MO HEALTHNET OVERSIGHT COMMITTEE
FEBRUARY 2, 2010

This packet contains the following information:

1. 2010 Tentative Meeting Schedule

2. MO HealthNet participation by eligibility category

3. FY 2011 MO HealthNet Budget Overview Presentation of Marga Hoelscher

4. MO HealthNet Comprehensive Assessment – Summary of Deliverables and Due Dates

5. Biographies of The Lewin Group Staff

6. Presentation to the MO HealthNet Oversight Committee by The Lewin Group

7. MO HealthNet Managed Care Cost Avoidance Presentation by Mercer

8. MO HealthNet Chronic Care Improvement Program (CCIP) Financial and Clinical Evaluation Presentation by Mercer

9. Handouts Offered During Open Public Comment Period

MO HEALTHNET OVERSIGHT COMMITTEE
2010 TENTATIVE MEETING SCHEDULE

February 2, 2010

May 25, 2010

August 3, 2010

November 9, 2010

All meetings will convene at 12:00 Noon and adjourn no later than 4:00 p.m.

205 Jefferson, 10th Floor, Conference Room B
Jefferson City, MO

CALL 573-751-6961 FOR ADDITIONAL INFORMATION

Revised February 2, 2010

MoHealthNet Participation

	Participants as of March 2008	Participants as of December 2009 (Preliminary)	Change Since March 2008	Percentage of December 2009 Participants (Preliminary)	Current Income Eligibility Maximums (Shown as a Percentage of Federal Poverty Level)	Budgeted Participants by June 2010
Children	484,750	532,134	+47,384	60.4%	300%	550,910
Persons with Disabilities	147,208	158,273	+11,065	18.0%	85%	160,569
Custodial Parents	74,561	84,025	+9,464	9.5%	TANF level (approximately 19%)	76,778
Seniors	76,808	78,317	+1,509	8.9%	85%	79,111
Pregnant Women	28,301	28,370	+69	3.2%	185%	32,563
Total	811,628	881,119	+69,491			899,931
Women's Health Services	19,831	37,107	+17,276		185%	63,622

Source: Missouri Department of Social Services, Family Support Division/MO HealthNet Division, Monthly Management Report

Budget Overview for MO HealthNet Oversight Committee

Presented by Marga Hoelscher, CPA MPA

Chief Financial Officer

February 2, 2010

Presentation Highlights

- State Revenues and Appropriations
- FY 11 Budget—All funds and GR
- FY 11 MO HealthNet Budget by Agency
- MO HealthNet Budget Reductions
- MO HealthNet Budget New Decision Items

State Revenues

State Revenues

- FY 2010 Original CRE was $7.764 billion
- Revised CRE for FY 2010 is $6.971 billion,
  - 6.4% **decline** from the FY 2009 actual net collections.
  - Reduction of $793 million from prior year collections
- FY 2011 CRE is $7.22 billion
  - 3.6% **increase** over revised CRE
  - Increase of $252.3 million
  - Below FY 2008 collections of $8 billion and FY 2009 collections of $7.45 billion

