	36,235	9.7%
8	1,267	5,624	3.4%	10,136	30,611	8.2%
9	913	4,357	2.6%	8,217	26,254	7.0%
10	675	3,444	2.1%	6,750	22,810	6.1%
15	179	1,342	0.8%	2,685	12,962	3.5%
20	78	685	0.4%	1,560	8,440	2.3%
25	43	423	0.3%	1,075	5,920	1.6%
30	20	258	0.2%	600	4,326	1.2%
40	7	129	0.1%	280	2,579	0.7%
50	1	67	0.0%	50	1,675	0.4%
60	3	42	0.0%	180	1,169	0.3%
Total	**166,002**			**372,958**		

Coverage and Usage Patterns of High-Volume ER Users Are Conducive to Intervention

- Most high-volume ER users are fairly habitual ER users across years; thus the pay-off from helping "mainstream" the way many of these persons access health care will accrue well beyond the confines of a given calendar year
  - Of the 15,298 persons with 5+ ER visits during CY2008, 51% had at least three ER visits during CY2007; 34% had at least five ER visits during CY2007
  - Those persons reaching 5 ER visits during CY2008 went on to have 54,201 *additional* ER visits during CY2008 alone
    - The average cost for ER visits themselves in 2008 was $204; the average cost for all outpatient services rendered during the ER visit was $395. Thus, the total outpatient hospital costs associated with the 54,201 ER visits occurring after persons' 5th ER visit were approximately $21 million during CY2008 (assuming these visits were of average intensity), with significant ER-related costs continuing to occur in 2009 and beyond

18 Hospitals Provided more than 5,000 ER Visits During CY2008

Provider Name	ER Visits, CY2008	Amount Paid for ER Visits	Amount Paid for All Outpatient Services in Conjunction With ER Visit	Average Paid Per ER Visit
L E COX MEDICAL CENTER	25,487	$4,846,646	$9,238,385	$190
ST JOHNS REGIONAL	17,725	$3,047,828	$5,668,120	$172
HEARTLAND REGIONAL MEDICAL CTR	12,756	$5,790,844	$9,953,514	$454
BARNES-JEWISH HOSPITAL	12,457	$3,540,990	$5,210,111	$284
ST JOHNS REGIONAL	12,113	$1,697,694	$2,718,416	$140
POPLAR BLUFF REGIONAL	11,488	$916,520	$2,358,347	$80
FREEMAN HEALTH SYSTEM	10,314	$1,802,895	$3,208,236	$175
TRUMAN MEDICAL CENTER HOSPITAL	9,684	$5,884,394	$9,388,060	$608
DOCTORS HOSPITAL OF SPRINGFIELD	9,446	$1,182,508	$2,185,011	$125
TWIN RIVERS REGIONAL MEDICAL	8,536	$1,355,178	$4,504,039	$159
SOUTHEAST MISSOURI HOSPITAL	7,987	$904,666	$2,470,843	$113
SKAGGS COMMUNITY HEALTH CENTER	6,997	$542,001	$1,557,490	$77
OZARKS MEDICAL CENTER	5,805	$1,097,521	$2,006,053	$189
FREEMAN NEOSHO HOSPITAL	5,623	$816,951	$1,226,436	$145
AURORA COMMUNITY HOSPITAL	5,606	$1,271,824	$2,051,154	$227
ST FRANCIS MEDICAL CENTER	5,555	$678,889	$2,041,035	$122
PHELPS COUNTY REGIONAL	5,131	$643,910	$1,395,102	$125
MISSOURI DELTA	5,033	$537,429	$1,788,167	$107
MCCUNE-BROOKS HOSPITAL	4,528	$611,726	$1,046,477	$135
ST LOUIS UNIVERSITY HOSPITAL	4,417	$1,034,226	$2,917,224	$234
Subtotal, Top 20 Hospitals	186,688	$38,204,640	$72,932,221	$205
All Other Hospitals (n = 530)	186,270	$37,861,378	$74,360,756	$203
Total	**372,958**	**$76,066,018**	**$147,292,978**	**$204**

Case Study: Individual with 457 ER Visits in 2008, 796 ER visits in 2006-2008

- This person had at least one ER visit on 255 different days during 2008
- ER visits were accessed at two or more hospitals on 140 different days
  - On 11 separate days, this person had four ER visits (each at a different hospital)
- Averaged 8.8 ER visits per week and 4.9 days a week
- Had ER visits on consecutive days more than 100 times
  - Widest gap between ER visits was 8 days
- Consistently a high user - 191 ER visits in 2007 and 148 ER visits in 2006
- On the CCIP roster in Jan 08, July 08, Jan 09, and July 09 (ER use ironically skyrocketed further during CY2008 when CCIP program began serving this person)
- Total outpatient cost associated with these ER visits was $45,000 in 2006, $68,000 in 2007, and $152,000 in 2008
- Extensive and intensive outreach to the highest volume ER users seems warranted and likely to yield sizeable net savings

Outpatient Hospital: Targeted ER Programs

- August 2008 National Health Service (NHS) Report states that in 2006, 13.9% of the Medicaid/SCHIP ER visits were for non-urgent reasons
- In 2008, 20 states, including Missouri, were awarded CMS grants for ER Diversion programs focused on the following "best practices":
  - Identification of high users from claims data
  - HIT as part of the ER & medical home coordination
  - Care coordinators co-located within the ER
    - Educate regarding appropriate non emergent alternative settings and self care
    - Coordinate ER transition care for follow up, medication, etc.
  - Specialty coordination for substance abuse, mental health and chronic medical conditions
  - New primary care access points
    - Expanded evening and weekend hours
    - Mobile clinics
    - Telemedicine
    - Urgent care clinics
- Missouri grantee is the St. Louis Integrated Health Network
  - Includes referral coordinators in ER and development of an electronic "network master patient index" (NPMI)

Source: CMS Grant Programs: Improving Access & Quality for Medicaid Beneficiaries and the Uninsured, 2008.

Outpatient Hospital: Targeted ER Programs (continued)

- ER diversion programs have shown success
  - A program in Manatee County, FL has diverted 3,000-4,000 Medicaid patients per year from ERs to community health centers[1]
    - Estimated $5.7 million dollars of Medicaid savings over 3.5 years
    - Plans to expand program into additional counties
  - Massachusetts League of Community Health Centers received funding for 15 different diversion projects in 2007[2]
    - Demonstrated utilization decreases of 1 – 15%
    - Awarded CMS grant in 2008
- MO HealthNet could work with St. Louis Integrated Health Network to identify successes and opportunities to expand program
- Opportunity to expand diversion programs through care coordination program

[1]http://www.chcanys.org/clientuploads/downloads/2008_Annual_Conference/Presentations/ManateeERDiversionProgram_Fusco_071408.pdf

[2]http://www.wcchc.com/Assets/Events/LeadershipConf08/MLCHC_12.3.08_JWHunt.pps#265,10,Successes

To Develop an Optimal Intervention Strategy, ER Usage Must be Assessed in Conjunction with Other Services

- Lewin's February deliverable on high-cost persons will assess following issues related to ER services:
  - Total claims cost distribution of high-volume ER users (across all covered services)
  - Degree to which high volume ER users are accessing care through office visits and/or clinic visits
  - Degree to which high-volume ER users are being admitted for inpatient care
- Outreach at the point of an ER visit may warrant consideration but also has drawbacks
  - The ER is a difficult setting for a care coordination conversation to take place
  - Patients often want to be treated and released ASAP

Prior Authorization Program for Outpatient Services

Prior Authorization Program for Outpatient Hospital Services

- Providers are required to seek pre-certification for certain diagnostic and ancillary procedures and services ordered by a health care provider unless provided in an inpatient hospital or ER setting
  - Services requiring pre-certification include CT scans and MRIs
- As shown earlier, MRI volume has decreased in recent years, dropping 3.4% from 2006-2007 and 2.3% from 2007-2008
- Overall volume for other outpatient diagnostic services increased 20% from 2006-2007 but only 1.2% from 2007-2008
  - The decrease in MRI volume during both years suggest that MO HealthNet's prior authorization requirements are having a meaningful and favorable impact for this service.
  - CT scan volume increased "only" 3.8% from 2007-2008 after a 24% volume increase from 2006-2007. However, CT scan volume increased more rapidly than did all other diagnostic services (excluding MRI exams and CT scans) in both years, raising some questions as to whether the prior authorization program for CT scans has been effective
- The impact of prior authorization programs cannot be easily measured. It is difficult to ascertain the degree to which providers do not even request an authorization (knowing that they may not receive approval) who would otherwise order the procedure if the prior authorization program did not exist

Source: Table 23 expenditure data, MO HealthNet.

Assessment of High-Volume Users of Imaging Services

- Imaging services were defined as being in any of the following revenue codes: CT Scans, MRI Exams, Nuclear Medicine, and Other Imaging
- 535 persons received an imaging exam on more than 10 different days during 2008, with highest individual receiving imaging on 92 different days
  - Many persons frequently receiving imaging during 2008 also received imaging on three or more days during 2007
- While some individuals may be receiving an excessive amount of imaging that could be detrimental to their health (and impose unnecessary costs on program), on the whole this assessment did not uncover any large-scale concerns
- MO HealthNet may want to track the number of imaging procedures each beneficiary receives to flag persons whose radiation accumulation may be becoming dangerous/detrimental

Number of Days an Imaging Exam Was Provided During 2008	Number Of Persons	Percentage of Persons Receiving At Least One Imaging Exam	Percentage of These Persons Also Receiving 3+ Imaging Exams During 2007
1 - 2 days	80,792	81.0%	4.3%
3 - 5 days	15,119	15.2%	13.2%
6 - 10 days	3,276	3.3%	26.6%
11 - 15 days	406	0.4%	41.1%
16 - 20 days	77	0.1%	48.1%
21+ days	52	0.1%	46.2%
Total	**99,722**	**100.0%**	**6.6%**

Revise Outpatient Reimbursement Methodology

MO HealthNet's Reimbursement Methodology for Outpatient Hospital Services Is Outdated

- MO HealthNet outpatient services are paid on a percent-of-charges basis
  - New Hampshire is the only other state to reimburse on a direct percent-of-charges basis
- More "modern" reimbursement methodologies are not tied to hospitals' charges, but rather involve predetermined payments for various types of services. Examples include:
  - Prospective or FFS payments using Medicare groupings – AZ,HI, IN, IA, KY, MI, MN, MT, NV, RI, TX, VT, WY
  - Hospital class/group rates – AR, UT, WA
  - Hospital-specific rates – CA, MA
  - Cost based payments – CO, DE, DC, GA, LA, ME, MS, NJ, NM, NC, OR, SD, VA, WI

Source: *Benefits by Service: Outpatient Hospital Services (October 2008).* Medicaid Benefits Online Database, Kaiser Family Foundation.