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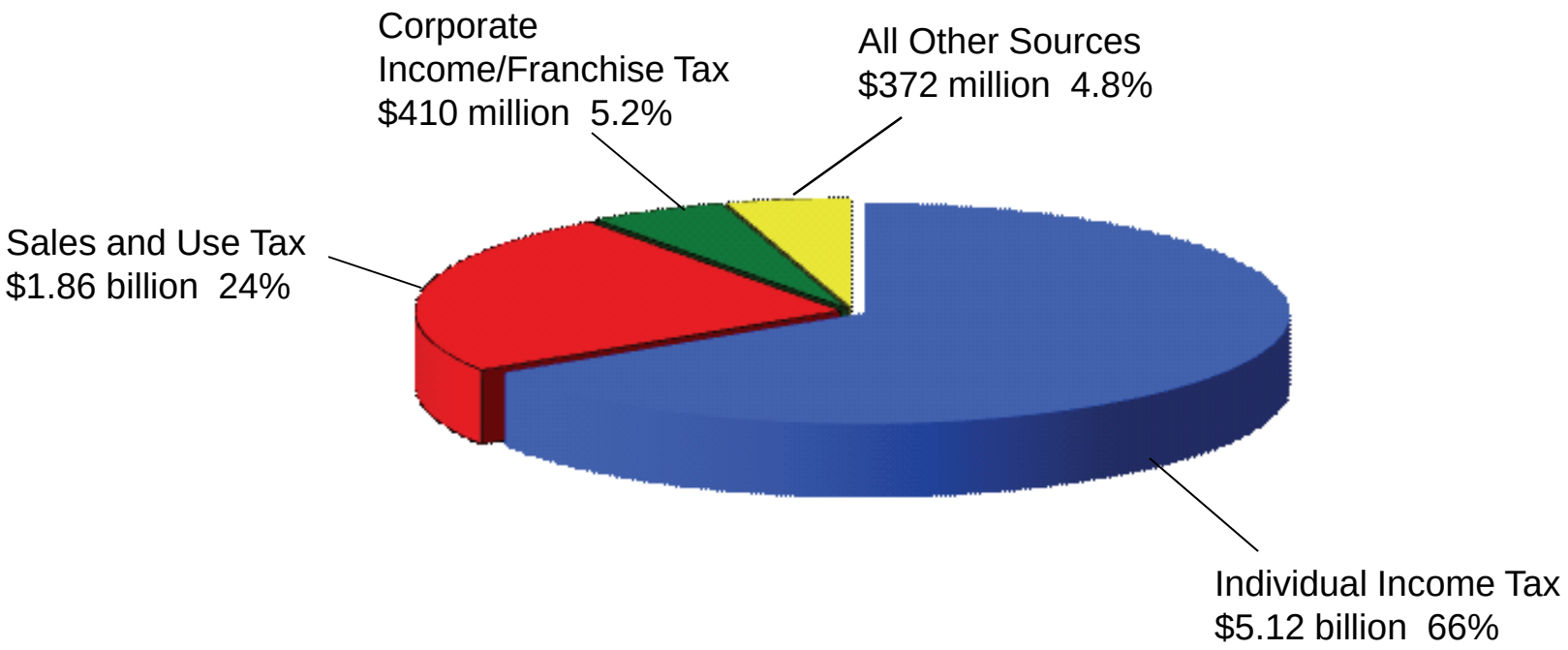
State Revenues

- Recession significantly impacted General Revenue collections

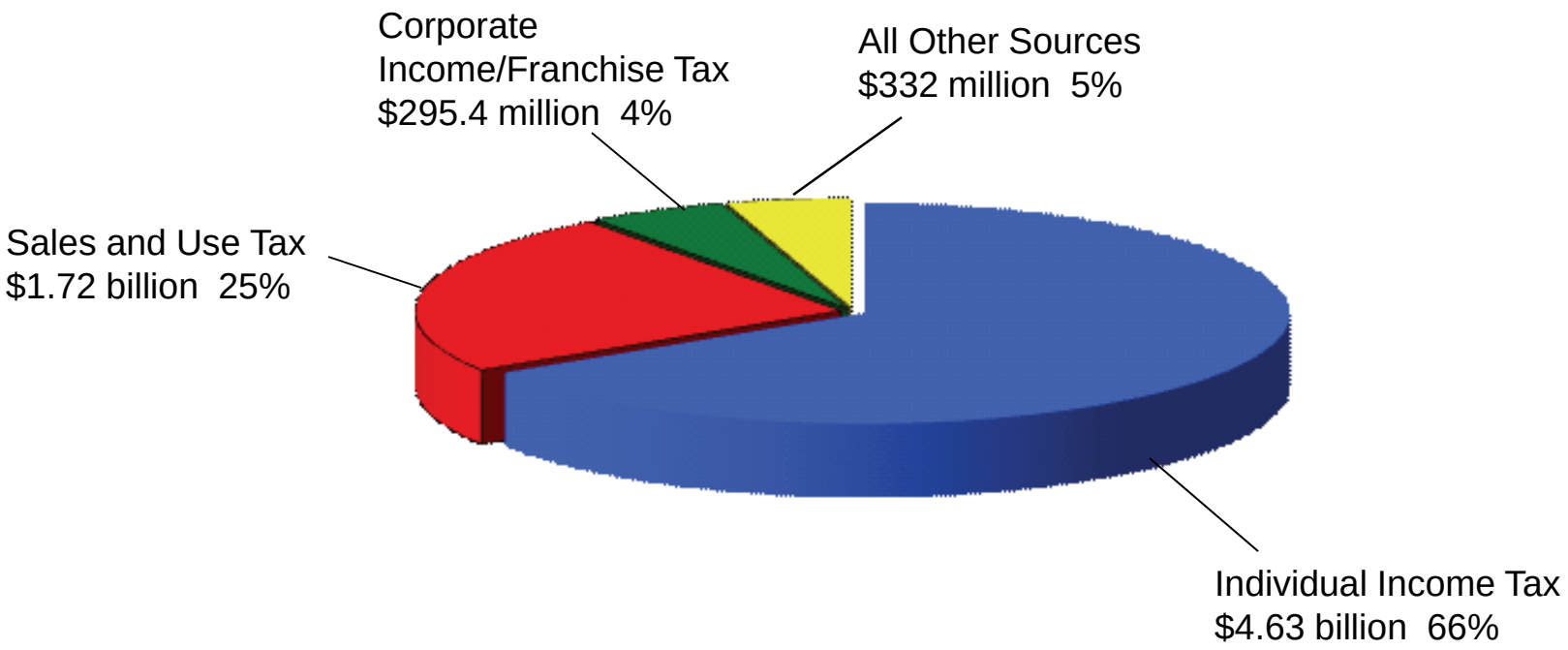
- FY 10 estimates of major revenue sources:
  - Sales and use tax collections **decrease** of 5.3%
  - Individual income tax collections **decrease** of 5.1%
  - Corporate income tax collections **decrease** of 17.5%

- FY 11 CRE assumes Missouri economy improves:
  - Sales and use tax collections **increase** of **2.7**%
  - Individual income tax collections **increase** of **3.7%**
  - Corporate income tax collections **increase** of **19.2%**

FY 2010 Original CRE
Net General Revenue $7.76 Billion



FY 2010 Revised CRE
Net General Revenue $6.97 Billion



General Revenue Growth Rates

Fiscal Year	% Growth
FY 2005	5.8%
FY 2006	9.2%
FY 2007	5.2%
FY 2008	3.1%
FY 2009	-6.9%
FY 2010*	-6.4%
FY 2011*	3.6%

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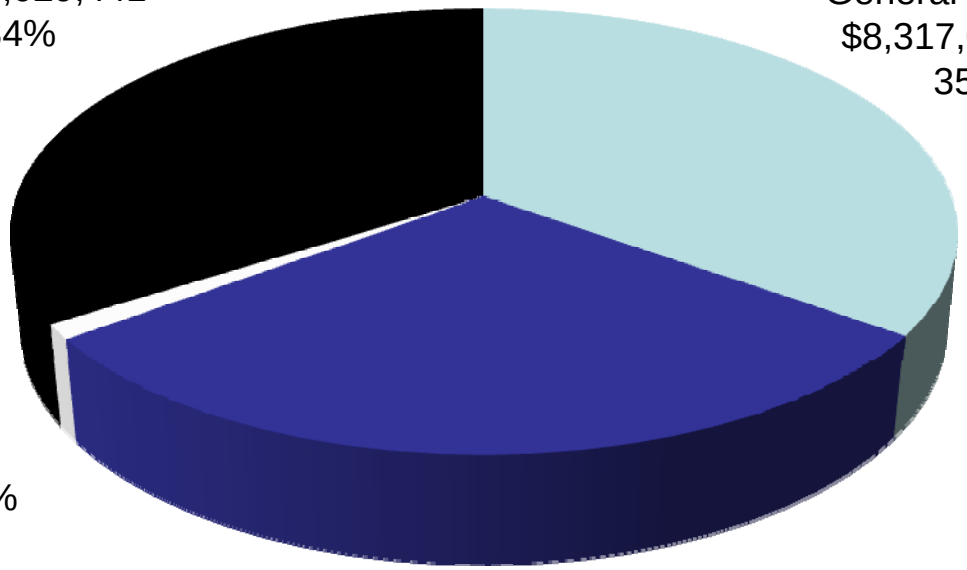
State Appropriations