Payment Approach for Outpatient Hospital Services Needs Revision

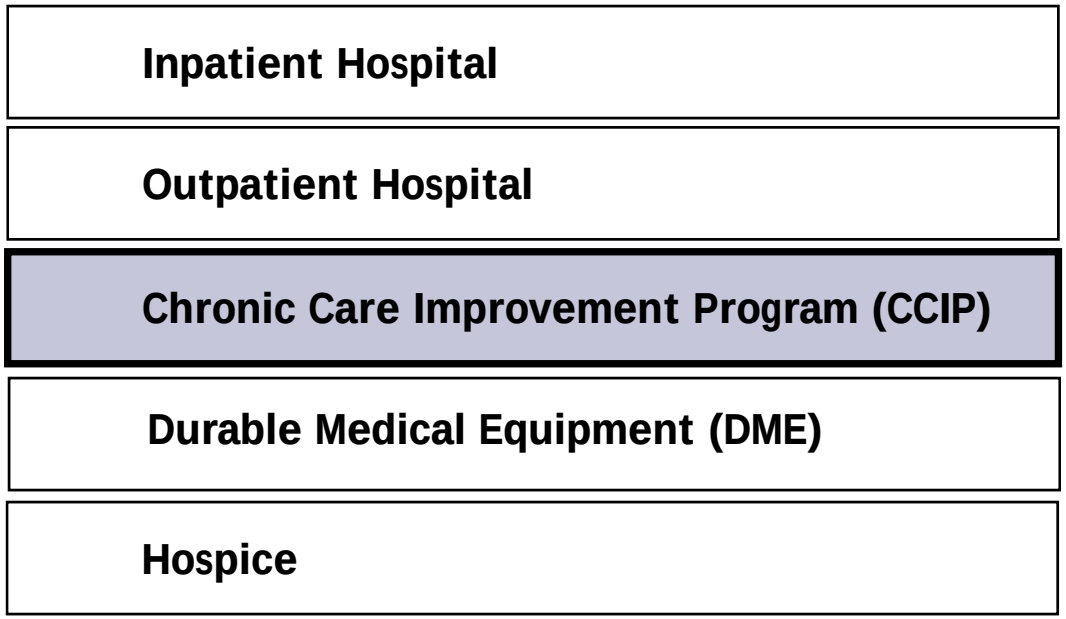
- Scope of this consulting engagement does not include an in-depth look at how to best reconfigure the payment system for outpatient hospital services
- MO HealthNet is well aware of the need to modernize its payment model and is committed to lining up a contractor to provide specific recommendations
- Lewin strongly concurs that MO HealthNet needs to move away from the percent-of-charges model of reimbursement
- Provider tax program implications will also need to be considered in this assessment; MO HealthNet's "hospital-friendly" outpatient payment methodology may be interwoven with the hospital tax program

Shift Routine Physician Care from Outpatient Hospital Setting to Less Costly Office/Clinic Settings

Shifting Routine Physician Care from Outpatient Hospital Setting to Less Costly Office/Clinic Settings

- Objectives:
  - Decrease avoidable procedures in hospital outpatient departments
    - Identify conditions and procedures that may be more appropriately addressed in a different outpatient setting (e.g. free-standing outpatient clinic)
    - Redirect procedures to ambulatory care settings as appropriate
  - Assess coordinated care model options that encourage/require linkage to primary care practitioners
  - Evaluate payment methodology
    - Identify reimbursement methodologies that are more acuity-based and/or that do not "up-pay" when routine services occur in an outpatient hospital setting
    - Consider payment differential based on site of service to incentivize appropriate office-based care

Clinical Focus Areas



Care Management in State Medicaid Programs

- Medicaid and other payers are increasingly interested in the prevention and management of chronic conditions, with a focus on beneficiary self-management
- Initial state Medicaid CM programs targeted beneficiaries with certain conditions, such as asthma, diabetes, or heart disease
- States are moving towards a population-based model that addresses all conditions and offers interventions based on risk level
- Interventions include care managers helping Medicaid beneficiaries understand their chronic conditions and strategies for self-management
- Majority of states do not enroll duals in care management programs due to lack of share savings model with Medicare

Trends in Medicaid Care Management

Trends	Characteristics	Rationale
Increased Accessibility and Availability of CM Staff	■ States are requiring CM vendors to operate call centers with local staff ■ States are increasing use of in-person care management	■ Local staff are more familiar with the community and local resources, and may create stronger relationships with providers ■ Limited evidence of the effectiveness of telephonic CM
Population-Based Care Management	■ CM programs focusing on high-risk or high-cost beneficiaries to manage co-morbidities ■ States use risk stratification or predictive modeling to classify beneficiaries into risk categories ■ States offer nearly all beneficiaries interventions based on their risk level	■ Increasing prevalence of co-morbidities or multiple conditions ■ Other conditions may be a barrier to treating a specific disease ■ High-risk or high-cost populations are those with the largest potential for cost savings
Patient and Provider Incentives	■ States are implementing incentive programs by providing gift cards and credits on Medicaid premium or prescription co-payments ■ Providers are paid for their participation in the program (e.g., reviewing care plan) or for performance improvement (e.g., increased screening rates)	■ Offering incentives to patients and providers encourages healthy behaviors and adherence to clinical guidelines

CCIP Program History and Structure

- MO HealthNet moved more towards a care management model with CCIP
  - Competitively bid for a qualified vendor to administer program
  - Contract awarded in 2006
  - Began enrolling members in November 2006
- CCIP provides care management to MO HealthNet FFS enrollees with:
  - Asthma
  - At-risk Cardiac (hypertension, hyperlipidemia and cardiovascular disease)
  - Heart failure
  - Chronic Obstructive Pulmonary Disease (COPD)
  - Diabetes (including gestational diabetes)
  - Gastroesophageal Reflux Disease (GERD)
  - Sickle cell
- Individual must have one of these "gateway" conditions to be eligible
- CCIP eligible individuals are then stratified based upon the severity of their condition and level of risk
  - Top 15%-High risk
  - Next 20%-Moderately high risk
  - Next 30%-Moderate risk
  - Bottom 35%-Low risk

CCIP Covered & Excluded Populations

- Voluntary program enrolling approximately 160,000 individuals
- Covers selected MO HealthNet populations
  - Initial implementation in I-70 “Corridor”
  - Includes dual eligibles
- Excluded other MO HealthNet populations
  - Enrolled in managed care
  - Residing in the Northwest or Southwest regions of the State
  - Residing in a Skilled Nursing Facility
  - Enrolled in Medicare Part C
  - Enrolled in MO Rx
  - Certain eligibility categories
  - Opting out of CCIP

CCIP Highlights

- CCIP has some important strengths
  - Interconnectivity between CyberAccess and CareConnection allows providers and health coaches to share patient information on a real time basis. Very few states have achieved a successful exchange of information between two systems. **Consider adding value to the two systems by enhancing provider involvement.**
  - The presence of health coaches in FQHCs and the Truman Medical Center offers in-person care management to members at a "teachable" moment, immediately following the provision of care. **Consider expanding this initiative to additional FQHCs/Medical Centers and coordinating with discharge planning.**

CCIP Has Likely Lost Money to Date

- It is very likely that the CCIP program is currently losing money
- This can largely be attributed to the fact that dual eligibles are enrolled in the program
  - Under the current program, it is possible for savings for dual eligibles to be realized by Medicare, while MO HealthNet bears the expense of the program
  - CCIP may also divert patients from Medicare-covered inpatient use and lead to increased utilization of Medicaid home- and community-based services among the dual eligibles, resulting in even greater spending by MO HealthNet
- It is likely that the CCIP program can generate savings for the Medicaid-only (non-dual-eligible) population
- However, it is not clear, after subtracting vendor fees and MO HealthNet administrative effort, how extensive these savings are under the current program design
- MO HealthNet has engaged Mercer to do a cost savings analysis on CCIP

Managed FFS Programs Typically Perform Better Over Time Than in First Year(s) of Operation (*see Appendix A*)

State	Program Overview	Select Outcomes
North Carolina (1998–present)	• Statewide enhanced PCCM program • All Medicaid beneficiaries	• $3.5M in savings over 3 years for asthmatics (attributed to decrease in ER visits) • $2.1M in savings over 3 years for diabetics
Wyoming (2004–present)	• Statewide program with APS • All Medicaid beneficiaries – population based interventions determined by risk level	• 14% decrease in average LOS • 50% decrease on asthma inpatient admissions
Pennsylvania (2005-2009)	• Contracts with McKesson to operate PCCM and DM program • Beneficiaries not in MCOs • Asthma, diabetes, CHF, cardiovascular disease, COPD	• $27 million in savings in FY 2006-2007 • 90% of members reported seeing their physician in the last year • Reduced LOS for premature infants
Indiana (2003-2007)	• Partnerships with local agencies and vendors • Targets Asthma, Diabetes, CHF, Cardiovascular disease, Chronic kidney disease	• Approximately $29 million in savings • Reduction in PMPM costs over 18 months, attributed to fewer and shorter hospitalizations
Washington (2002–2006)	• Statewide CM program with McKesson • Targeted asthma, diabetes, CHF, COPD, ESRD, kidney disease • 2007 – Developed new program for co-morbid conditions	• No net savings until 4th year - $13M across all diseases • Hospital LOS decreased for high-risk asthmatics

Note that savings estimates in this arena are often prone to error and are heavily swayed by the methodologies and assumptions used. State agencies need to be vigilant in assessing and testing savings analyses.

Our Most Important Recommendation: Keep a Care Coordination Program but Modify It

- We strongly recommend that some form of care coordination be continued
  - Program has established a strong foundation for providing much-needed care coordination services to MO HealthNet's non-capitated high-need beneficiaries
  - Eliminating care coordination altogether would move MO HealthNet backwards in terms of its efforts to move beyond "simply sitting back and paying claims"
- We believe a well-conceived and operated care coordination program can and will achieve significant cost savings for MO HealthNet, as well as improve the well-being of thousands of high-need beneficiaries
- MO HealthNet should build on the existing program's strengths
  - Shifting providers to new vendors and IT systems is disruptive and potentially counter-productive – no changing of vendors is recommended outside of normal reprocurement cycles
- We believe the program needs to be significantly modified, however, as described on following slides

Approaches for Potential Cost Containment and Operational Efficiencies

	Shorter Term Impact	Longer Term Impact	Key Points
Exclude Dual Eligibles	X		• Immediate annual savings if eliminate the dual eligibles of $14.3 million
Focus on High-Risk/High-Cost Members Amenable to Intervention	X	X	• Potential shorter term savings for newly enrolled members; longer term quality improvement with focus on "whole person" • Use risk scoring and stratification to identify
Enhanced Effectiveness of Physician Incentive Payments		X	• Potential longer term impact with increased provider role in patient self-management
Care Coordination Program Enrollee Hospital Admission Alert		X	• Potential longer term savings, likely offset with cost to implement; improved management of care through coordination with discharge planner
Care Coordination Program Contract Procurement and Payment Terms		X	• Build in risk-sharing mechanisms; consider direct contracting with some hospitals
Enhanced Value of Physician Incentive Payments		X	• Potential longer term impact with increased provider involvement in patient self-management
Enhance Care-Coordination Model		X	• Current interactions are primarily telephonic

Exclude Dual Eligibles

Excluding Dual Eligibles From Care Coordination is Recommended

- Potential short-term cost savings
- Approximately 58% of CCIP enrollees are duals
  - 160,000 enrolled * $12.85/month = $2,056,000
  - Eliminating duals would save $1,192,480/month or $14,309,760/year
- Dual eligibles are high-risk group with complex medical and behavioral health care management needs
- Majority of states do not enroll duals in care management programs *
  - Medicaid pays cost of care management; Medicare realizes medical savings
- Areas for further consideration
  - Lack of management may result in increased long term care costs for Medicaid

* Source for this bullet is: Rosenbaum, S., Thorpe, J., Schroth, S. *Supporting Alternative Integrated Models for Dual Eligibles: A Legal Analysis of Current and Future Options.* Center for Health Care Strategies, November 2009.

Opportunities for Care Coordination to Save State Money for Dual Eligibles are Limited

- While dual eligibles' per capita Medicaid costs are very low due to Medicare's primary payer status, there may be some potential for *Medicaid* coordinated care savings to occur within the "medical" category (shown in table below). Costs in all other categories are low and not amenable to care coordination savings.
  - Costs in the "medical" category exceeded $500 per CCIP-enrolled dual eligible during 2008, and were predominantly attributable to personal care services, habilitation services, attendant care services, and substance abuse treatment.
  - If care coordination model can impact these costs substantially, there may be grounds for continuing to serve some selected dual eligibles in the care coordination program (rather than discontinuing to serve all duals)

Average Costs for 2008 for People Enrolled in CCIP in July 2008 by Dual Eligible Status

	Inpatient Average	Outpatient Average	Medical Average	Home Health Average	Dental Average	Crossover Average	Pharmacy Average	Capitation Payment Average	Nursing Home Average	Total Expenditure Average
Not Dual Eligible	$200	$215	$421	$5	$4	$2	$446	$11	$41	**$1,345**
Dual Eligible	$12	$9	$505	$0	$1	$151	$36	$11	$73	**$798**

Average Costs for 2008 for Non-CCIP Enrollees in July 2008 by Dual Eligible Status

	Inpatient Average	Outpatient Average	Medical Average	Home Health Average	Dental Average	Crossover Average	Pharmacy Average	Capitation Payment Average	Nursing Home Average	Total Expenditure Average
Not Dual Eligible	$49	$39	$68	$0	$3	$1	$45	$130	$162	**$497**
Dual Eligible	$7	$33	$216	$0	$1	$82	$13	$9	$1,630	**$1,990**

New and Improved Opportunities To Coordinate Care for Dual Eligibles May Emerge

- CMS is demonstrating interest in working with states to manage care for dual eligibles
  - CMS provides states with "Medicare side" of dual eligibles' claims data
  - CMS has approved North Carolina's shared savings waiver
  - Language for "dual eligibles integration center" is included in proposed health reform bills
- Opportunities may soon arise to craft a strong program for Missouri's dual eligibles through a shared savings partnership with CMS
- MO HealthNet is strongly encouraged to explore these possibilities

Focus on High-Risk / High-Cost Members Amenable to Intervention

State Medicaid CM often Targets Beneficiaries with Asthma, Diabetes, or Heart Disease

Disease	Reasons for Inclusion in CM
Asthma	• High prevalence, especially among TANF population • Availability of consistent clinical practice guidelines • Easy avoidance of costly complications (e.g., decreased ER visits)
Congestive Heart Failure	• High prevalence • Availability of consistent clinical practice guidelines
Diabetes	• High prevalence • Simple identification of patients • Availability of consistent clinical practice guidelines

Focus on Selected Subgroups and High-Risk/High Cost Enrollees Amenable to Intervention

- Potential short term savings for newly enrolled members, although difficult to quantify
- Other states are moving from "gateway" diseases as the initial enrollment indicator and towards the management of high-risk/high-cost members
  - Members with the "gateway" diseases may not be the most costly or the most difficult to manage
    - For example, of the 1,000 most expensive beneficiaries in CY 2008, 262 were care coordination program enrollees
  - Offers opportunity to focus resources on members that will most benefit from management of care
  - Provides management for behavioral health conditions and other co-morbidities
- Use risk scoring to identify highest-risk/highest-cost members, regardless of diagnosis, and leverage the current practice of managing co-morbidities
- Revisit the proposed ASO services contract for stratification and intervention strategies

Expanding Strengths and Opportunities for Improvement

- The management of members' co-morbidities leads to improved coordination of care, patient self-management, and improved quality
- Consider leveraging this success by expanding the care coordination program beyond the "gateway" diseases to manage high cost/high risk members
  - The ASO Services, described in Amendment #2 to the care coordination contract at the time of analysis and later cancelled, focused on providing care management to the 20% of the population driving 80% of the healthcare costs
  - The proposed ASO Case Management Services for the 5% of members with the highest risk provide an excellent basis for restructuring the care coordination program to focus on the high cost/high risk members

Recommendations Regarding Enrollment in the Care Coordination Program

- Modify using "gateway" conditions as entry into care coordination program
  - Do not enroll persons just because they have evidence of a health condition
  - Do not enroll persons who are low users of health services and who appear to be accessing needed services to manage their disease (e.g., diabetics with an established relationship with a primary care physician or endocrinologist, who appear to be on appropriate medication regimens, and who are not utilizing inpatient or ER services)
  - Discontinue using GERD as a "gateway" condition
- Consider targeting certain subgroups
  - Persons with multiple inpatient admissions (regardless as to what health conditions they have)
    - Intervention model would not always involve clinical protocols for this group, given spectrum of illnesses and comorbidities involved
    - It would entail attempting to discern why person is experiencing so many major health crises and seeking to help stabilize his/her health status to avert continued admissions
    - May require a cross-agency approach to address "special" issues contributing to health problems
  - Persons with one or more admissions in certain areas (e.g., behavioral health) with no evidence of receiving care for such conditions in the outpatient setting
  - Persons with potentially excessive/inappropriate pharmacy usage
  - Persons with a high volume of ER visits
- Discontinue serving dual eligibles

Several Populations Clearly Needing Care Management were Cross-Tabbed with Care Coordination Enrollment List

- In the pharmacy analysis, 3,399 persons met all of the following criteria during CY 2008:
  - $5,000+ in pharmacy claims costs, 80 or more prescriptions, 25 or more different NDCs, 15 or more different standard therapeutic classes, 8 or more prescribers, and 4 or more pharmacies
  - Of these persons, 2,403 (71%) have been enrolled in CCIP at some point
- In the inpatient assessment, 23,168 persons had at least three inpatient admissions during CY2006-CY2008 (counting medical/surgical and behavioral health admissions and excluding dual eligibles)
  - Of these persons, 13,848 (60%) have been enrolled in CCIP at some point
- In outpatient assessment, 15,298 persons had at least five ER visits during CY2008 (excluding dual eligibles)
  - Of these persons, 9,874 (65%) have been enrolled in CCIP at some point

Above figures demonstrate that CCIP is capturing most persons, but also indicate that CCIP enrollment criteria need to be fine-tuned. All persons in above subgroups probably warrant inclusion in the care coordination program and most also warrant an intensive level of outreach.

Enhance Effectiveness of Physician Incentive Payments

Physician Participation

- ~ 2,000 physicians participating in current care coordination initiative
- Providers are paid incentive payments for the development and coordination of POC
  - $50 per patient for initial review and approval of POC
  - $25 per member per month for continued review of POC
- Varying physician involvement, approximately:[1]
  - 1/3 not involved at all with coordination of POC
  - 1/3 of physicians moderately involved in development of POC and coordination of care
  - 1/3 highly involved in development of POC and patient care management

[1]Based on approximations from vendor's Medical Director

Enhanced Value of Physician Incentive Payments

- Currently: Approximately 1/3 of physicians do not regularly check the POC; 1/3 are moderately involved in care management of their patients; and 1/3 are extremely involved in care management
- High dollar value associated with initial and monthly physician incentive payments
- Enhancing provider engagement through the incentive likely would add value to the program by increasing provider involvement in patient self-management and coordination with the Health Coach
- Consider requiring providers to update the POC, contact the patient by phone, and communicate with the Health Coach to receive the monthly payment, particularly for months where the POC has not been updated
- Conduct a pre/post study of care coordination program participants with “engaged” physicians compared with participants whose physicians are not “engaged”
  - Any difference in cost-reduction outcomes?

Care Coordination Program
Enrollee Hospital Admission Alert

Enrollee Hospital Admission Alert

- Currently no real-time alert indicating that a care coordination program enrollee has been admitted to the hospital
  - FFS members are not subject to prospective UM or other pre-certification activities
  - CCIP vendor can determine hospital admissions only retrospectively through claims
- Real-time hospital admission alert would allow Health Coaches to reach out to the members at a "teachable" moment
  - Research suggests this is the best way to impact behavior and utilization, manage care, and ultimately generate savings
  - Provides opportunity to coordinate with discharge planner, which is believed to reduce readmissions
  - This is an area of desired improvement for many states, but a difficult one to achieve
- Consider working with current vendor to tailor program similar to UM activities provided in Alabama
  - Pre-certification is required for hospital admission, providing the care coordination vendor real-time information about certain admissions and procedures

Care Management and Coordination Contract Procurement and Payment Terms

Contractor Risk Sharing

- Payments to care coordination program need to be strongly tied to achievement of the program goals
- Suggest withhold of sizable percentage of fees (e.g., 15% - 20%); level of withholds returned would be tied to the degree specific program objectives were met:
  - Demonstrated overall cost savings (based on tabulations by independent firm)
  - Enrollee satisfaction surveys
  - Physician engagement in program
  - Usage reductions for specific target groups (e.g., high-volume users of inpatient, ER, and pharmacy services)
- DSS may want to consider making bonus payments available tied to level of program cost savings that occurs.
- Methodology for calculating cost savings will require careful and thoughtful development
  - For many target groups – e.g., persons entering program due to high usage/costs of inpatient, ER, and/or Rx services, savings levels can be quantified

Selecting Multiple Contractors in Next Care Coordination Procurement Might Prove Beneficial

- One possible option is to select one contractor to perform general care coordination services (as occurs under contract at time of analysis – dividing State into regions is not recommended)
  - Consider creating a competing model inviting interested hospitals to contract with state directly to provide hospital-based care coordination services to selected subgroups (persons with multiple admissions, frequent ER users, etc.)
  - Award contracts (with shared-risk payment terms) to 3-5 hospitals that submit the most attractive proposals
- Assess which approach is yielding the most favorable outcomes and expand that approach
- If MO is unable to enlist hospitals to reduce inpatient usage, more extensive use of hospital-located care coordination can be added to the broader care coordination contract

Enhance Care Coordination Model

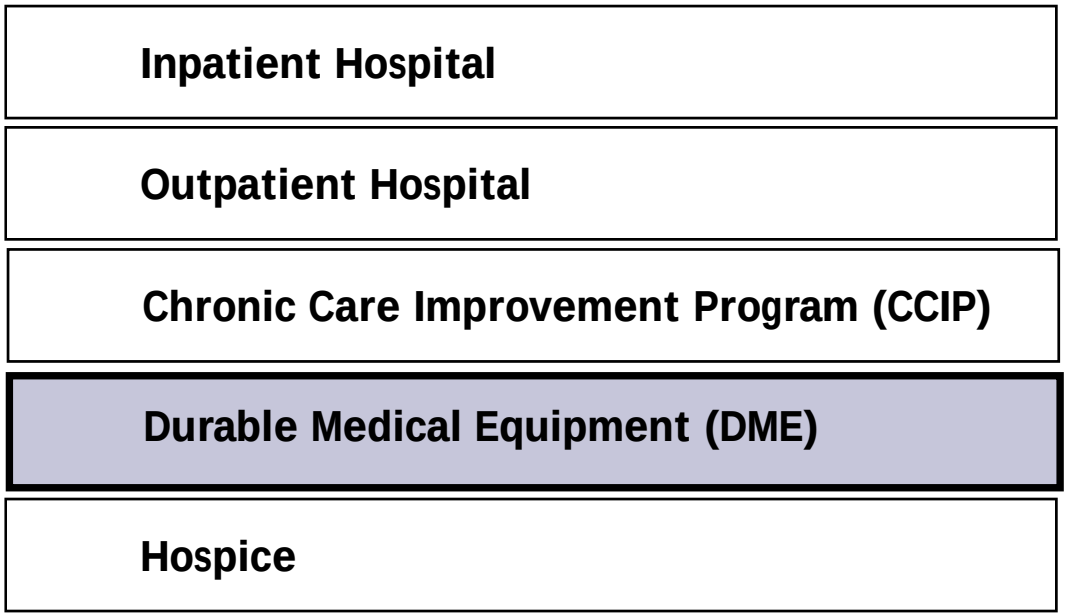
Recommendations Regarding Care Coordination Model

- Care management and coordination interventions are currently almost entirely telephonic
- Large populations in St. Louis and Kansas City enhance the viability of deploying models that establish a strong relationship between the patient, the family, and the care coordinator
  - Certain enrollees warrant at least an initial face-to-face visit to establish a stronger relationship than can occur telephonically
  - For certain enrollees, multiple visits may be most cost-effective approach
- High-cost beneficiary assessment (to be completed in February) will convey specific recommendations as to which persons should receive which model of intervention
  - Care management and coordination program expansion is not the only option for providing "ramped up" care coordination services, but it is an important option given that the program has a solid foundation in Missouri

Interventions are Mostly Telephonic, Although Face-to-Face Interaction is Growing

- Upon entry into the current care coordination program, every enrollee receives a person-specific plan of care (POC)
- Level of intervention based on level of ranking in stratification
  - High-risk
    - Enrollees are contacted by phone at least *once per quarter*
  - Moderately high-risk
    - Enrollees are contacted by phone at least *once every four months*
  - Moderate-risk
    - Enrollees are contacted by phone at least *semi-annually*
  - Low-risk
    - Enrollees are contacted by phone at least *once a year*
- Face-to-face interactions with health coaches take place at 13 of the 22 FQHCs and at Truman Medical Center
  - Face-to-face interactions are a new intervention – begun in the last 6 months
- Co-morbidities are managed through educational materials provided to enrollees
- Earlier section on highest volume inpatient and ER users argues for a much more intensive/extensive model of care coordination for certain participants

Clinical Focus Areas



Approaches for Potential DME Cost Containment and Operational Efficiencies

	Short Term	Longer Term	Key Points
Rate Reduction	X		• $2.37 million in total fund savings, with limited beneficiary impact anticipated
Preferred Provider Contracting		X	• Evaluate options around negotiating with manufacturers for oxygen & respiratory equipment, incontinence supplies, and parenteral nutrition products • Estimated savings of $835K (assuming a 5% savings rate)
Competitive Bidding		X	• Limit provider participation for volume discounts • Look to the current CMS competitive bid pilot project as an example
Rent to Own		X	• Remove the 12% add-on payment made for certain rent-to-own items
Program Integrity		X	• Monitor OIG initiatives surrounding appropriate payment levels, and potential fraud and abuse
Prior Authorization Expansion		X	• Expand PA list to review and control high cost areas

DME Coverage – Missouri Senate Bills 539 and 577

- SB 539 (2005)
  - Excluded coverage for adults (exceptions for pregnant women, those receiving home health services and the blind eligibility category) for the following DME:
    - Apnea monitors, Artificial larynx and related items, Augmentative communication devices, Canes and crutches, Commodes, Bed pans and urinals, CPAP devices, Decubitus care equipment, Hospital beds and side rails, Humidifiers, BiPAP machines, IPPB machines, Nebulizers, Orthotics, Patient lifts and trapeze, Scooters, Suction pumps, Total parenteral nutrition mix, Supplies and equipment, Walkers, Wheelchair accessories, and Labor and repair codes
- Comprehensive coverage for adults reinstated in 2007
  - The Code of State Regulations language notes that items must be "reasonable and necessary for treatment of the illness or injury, or [be found to] improve the functioning of a malformed or permanently inoperative body part and the equipment meets the definition of DME."

Sources: 13 CRS 70-60.010. Missouri Register. Vol 30, No. 18. September 15, 2005, 13 CSR 70-60.010. Code of State Regulations. June 30, 2009

DME Payment and Utilization Controls

- Payment related to the Medicare fee schedule with the following also considered:
  - State Medical Consultant and/or advisory committee recommendations
  - Charge information from providers in different areas of the state
  - However, Medicare's allowable reasonable and customary charge payment or cost-related payment infrequently used to update the DME fee schedule
- Utilization controls include medical necessity review via prior authorization (PA):
  - Required for several items, including certain Healthy Children and Youth products, miscellaneous incontinence supplies, wound cleansers, and heavy duty walkers
  - Medical consultants and other staff review the Certificate of Medical Necessity and the claim form to make a determination regarding claim payment
  - Providers are required to seek PA before delivery of the services above
  - Providers can request or check PA request status on CyberAccess or through E-Momed, the MO HealthNet web portal
  - DME pre-certification criteria documents listed on MO HealthNet website

MO HealthNet DME Expenditures and Growth

- MO HealthNet DME cost trends have been distorted by coverage fluctuations
  - While DME experienced negative growth following the 2005 cuts in adult coverage; recent years have seen sharp expenditure growth as coverage has been reinstated

MO HealthNet DME Spending - Annual Growth Rate[1]				
2005-2006	**2006-2007**	**2007-2008**	**2008-2009**	**2005-2009**
-9%	-6%	20%	7%	2.4%

- Overall DME cost growth in MOHealthNet from 2005-2009 appears to be less steep than national norms. Nationwide DME costs increased 3.8% annually on average from 2005-2008; Medicare DME costs increased 6.8% annually and non-Medicare costs increased 2.6% annually. (Source: National Health Expenditures data tables)

- DME comprised approximately 0.9% of MO HealthNet expenditures in FY 2009 ($63 million in total expenditures)

[1]Table 23 Expenditure Data, 2005-2009, Expenditures & Units of Service

Overview of CY2008 DME Costs by Product Category

DME Category	Paid Amount, CY2008	Share of All DME Expenditures
OXYGEN AND RESPIRATORY EQUIPMENT	$13,703,338	27.6%
WHEELCHAIR ACCESSORIES	$9,192,029	18.5%
WHEELCHAIRS POWER CHAIR	$4,187,138	8.4%
NUTRITION AND SUPPLIES	$3,895,852	7.8%
PROSTHETICS	$2,957,165	6.0%
ORTHOTICS	$2,608,312	5.3%
TOTAL PARENTERAL NUTRITION	$1,868,082	3.8%
WHEELCHAIRS STANDARD	$1,662,650	3.3%
MISCELLANEOUS	$1,280,684	2.6%
INCONTINENCE SUPPLIES	$1,143,695	2.3%
WHEELCHAIRS CUSTOM	$1,134,119	2.3%
HOSPITAL BEDS	$555,044	1.1%
MEDICAL SUPPLIES	$540,724	1.1%
WHEELCHAIRS LIGHTWEIGHT	$483,081	1.0%
MISCELLANEOUS SUPPLIES	$466,930	0.9%
AUGMENTATIVE COMMUNICATION DEVICE	$420,670	0.8%
OSTOMY SUPPLIES	$382,957	0.8%
WHEELCHAIRS PEDIATRIC CHAIR	$362,383	0.7%
INFUSION SUPPLIES	$349,453	0.7%
WHEELCHAIRS REPAIR OF EQUIPMENT	$333,697	0.7%
TRACHEOSTOMY CARE SUPPLIES	$231,597	0.5%
RESPIRATORY EQUIPMENT	$212,033	0.4%
IV DRUG THERAPY	$210,432	0.4%
WHEELCHAIR HEAVY DUTY	$201,363	0.4%
WALKERS	$199,643	0.4%
DIABETIC SHOES AND INSERTS	$170,188	0.3%
SUPPLIES FOR RADIOLOGIC PROCEDURES	$155,067	0.3%
WHEELCHAIRS SCOOTER	$144,422	0.3%
DRESSINGS	$127,309	0.3%
PATIENT LIFT TRAPEZE	$104,889	0.2%
WHEELCHAIR HIGH STRENGTH LIGHTWEIGHT	$101,772	0.2%
CANES AND CRUTCHES	$70,540	0.1%
COMMODES BED PANS AND URINALS	$58,147	0.1%
BEDS	$55,140	0.1%
All Other DME Products	$82,349	0.2%
Total, All DME Products	**$49,652,892**	**100.0%**

Note: products provided to dual eligibles excluded from this table

MO HealthNet Top 10 DME Expenditure Areas, Adults and Children

- Lewin calculated growth and expenditures using the fee schedule and HCPCS codes which we grouped into major categories
- 8 of the top 10 categories showed double digit growth from CY 2007-2008
  - Oxygen & Respiratory Equipment and Wheelchair Accessories combined represent nearly half the DME budget
  - Some of these areas represent potential supply contracting opportunities

Top 10 2008 DME Expenditures (Adult and Children Combined)

DME Category of Care	Total Expenditures (in millions)	% of Expenditures	% Growth 2007-2008
1. Oxygen & Respiratory Equipment	$13.7	27.6%	10.7%
2. Wheelchair Accessories	$9.2	18.5%	5.8%
3. Power Wheelchairs	$4.2	8.4%	18.9%
4. Nutrition & Supplies	$3.9	7.8%	11.7%
5. Prosthetics	$3.0	6.0%	13.7%
6. Orthotics	$2.6	5.3%	16.6%
7. Total Parenteral Nutrition	$1.9	3.8%	26.8%
8. Standard Wheelchairs	$1.7	3.3%	10.9%
9. Miscellaneous	$1.3	2.6%	3.1%
10. Incontinence Supplies	$1.1	2.3%	12.1%
All Other DME Categories	*$7.2*	*14.4%*	*3.3%*
TOTAL	$49.7	100.0%	10.2%

Note: Expenditure data based on FY 2008 DME claims data, by incurred date.

MO HealthNet Top 10 DME Expenditure Areas, Adults

- High growth rates for orthotics, total parenteral nutrition, and hospital beds are likely partially due to the reinstatements. All experienced high growth rates from 2006-2007 (991%, 33%, and 361% respectively)
- Custom wheelchair growth appears to have moderated some, following a near 30% growth rate from 2006-2007

Top 10 2008 DME Expenditures (Adult Only)			
DME Category of Care	**Total Expenditures (in millions)**	**% of Expenditures**	**% Growth 2007-2008**
1. Oxygen & Respiratory Equipment	$11.7	34.2%	13.7%
2. Wheelchair Accessories	$7.5	21.8%	5.5%
3. Power Wheelchairs	$3.8	11.2%	19.0%
4. Prosthetics	$2.8	8.1%	16.6%
5. Standard Wheelchairs	$1.5	4.4%	11.4%
6. Custom Wheelchairs	$1.1	3.3%	-9.8%
7. Orthotics	$0.9	2.7%	68.0%
8. Total Parenteral Nutrition	$0.9	2.6%	39.8%
9. Nutrition and Supplies	$0.5	1.5%	11.9%
10. Hospital Beds	$0.5	1.4%	130.7%
All Other DME Categories	*$3.0*	*8.7%*	*12.8%*
TOTAL	$34.2	100.0%	13.8%

Note: Expenditure data based on FY 2008 DME claims data, by incurred date.

MO HealthNet Top 10 DME Expenditure Areas, Children

- Children's DME products in top 10 similar to adults
  - Medical supplies appear in top 10 for children, and reflect highest growth rate at 31.0%
  - Nutrition and supplies, wheelchair accessories, incontinence supplies, total parenteral nutrition, and power wheelchairs continue to be areas of interest
  - Oxygen and respiratory equipment, orthotics, miscellaneous categories all had negative growth rates from 2007-2008

Top 10 2008 DME Expenditures (Children Only)			
DME Category of Care	**Total Expenditures (in millions)**	**% of Budget**	**% Growth 2007-2008**
1. Nutrition and Supplies	$3.4	22.0%	11.7%
2. Oxygen and Respiratory Equipment	$2.0	12.9%	-4.3%
3. Wheelchair Accessories	$1.7	11.1%	7.3%
4. Orthotics	$1.7	10.8%	-.5%
5. Incontinence Supplies	$1.1	7.4%	12.2%
6. Miscellaneous	$1.1	6.9%	-6.7%
7. Total Parenteral Nutrition	$1.0	6.3%	16.7%
8. Medical Supplies	$0.5	3.2%	31.0%
9. Power Wheelchairs	$0.4	2.3%	18.1%
10. Pediatric Chair Wheelchairs	$0.3	2.3%	-18.9%
All Other DME Categories	*$2.3*	*14.8%*	*-8.8%*
TOTAL	$15.4	100.0%	2.9%

Note: Expenditure data based on FY 2008 DME claims data, by incurred date.

Rate Reduction

DME Rate Reduction Opportunity

- MO HealthNet estimates that current rates are approximately 90% of Medicare rates
- Several states have recently reduced DME rates:
  - Georgia – DME rates at 80% of the Medicare fee schedule[1] (reimbursed FFS at 80% of CMS 2007 rates)
  - Arizona – Physician rates (DME included) reduced by 5% earlier in FY 2009[2] (reimbursed FFS using Medicare payment ceilings)
  - North Carolina – 4.16% DME reduction[3] (reimburse FFS based on Medicare rates or reasonable cost)
  - Michigan - 4% cut to all Medicaid fees[4] (reimburse FFS for most products)
- Beneficiary Access Implications:
  - Georgia did not identify reductions in beneficiary access following rate cuts[5]
  - A Michigan Dept. of Community Health committee, established to identify potential DME program savings in 2006, recommended the State consider a rural add-on payment to preserve beneficiary access if across the board rate reductions were implemented[6]
  - Medicare's 1999-2002 DMEPOS Competitive Bid Pilot Project resulted in a near 20% reduction in allowable charges. Beneficiary access and quality of services were reported as "essentially unchanged"[7]
- According to MO HealthNet estimates, reducing DME fees that exceed 80% of Medicare to an 80% ceiling would result in approximately $2 million in total computable annual savings
  - Note: these savings are included in the fee schedule reduction opportunity in Lewin's short-term cost containment deliverable

Sources: [1]Georgia Department of Community Health. Provider Communication, DME Coding/Price Update, July 2009, [2]AHCCCS 2009 Legislative Update. FFS Rate Update Effective October 1, 2009, [2]Reimbursement Rate Update. NC Medicaid Bulletin, October 2009, [4]Summary of Executive Order 2009-22. Senate Fiscal Agency. May 5, 2009. [5]Lewin Correspondence with Health Management Associates, Mark Trail. [6]Report of the Committee on Durable Medical Equipment, Prosthetics and Orthotics Mandated by Boilerplate Section 1735 of P.A. 330 of 2006, [7]Evaluation of Medicare's Competitive Bidding Demonstration for DMEPOS. Final Report to Congress. November, 2004
Reimbursement Methodology: Kaiser Family Foundation Medicaid Benefits Online Database

DME Cost Drivers – Wheelchairs and Oxygen

- DME claims costs (excluding products delivered to dual eligibles) totaled $50 million in CY2008.
- While costs are dispersed across a wide range of categories, 60% of the DME expenditures were concentrated in two areas: wheelchairs and wheelchair accessories ($17 million) and oxygen ($14 million)
  - A beneficiary-level distribution of expenditures in these two categories is provided on the following two slides

Wheelchairs and Wheelchair Accessories, CY2008

- Vast majority (94%) of the 6,026 persons obtaining wheelchairs and/or wheelchair accessories generated less than $10,000 in DME costs for these products during CY2008
- However, the 359 persons reaching the $10,000 cost threshold generated $5.9 million in claims costs – one third of all spending in this DME area
- For persons with 2008 costs below $10,000, wheelchair accessories represented 47% of spending; for those above $10,000, accessories represented a much larger proportion (64%) of spending
- Closer monitoring of wheelchair and accessory costs may be warranted for certain beneficiaries

Wheelchair and Wheelchair Accessory Costs by Individual Cost Cohort, CY2008

Individual Cost Cohort	Number of Persons	Percentage of Persons	Amount Paid	Percentage of Payments
$1 - $999	2,818	46.8%	$925,046	5.3%
$1,000 - $4,999	2,269	37.7%	$7,109,123	40.7%
$5,000 - $9,999	580	9.6%	$3,563,218	20.4%
$10,000 - $19,999	269	4.5%	$3,773,184	21.6%
$20,000+	90	1.5%	$2,109,975	12.1%
Total	**6,026**	**100.0%**	**$17,480,546**	**100.0%**

Many Wheelchair Users Reside in Nursing Homes; Medicare is Primary Payer for Most of These Persons

Persons Acquiring a Wheelchair During 2007 and/or 2008

	2007	2008	Percent Change, 2007-2008
Institutionalized Persons			
Medicaid Only	305	401	31%
Dual Eligibile	1,270	1,254	-1%
Subtotal, Institutionalized Persons	1,575	1,655	5%
Non-Institutionalized Persons			
Medicaid Only	2,133	2,324	9%
Dual Eligibile	214	293	37%
Subtotal, Non-Institutionalized Persons	2,347	2,617	12%
All Persons			
Medicaid Only	2,438	2,725	12%
Dual Eligibile	1,484	1,547	4%
Total	3,922	4,272	9%
Percent of Wheelchair Acquirers Who Are:			
Dual Eligibles, Non-Institutionalized	5.5%	6.9%	
Dual Eligibles, Institutionalized	32.4%	29.4%	
Dual Eligibles (all)	37.8%	36.2%	
Medicaid Only, Non-Institutionalized	54.4%	54.4%	
Medicaid Only, Institutionalized	7.8%	9.4%	
Medicaid Only (all)	62.2%	63.8%	

Oxygen Products, CY2008

- Vast majority (99.4%) of the 15,130 persons using oxygen generated less than $5,000 in costs for these products during CY2008
- While 98 persons reached the $5,000 cost threshold and the highest-cost person obtained $17,754 in oxygen products, our assessment has not identified any large-scale problem that appears to warrant attention

Oxygen Costs by Individual Cost Cohort, CY2008

Individual Cost Cohort	Persons With Costs in This Cohort	Percentage of Persons	Paid Amount	Percentage of Payments
$1 - $499	8,867	58.6%	$1,366,734	10.0%
$500 - $999	1,599	10.6%	$1,156,549	8.4%
$1,000 - $2,499	3,059	20.2%	$5,748,731	42.0%
$2,500 - $4,999	1,507	10.0%	$4,353,913	31.8%
$5,000 - $9,999	47	0.3%	$345,423	2.5%
$10,000+	51	0.3%	$731,989	5.3%
Total	**15,130**	**100.0%**	**$13,703,338**	**100.0%**

Preferred Provider Contracting

Preferred Provider Contracts

- MO HealthNet could explore contracting with suppliers based on negotiated discounts and/or rebates
- For example, MO HealthNet started a preferred provider initiative for diabetic testing supplies
  - Non-exclusive contracts, with no limitations on provider participation
  - Implemented in 2004 - participating manufacturer offered the State rebates on diabetic testing supplies and syringes based on net sales
  - Part of the preferred drug list services
    - Abbott was initially the sole participant; as of 2005 the program became multi-source
  - To date, no savings have been calculated
- Consider program expansion
  - Confirm cost savings realized and consider extending the diabetic testing supply preferred provider initiative to other diabetic products such as shoes & inserts
    - Diabetic shoes & inserts expenditures have grown 179% from 2005-2008 (FY 2008 expenditures were $170,000, up from $61,000 in 2005)

Notes: Expenditure data based on FY 2008 DME claims data, by incurred date.

Preferred Provider Contracts (continued)

- If Missouri negotiated rates and/or guaranteed rebates from manufacturers for oxygen & respiratory equipment, nutritional products, and incontinence supplies, total estimated savings of $835,500 per year could be realized, assuming a 5% savings
  - Caution about staffing resources – MO HealthNet's staff resources likely to be strained in implementing such an initiative
  - Administrative expense of contract development may reduce total savings. Consider issuing a Request for Information (RFI) prior to completing contracting arrangements

Savings Achieved through Preferred Provider Contracts
Assuming 5% Rate Reduction

DME Category of Care	2008 Expenditures	Total Savings (5% of Expenditures)
Oxygen & Respiratory Equipment	$13.7 million	$685,000
Total Parenteral Nutrition	$1.9 million	$93,500
Incontinence Supply Products	$1.1 million	$57,000
Combined Savings		**$835,500**

Notes: Expenditure data based on FY 2008 DME claims data, by incurred date.

Preferred Provider Contracts (continued)

Other States' Experience

- California[1,2]:
  - Implemented in 2003, with medical supplies covered under the Medi-Cal pharmacy benefit
  - Negotiates with manufacturers according to the maximum acquisition cost (MAC). Providers may not be reimbursed at rates greater than the MAC + 23% for medical supplies and MAC + 38% for urological supplies
  - Contracts may include rebates; if included, they are provided by the manufacturer on a quarterly basis. Calculated based on a manufacturer's total units sold to the State per quarter, multiplied by a specified percentage of the covered product's MAC
  - Contracts for products include enteral nutrition, incontinence, wound care, ostomy, tracheostomy, urologicals, and diabetic supplies
  - Unit staffed with 3 nurses, 3.5 pharmacists, and 2 analysts
- North Carolina[3]:
  - Preferred manufacturer for glucose meters, test strips, control solutions, lancets, lancing devices, and syringes (November 2009)
- Michigan[4]:
  - Volume purchase contracts for incontinence supplies
  - As of FY 2006-2007, $2.1 General Fund savings reported
- Minnesota[5]:
  - Three to ten oxygen equipment vendor contracts per county

Sources: [1]Medi-Cal Medical Supply Contracting, 10/26/09 conference call materials; [2]Medi-Cal Durable Medical Equipment and Medical Supplies Provider Manual; [3]NC Medicaid Pharmacy Newsletter, Number 175. October, 2009; [4]*Managing Medicaid Costs in Michigan*. Fiscal Forum, January, 2007; [5]Admin Minnesota: Materials Management Division. Contract Release O-64(5)

Competitive Bidding

Competitive Bidding

- Competitive bidding
  - DME providers compete for MO HealthNet business based on cost and quality
  - Requires a waiver, as beneficiary access is restricted to contracted providers
- CMS competitive bidding attempts: past and present
  - DME Prosthetics, Orthotics, and Supplies (DMEPOS) Pilot Project 1999-2002:
    - CMS contracted with 16 vendors for oxygen equipment and supplies, hospital beds and accessories, enteral nutrition formulas and equipment, urological supplies, and surgical dressings[1]
    - Implemented at two demonstration sites; program savings ranged from 17-22%, with Medicare net savings of $2.7 million
    - Later state attempts to replicate were thwarted by law suits and/or lobbying efforts
  - DMEPOS Re-Bid, 2009: With a bid submission of December 2009, CMS is moving to replicate its pilot project
    - Missouri's dual eligible population will be affected: Kansas City is one of the nine metropolitan areas included
    - CMS has projected program savings of 26%[2]

Sources: [1] Evaluation of Medicare's Competitive Bidding Demonstration for DMEPOS. Final Report to Congress. November, 2004

[2] Medicare to Save Average of 26% for some DMEPOS in Selected Areas. CMS Press Release. March, 2008

Competitive Bidding (continued)

- Implications for Missouri
  - CMS' successful push for DMEPOS competitive bidding potentially offers states options:
    - Despite potential opposition, competitive bidding may offer savings:
      - A 2005 Missouri State Auditor Report estimated the State could save $5.4 million annually with competitive bids (based on the 1999-2002 CMS Pilot Savings)[1]
  - In selecting items to competitively bid, look to high cost/high volume areas, including:
    - Oxygen & respiratory equipment, wheelchairs, total parenteral nutrition, and incontinence products
    - Consider staffing constraints and administrative expense
      - For the 1999-2002 CMS Pilot Project, 64% of total savings went to administrative costs[2]

Sources: [1]Missouri State Auditor Report. Medicaid: Controlling Costs for Medical Equipment and Transportation. October, 2005, [2] Evaluation of Medicare's Competitive Bidding Demonstration for DMEPOS. Final Report to Congress. November, 2004

Rent to Own

Rent to Own

- Standardize rental policy
  - Currently MO HealthNet determines whether items should be purchased or rented based on cost considerations following review of medical necessity or prior authorization forms
  - While many states use similar rent vs. purchasing guidelines, CMS has developed a more standardized rental policy
    - 13 month capped rentals: hospital beds, infusion pumps, nebulizers, CPAP devices, and wheelchairs (motorized wheelchairs), with beneficiaries given the opportunity to purchase the wheelchair when initially furnished[1]
      - Capped rentals allow for potential administrative efficiencies, standardized rental policies for certain products, and ensuring total allowable charges are at or below purchase price
    - Oxygen equipment rental payments are limited to 36 months (per 5 year cycle)
      - Limited oxygen equipment rental payments could also allow for savings given oxygen equipment accounts for over 34% of program expenditures
- Eliminate rent-to-own add on payments
  - MO HealthNet automatically purchases rental equipment once it has reached the allowed purchase price, including a 12% add-on to the final rental payment (wheelchair codes, chest wall oscillating devices, and cough stimulating devices exempt)
  - Consider removing the 12% add on payment
    - A review of the following states' provider manuals shows this add-on payment is not included: Ohio, Nebraska, Wisconsin, Michigan, and New Mexico
    - Currently under consideration by MO HealthNet

Sources: [1]CMS Medicare Supplier Directory: Can I rent a supply then purchase it? http://questions.medicare.gov/cgi-bin/medicare.cfg/php/enduser/std_adp.php?p_faqid=1294&p_created=1035308284

Program Integrity

Strengthening Program Integrity Initiatives

- Given DME fraud issues that other states have experienced and MO HealthNet's recent reinstatement of many DME items, this is a critical area of focus
- Several guidelines have been developed by OIG in this arena, including:[1,2,3]
  - Payments with Modifiers
  - Medical Necessity & Appropriate Documentation
  - Enrollment
  - Power Wheelchairs
  - Adverse Event Reporting
  - Price Comparisons

Sources [1] U.S. DHHS, OIG, Fiscal 2008 Management Challenges and "Hot Topics" [2] OIG Reports Subject Index, Medical Devices and Equipment , [3] U.S. DHHS, OIG Work Plan, Fiscal Year 2009.

DME has Consistently Been an OIG Area of Focus

- Interest has focused on containing fraud and abuse and addressing high payment rates
  - The 2009 OIG Work Plan emphasized the need to ensure that "appropriate" payments are made for power mobility devices, hospital beds and accessories, oxygen concentrators, and enteral/parenteral nutrition products
  - These areas parallel many of Missouri's high growth and potential focus areas
  - Cost containment efforts have looked largely to costly, high volume areas (e.g., wheelchairs, oxygen)

DME Costs and Usage by Provider's Duration of Participation in MO HealthNet

- Because licensure requirements for DME are not restrictive, and because DME has been an area where substantial fraudulent billing has occurred in other states, the degree to which new DME vendors have entered Missouri and their claims patterns was briefly assessed
- 78% of DME providers have contracted with MO HealthNet for at least the past five years. These longstanding vendors account for roughly 90% of DME patients, claims, and expenditures
- Nothing about the newer vendors collectively jumps out as being cause for overbilling concern

First Year as MOHealthNet Provider	Number of Providers	Number of Recipients With 1+ DME Claim	Total Claims	Total Paid	Average Cost Per Recipient	Average Cost Per Claim	Average Claims Per Recipient
2004 or Before	435	34,290	222,672	$43,711,004	$1,275	$196	6.5
2005	35	1,234	7,608	$1,442,855	$1,169	$190	6.2
2006	35	1,680	8,838	$2,865,782	$1,706	$324	5.3
2007	39	999	4,417	$1,159,690	$1,161	$263	4.4
2008	13	162	881	$167,585	$1,034	$190	5.4
Total	**557**	**38,365**	**244,416**	**$49,346,915**	**$1,286**	**$202**	**6.4**

Potential DME Overbilling Does Warrant Ongoing Monitoring

- Table below shows 12 DME vendors with a high volume of CY2008 billing activity ($300,000+ in payments, at least 50 different patients, and at least 500 claims), and who all received more than $3,000 per recipient served
  - DME vendors' statewide average claims costs per recipient served is $1,286, well below this threshold
  - The table by no means indicates that any inappropriate billing is occurring on the part of any specific providers, but these vendors may warrant closer review
- DME services in general warrant some "street level" spot-check monitoring to verify that patients are in fact receiving and using the products the State is purchasing or renting

Provider	Number of Recipients With 1+ DME Claim	Total Claims	Total Paid	Average Cost Per Recipient	Average Cost Per Claim	Average Claims Per Recipient
625995808	64	1,179	$314,183	$4,909	$266	18.4
624009700	436	1,440	$1,872,327	$4,294	$1,300	3.3
627718802	704	3,066	$2,926,274	$4,157	$954	4.4
621501725	189	2,974	$767,507	$4,061	$258	15.7
626265607	384	1,830	$1,538,105	$4,005	$840	4.8
626071005	372	2,562	$1,432,168	$3,850	$559	6.9
622199008	89	1,939	$333,199	$3,744	$172	21.8
620075507	93	1,040	$347,859	$3,740	$334	11.2
628673600	152	600	$564,681	$3,715	$941	3.9
623419900	488	3,395	$1,733,016	$3,551	$510	7.0
620055400	292	5,268	$949,404	$3,251	$180	18.0
625373709	541	3,478	$1,637,704	$3,027	$471	6.4

Prior Authorization (PA) Expansion

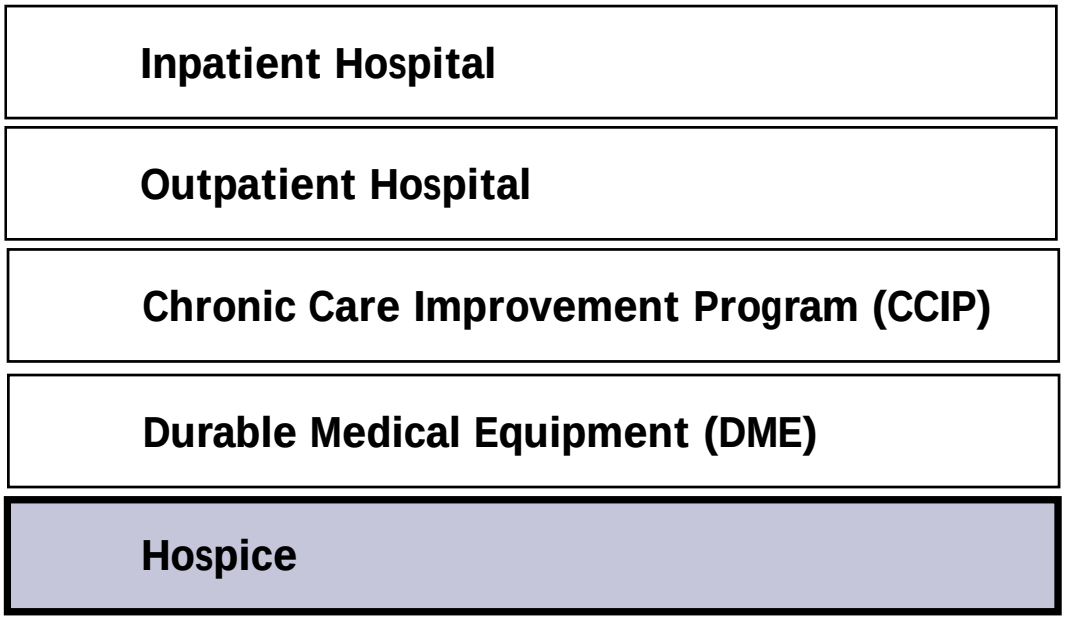
Prior Authorization (PA) Expansion

- DME PA requirement imposed by MO HealthNet is extensive; however, there is potential to expand it and decrease potentially inappropriate utilization:
  - Midwestern state comparison shows additional PA expansion potential (Nebraska, Michigan, Wisconsin, Illinois, and Arkansas)
  - Some opportunities to include additional high cost equipment and wheelchair products in the PA process, and more closely track miscellaneous items, including:
    - All items categorized as "Not Otherwise Classified," or for such items when the purchase exceeds $400/$500 (blanket requirement may discourage inappropriate use)
    - Wheelchair Bases & Wheelchair Options/Accessories when part of rental or initial wheelchair purchase (consider blanket requirement)
    - DME Equipment exceeding $1,000

Assessment of Annual Limit on Prosthetics

- During 2008, more than 1,200 beneficiaries received 1+ prosthetic devices, with collective expenditures totaling $2.9 million
- Arizona completed a detailed assessment of Medicaid benefits limit options earlier during 2009; one of their work group's recommendations limits was a $1,250 annual limit per individual on Medicaid payments for prosthetic devices on behalf of any given beneficiary
  - Clinicians' input was that this limit would force a few persons to use lower cost prosthetic devices, but that this would not jeopardize their health status (although it would lessen their mobility somewhat)
- We estimate that applying this benefits limit in the MO HealthNet program would yield annual savings of roughly $50,000
  - Based on assessment of CY2008 prosthetic claims
  - 5-10 beneficiaries would be affected by this benefits limit annually

Clinical Focus Areas



Approaches for Potential Cost Containment and Operational Efficiencies

	Short Term	Longer Term	Key Points
Reduce Length of Stay (LOS) as Appropriate		X	• Monitor vendors for LOS • Focus on MO HealthNet only recipients
Strengthen Certification and Recertification Requirements		X	• Enhance recertification requirements
Closely Monitor MedPac Recommendations for Potential Implementation		X	• MedPac recommendations important to monitor since Medicare drives hospice policy • Potential of changing reimbursement model to a per diem model where rates at the start of the hospice beneficiary term begin are relatively high, then decline as the length of the episode increases
Enhance Claims Monitoring		X	• Increase plan of care oversight and certification of terminal illness requirements • Ensure nursing facilities are not receiving double payments • Review services received outside hospice • Ensure not paying for duals beyond NF per diem

The Hospice Concept

- A treatment approach that recognizes that an individual's impending death warrants a change in focus from curative to palliative care for relief of pain and for symptom management
- The goal is to help the terminally ill continue life with minimal disruption to normal activities while remaining primarily in the home environment
- To be eligible to elect hospice care, an individual must be certified as being terminally ill. An individual is considered to be terminally ill if he/she has a medical prognosis that his/her life expectancy is six months or less

Source: [1] Federal Register: April 24, 2009 (Volume 74, Number 78)

National Landscape

- States electing to provide hospice care must follow the Medicare reimbursement methodology
  - As such, Medicare policy and reimbursement trends are crucial to better understanding the hospice landscape
- Increasing Average Lengths of Stay (ALOS) (Medicare)
  - In 1998, the ALOS for hospice was 48 days. By 2006 it had increased to 73 days, a 52% increase. 2008 showed a slight decline to an ALOS of 71 days
- Increasing utilization and expenditures
  - In 2005, ~40% of Medicare deaths occurred in hospice, compared to 27.3% in 2000
  - National Medicare hospice expenditures rose from $1.8 billion in 1995 to $11.2 billion in 2008, an average annual increase of 15%. From 2005-2008, the average annual increase was 11%.
  - Hospice spending is expected to double over the next 10 years

Sources: Medicare Hospice Data. Medicare Hospice Expenditures and Units of Care, http://www.cms.hhs.gov/ProspMedicareFeeSvcPmtGen/downloads/FY05update_hospice_expenditures_and_units_of_care.pdf

National Landscape (continued)

- A shift in beneficiary mix[1]
  - The frequency of non-cancer terminal diagnoses has increased. The percentage of all Medicare hospice patients with a terminal diagnosis of cancer decreased from 52.8% in 1998 to 31.1% in 2008
  - Non-Alzheimer's dementia became the most common diagnosis in 2006
  - There has been a marked increase in non-specific diagnoses such as "debility, not otherwise specified," and "adult failure to thrive"

- Despite continued growth in length of stay, hospice reduces Medicare costs by an average of $2,309 per patient[2]
  - For cancer patients, hospice use decreases costs until Day 233 of hospice
  - For non-cancer patients, cost savings seen until 154th day

Sources: [1]Medicare Hospice Data. Hospice Data 1998-2008, [2]Taylor DH Jr, Ostermann J, Van Houtven CH, Tulsky JA, Steinhauser K. What length of hospice use maximizes reduction in medical expenditures, near death in the US Medicare program? Soc Sci Med. 2007 Oct;65(7):1466-78.

MOHealthNet Hospice Spending Has Increased Rapidly

- MO HealthNet hospice spending has grown an average of 15.4% per year from 2005-2009
  - This is a sharper trend than Medicare experienced nationally (11%) from 2005-2008
- FY09 MOHealthNet hospice expenditures totaled $68.5 million[1]

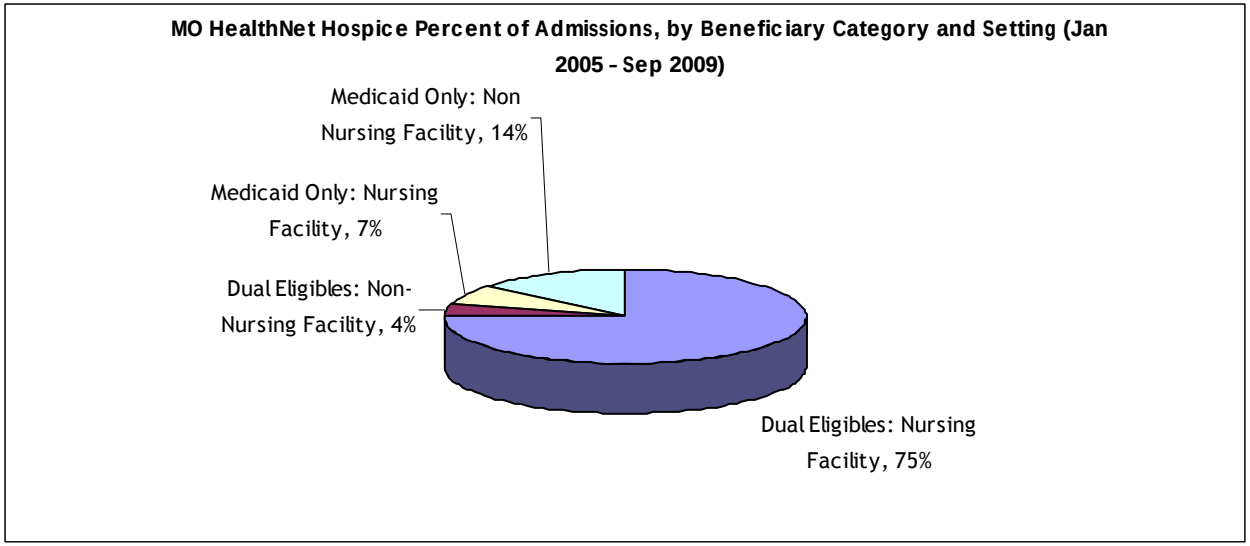
Medicaid Hospice Spending, Annual Growth Rate[3]				
FY2005-2006	FY2006-2007	FY2007-2008	FY2008-2009	FY2005-2008
20%	18%	9%	15%	15.4%

Sources: [1] Table 23 Expenditure Data, 2005-2009. Expenditure & Units of Service

Reduce Length of Stay as Appropriate

MO HealthNet's Hospice ALOS is Well Above the National Average

- High ALOS
  - The MO HealthNet ALOS from Jan 2005 – Sep 2009 was 100.7 days[1]
    - Dual eligibles: 112.9
    - Medicaid only: 51.8
  - In contrast, the national Medicare ALOS for hospice was 71 days in 2008[2]
- Heavy nursing facility (NF) reliance[2]
  - Nationally, only 28% of Medicare hospice beneficiaries are in NFs



- Overall, 16% of MO HealthNet hospice users are Medicaid only; 84% are dual eligibles

Sources: [1]Lewin analysis; [2] DHHS OIG Report. Medicare Hospice Care – A Comparison of Beneficiaries in Nursing Facilities and Beneficiaries in Other Settings. Dec, 2007; [3] MO HealthNet Data. File Name: Hospice –Third Round Split

LOS distribution for Dual Eligibles and Medicaid Only, Jan 2005 – Sep 2009

Dual Eligible

LOS (days)	Admissions	Paid Amount	% of Admissions
0-30	9,264	$9,419,743	44%
31-60	2,690	$10,447,916	13%
61-90	1,930	$12,962,837	9%
91-120	1,178	$10,770,256	6%
121-180	1,846	$24,473,756	9%
181-300	2,107	$43,197,172	10%
301-400	882	$26,413,301	4%
401+	1,395	$71,646,019	7%
Total	21,292	$209,330,999	100%

Medicaid Only

LOS (days)	Admissions	Paid Amount	% of Admissions
0-30	3,377	$7,420,884	62%
31-60	844	$6,095,403	15%
61-90	420	$5,425,724	8%
91-120	216	$3,879,569	4%
121-180	271	$7,848,613	5%
181-300	181	$8,324,015	3%
301-400	74	$4,517,866	1%
401+	71	$7,995,398	1%
Total	5,454	$51,507,471	100%

- 21% of dual eligible hospice admissions had an LOS greater than 180 days
- 6% of Medicaid only admissions had an LOS greater than 120 days

Monitor LOS

- Missouri's high ALOS is linked to the large number of hospice beneficiaries residing in NFs, both dual eligible and Medicaid only populations[1,2]
- NFs have significantly higher ALOS and reimbursement rates than those receiving care at home or other community-based settings[1,3]
  - Average Medicare reimbursement for beneficiaries in NF was 25% higher than for beneficiaries in other settings
  - Hospices that did not rely on institutionalized beneficiaries as a large percentage of their caseload (less than 15% institutionalized) had ALOS of 79 days in 2005. In contrast, for hospices with a high share of institutionalized beneficiaries (more than 40%) an ALOS of 117 days was reported. Such hospices had two times the proportion of stays with 180+ days
    - Beneficiaries in NF tend to be older, female, and more likely to have ill-defined conditions than their counterparts
    - Hospice patients in NFs are two times as likely to have diagnosis of (1) symptoms, signs, and ill defined conditions, (2) mental disorders, or (3) Alzheimer's. All these diagnoses experience the longest ALOS in hospice care, regardless of setting

Sources: [1]DHSS OIG Report. Medicare Hospice Care – A Comparison of Beneficiaries in Nursing Facilities and Beneficiaries in Other Settings. Dec, 2007, [2]MO MO HealthNet Data. File Name: Hospice –Third Round Split, [3]MedPac Report to Congress: Medicare Payment Policy, March 2009

MO HealthNet Hospice Statistics, by Beneficiary Category and Setting (Jan 2005 – Sep 2009)

Beneficiary Category	Hospice Setting	Admissions	Days	Paid Amount	$ Paid Per Day	ALOS	Percent of Admissions	Percent of Days	Percent of Payments
Dual Eligibles	Nursing Home	20,028	2,277,184	$197,895,722	$87	114	75%	85%	76%
	Other	1,189	107,248	$9,802,576	$91	90	4%	4%	4%
	Total	21,217	2,384,791	$207,698,298	$87	112	80%	89%	80%
Medicaid Only	Nursing Home	1,766	125,739	$28,019,459	$223	71	7%	5%	11%
	Other	3,683	156,159	$23,443,807	$150	42	14%	6%	9%
	Total	5,449	281,713	$51,463,266	$183	52	20%	11%	20%
All Hospice Users	Nursing Home	21,794	2,402,923	$225,915,181	$94	110	82%	90%	87%
	Other	4,872	263,407	$33,246,383	$126	54	18%	10%	13%
	Total	26,666	2,666,504	$259,161,564	$97	100	100%	100%	100%

* An admission was considered to be in a nursing facility setting if the facility room and board revenue code (658) had been billed during the admission.

- 94% of dual eligible hospice admissions occurred in a nursing facility setting; average length of stay (ALOS) across these admissions was 26% longer than those at home or in the community
- 32% of Medicaid only admissions occurred in a nursing facility setting; the ALOS for these admissions were 68% longer than those at home or in the community

Most NF Residents Who Transfer to NF-based Hospice Care are Dual Eligibles

- Nearly 85% of NF-based hospice patients appear to have been NF residents prior to the hospice span
- 89% of these residents are dual-eligible, and their hospice service is paid as a Medicare Part A benefit
- Upon transfer to hospice, MO HealthNet liability is reduced from 100% of the NF per diem to 95%

Source: Lewin analysis of Mo HealthNet claims data

Address High Length of Stay

- Monitor hospice vendors for LOS, especially for Medicaid-only participants
  - Current MO HealthNet Policy
    - No policies in place regarding LOS other than fulfilling recertification standards and document requests
  - Recommendations:[1]
    - Identify and expand oversight of vendors having greater than predetermined percentage of clients over the 180-day period
    - Require medical director review of all cases with certifying physician/NP
    - Explore possibility of requiring prior authorization for hospice care in nursing facilities
    - Focus on Medicaid-only participants for whom MO HealthNet is bearing the full cost of care
      - For duals, hospice length of stay is not an impactful issue itself (since MO HealthNet pays only 95% of the NF per diem); location of hospice services deserves attention
      - Savings would be realized by shifting hospice service to the community

Source: [1] MedPac Report to Congress: Medicare Payment Policy, March 2009

Strengthen Certification and Recertification Requirements

Enhance Recertification Requirements

- Current MO HealthNet policy follows Medicare certification and recertification processes:
  - Hospices submit a Physician Certification of Terminal Illness
  - Election periods are 90-90-60, followed by an unlimited number of 60 day periods
- MedPac Recommendations (March 2009 Report to Congress):[1]
  - Require that a hospice physician or nurse practitioner visit the patient to determine continued eligibility prior to the 180th day recertification, and each subsequent recertification
  - Mandate documentation demonstrating that such visits took place
  - Require certifications and recertifications to include a brief paragraph describing the clinical basis for the decision

Source: [1] MedPac Report to Congress: Medicare Payment Policy, March 2009

Closely Monitor MedPac Recommendations for Potential Implementation

Closely Monitor MedPac Recommendations for Potential Implementation

- MedPac direction:
  - Looking to change from the flat per diem rate model, suggesting a per diem model where rates at the start of the hospice beneficiary term are relatively high, then decline as the length of the episode increases
  - An additional payment would be provided at the time of the beneficiary's death to account for costs
- While CMS has not yet moved forward with this recommendation, it has the potential to reform current LOS incentives

Source: [1]MedPac Report to Congress: Medicare Payment Policy, March 2009

Enhance Claims Monitoring

Claims Monitoring

- In a recent OIG report, over 80% of claims for hospice beneficiaries in nursing facilities did not meet at least one Medicare coverage requirement. 33% did not meet election requirements[1]
  - 63% did not meet Plan of Care requirements
  - 31% provided fewer services than noted in the Plan of Care
  - 4% did not meet certification of terminal illness requirements
  - Claims for not for profit hospices were less likely to meet Medicare requirements than for profit
- Such findings indicate enhanced oversight is likely needed in the certification and recertification process
  - Staffing costs and constraints may limit ability to provide additional oversight

Source: [1] DHHS OIG Report. Medicare Hospice Care for Beneficiaries in Nursing Facilities: Compliance with Medicare Coverage Requirement, Sept. 2009

Claims Monitoring (continued)

- Additional areas to monitor / incorporate new MMIS edits:
  - Terminal illness services
    - Monitor additional payments made outside of the hospice daily rate, ensuring MMIS edit is preventing incorrect payments
    - Such payments must be unrelated to the beneficiary's terminal illness diagnosis
  - Ensure nursing homes are not receiving "double payments"
    - Potential for the NF hospice residents to receive NF room and board payments twice – to both the hospice and to the NF
    - In a few cases (less than 100 per year from 2006-2009) Lewin identified NF hospice room and board claims that appeared to overlap NF claims
      - While the number of claims and payments is small, this is an opportunity to monitor MMIS edit
      - Timing of claims from hospice and NF would determine which claim is impacted
  - Ensure MO HealthNet is not paying for hospice services (other than room and board and applicable cost sharing) for dual eligibles since this is under the Medicare benefit

Appendix A:
State Care Management Program Overviews

North Carolina: Program Overview

- 1998 – Present: Community Care of North Carolina
- Model: Contracts directly with 14 physician networks
- Populations: Medicaid enrollees (with few exceptions)
- Conditions targeted: asthma, CHF, diabetes, high ER utilization, and high cost patients
  - Individual networks are piloting programs in obesity, attention deficit or hyperactivity disorder, COPD, mental health integration, dual eligibles, and sickle cell anemia
- Program interventions:
  - Medical home
  - Call center
  - Telephonic and in-person care management
  - Provider reporting
  - Evidence-based guidelines

North Carolina: Program Outcomes

Type of Measure/Disease	Outcomes
Financial and Utilization: Asthma	$3.5 million in savings over 3 years attributed to decrease in ER visits
Access: Asthma	112% increase in the number of asthmatic patients receiving flu vaccines
Financial: Diabetes	$2.1 million in savings over three years
Utilization: Diabetes	9% lower hospital admissions
Financial: Pharmacy	Almost $1 million in savings achieved during the first two quarters of SFY05 attributed to coverage of OTC medications and selected drugs from PAL

Sources: Program Impact. Community Care of North Carolina, 2007. Mercer OTC Report. Community Care of North Carolina, 2005.

Indiana: Program Overview

- 2003–2007: Indiana Chronic Disease Management Program (ICDMP)
- Model: partnerships with local agencies and vendors
  - Call Center: Americhoice
  - Nurse Care Managers: Indiana Primary Health Care Association
  - Program Evaluation: Regenstrief Institute at Indiana University
- Populations: aged, blind, and disabled population in PCCM
- Conditions targeted:
  - Asthma
  - Diabetes
  - Congestive heart failure
  - Cardiovascular disease
  - Chronic kidney disease

Indiana: Program Overview

- Program interventions:
  - Call center
  - Telephonic and in-person care management
  - Clinical disease management registry
  - Provider collaboratives and toolkits
    - At program implementation, Indiana conducted provider collaboratives, which included 3 learning sessions followed by action periods. Teams implemented practice site improvements and reported results back to the State
- 2007: Drawing on the strengths of ICDMP, Indiana is implementing Indiana Care Select Program to provide comprehensive care coordination for all non-dual eligible PCCM/FFS Medicaid beneficiaries
  - Indiana will wrap ICDMP into Indiana Care Select

Indiana: Program Outcomes

Type of Measure/Disease	Outcomes
Financial: CHF and Diabetes combined	Approximately $29 million in savings
Financial and Utilization: CHF	Reduction in PMPM costs over 18 months, attributed to fewer and shorter hospitalizations
Financial: CHF	Beneficiaries in the care management program had lower hospital costs, but higher drug costs The net savings found were $720 PMPM or $36 million annually for 4,300 beneficiaries statewide
Financial: Diabetes	Net cost of $41 PMPM
Clinical: Diabetes	Decrease in HbA1c levels
Satisfaction: Program-wide	94% of patients found the nurse case management helpful in managing their disease

Source: Press Release: Chronic Disease Management could save millions. State of Indiana, 2005.

Washington: Program Overview

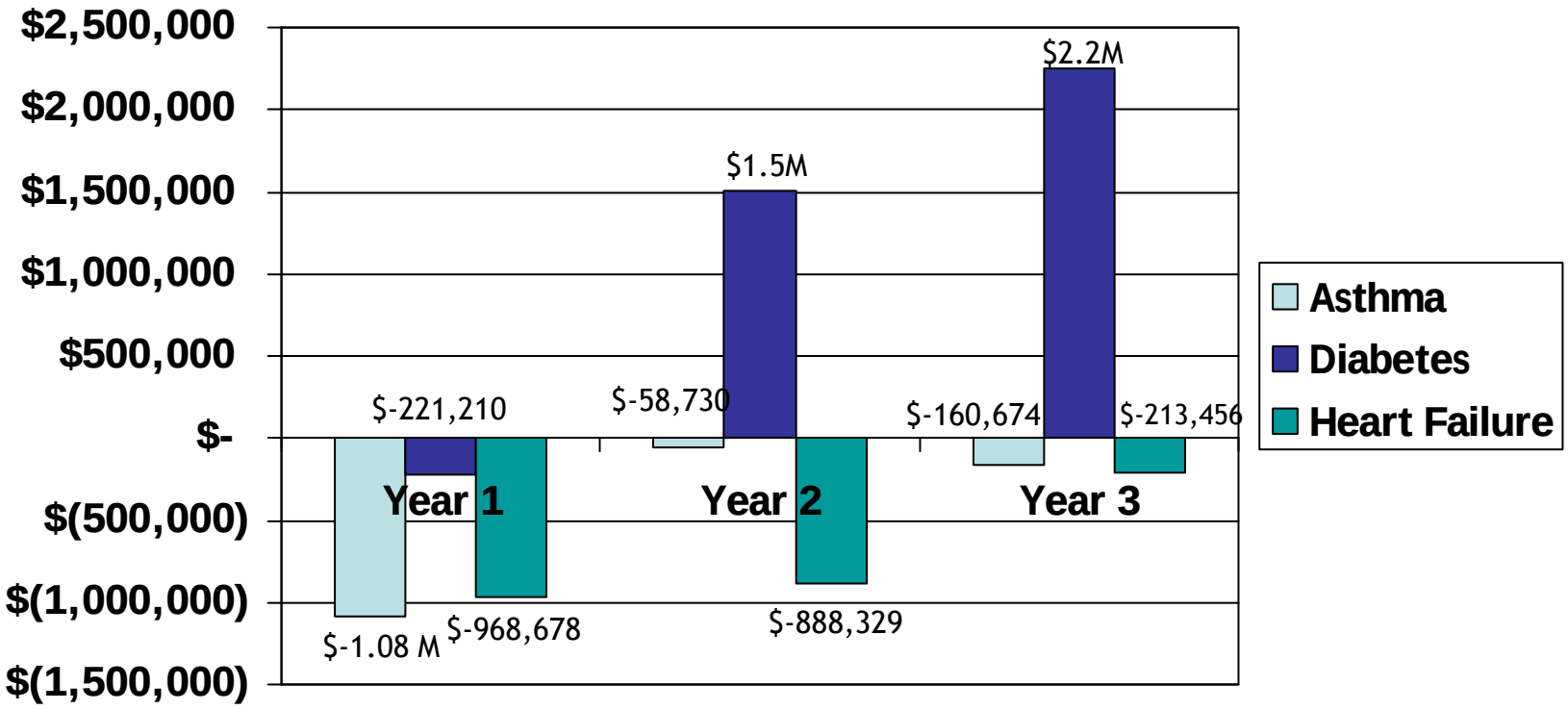
- 2002 – 2006: Chronic Disease Management Program
- Model: Contracted with McKesson Health Solutions and Renaissance
- Conditions targeted: asthma, diabetes, CHF, COPD, end stage renal disease, and kidney disease
- Program interventions: assessment, nurse advice line, nurse care managers, patient education
- Program difficulties included difficult financial reconciliation and few significant outcomes

Washington: 2006 Outcomes (4th year)

Type of Measure/Disease	Outcomes
Financial: Program-wide	Approximately $13 million
Financial: Asthma	$63.42 PMPM savings
Utilization: Asthma	Hospital LOS decreased for high risk patients who were hospitalized
Financial: Diabetes	$122.22 PMPM savings
Access: Diabetes	21% increase in % of patients with LDL ≤ 100
Access: Diabetes	Twice as likely to receive an HbA1c test
Financial: COPD	$117.19 PMPM savings

Source: McKesson Disease Management Savings Evaluation, Contract Period 8/01/05 – 6/30/06. Washington State, 2007.

Washington's DM Program Experienced Program Net Savings Only in the 4th year (2006)



In Year 4, Washington observed a $13.3 million program-wide savings

Sources: McKesson Disease Management Savings Evaluations, Contract Period 8/01/05 – 6/30/06. Washington State, 2007.

Washington: New Strategy (2007)

- Created a new program with both a statewide vendor and local vendor
  - **Statewide program:** Contracts with Americhoice to provide care management services and a predictive modeling mechanism
  - **Local pilot program:** Contracts with a local organization, Seattle Aging and Disability Services (Seattle ADS), to coordinate medical home and care management services for residents of King County
- Program goals
  - Identify clients who need care management, using predictive modeling
  - Support medical home development for Medicaid clients
  - Improve health outcomes for program enrollees using evidence-based medicine
  - Intervene with enrollees to prevent avoidable medical costs through improving self-management skills

Pennsylvania: Program Overview

- 2005 – 2009
- Model: Contracts with McKesson to operate PCCM and DM program
  - McKesson subcontracts with Automated Health Systems' for PCCM program
- Populations: beneficiaries not in MCOs
- Conditions targeted: asthma, diabetes, CHF, cardiovascular disease, COPD, high-risk
- Program Interventions: prevention, telephonic and in-person care management, intensive case management for high-risk beneficiaries, and pay for participation program for providers
- New contract awarded on 2009

Wyoming: Program Overview

- 2004 – Present: Healthy Together
- Model: Contracts with APS Healthcare to operate DM program
- Populations: All Medicaid enrollees
- Conditions targeted: asthma, diabetes, CHF, coronary artery disease, COPD, depression, high-risk obstetrics
- Program Interventions: education and motivational events, telephonic and in-person care management, physician outreach, telemedicine through Healthy Buddy device
- Program Evaluation: Contracts with actuarial consulting firm

Wyoming: Year 2 Program Outcomes

Type of Measure/Disease	Outcomes
Access: Coronary Artery Disease	42% increase in the number of CAD clients with a flu vaccine in the last year
Access: Depression	27% increase in number of clients who underwent an acute 180-day treatment with antidepressant medication
Utilization: Asthma	50% decrease in the number of inpatient admissions related to asthma
Utilization: Program-wide	14% decrease in average length of hospital stay
Clinical: Congestive Heart Failure	11% increase in the number of clients with a prescription for ACE inhibitor or an ARB