FY 2011 Total Operating Budget

Sources of Funds – Governor's Recommendation

All Funds

$23,857,795,551



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FY 2011 Budget Reductions

Governor's Recommendation

Actions Recommended to Balance the Budget:

- 544 fewer positions
- $253 million in General Revenue reductions
  - MO HealthNet ($121 million)
- $27 million transfer from other state funds
- $26 million DOR collection efficiencies

TOTAL MEDICAID ALL AGENCIES
FY 2011 Governor's Recommendation

	FY 2011 Core and New Decision Items-Governor			
	GR	**FED**	**OTHER**	**TOTAL**
Elementary and Secondary Education	$0	$500,000	$2,945,254	$3,445,254
Mental Health	$239,749,327	$445,025,169	$19,066,523	$703,841,019
Health and Senior Services	$196,620,346	$339,718,476	$450,001	$536,788,823
Social Services	$1,269,043,912	$3,435,285,968	$2,086,983,131	$6,791,313,011
Total	$1,705,413,585	$4,220,529,613	$2,109,444,909	$8,035,388,107

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New Decision Items – Governor's Recommendation

	FY 2011 New Decision Items-Governor			
	GR	**FED**	**OTHER**	**TOTAL**
Elementary and Secondary Education	$0	$0	$0	$0
Mental Health	$15,443,596	$21,009,935	$275,228	$35,090,346
Health and Senior Services	$20,500,250	$30,887,537	$0	$51,387,787
Social Services	$216,464,313	$423,491,259	$248,386,699	$888,342,271
Total	$252,408,159	$475,388,731	$248,661,927	$974,820,404

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MO HealthNet - FY 2011 DSS New Decision Items

	Governor Recommendation
Cost-to-Continue Medicaid Programs	$242,788,407
MHD Caseload Growth	$155,425,259
Managed Care GR Tax Replacement	$7,443,750
Pharmacy PMPM Increase	$49,964,292
Pharmacy Clawback	$10,701,025
FMAP Adjustment	$44,208,303
Medicare Premium Increases	$21,748,045
Hospice Rate Increase	$220,621
IGT Safety Net Increase	$20,654,549
Cyber Access Pick-up	$2,187,500
Ambulance Reimbursement Methodology and Tax FTE	$2,958,188
IGT DMH	$178,630,216
Increase FRA Authority	$63,329,394
Pharmacy Reimbursement Authority	$88,082,722
DSS NDI Total	$888,342,271

FY 2011 MO HealthNet GR Savings

Items in italics suggested by Lewin	**Governor Recommendation**
Increase NFFRA Tax (Nursing Facility)	*$1,046,419*
Medicare Part A Repricing (Nursing Facility)	*$12,000,000*
Require Medicare Certification (Nursing Facility)	*$40,000*
Improve Long-Term Sustainability of HCBS (In-Home)	*$3,644,930*
High Cost HCBS Review (In-Home)	*$750,000*
Telephony (In-Home)	*$750,000*
Eliminate Advanced Personal Care (In-Home)	$306,896
Reduce Adult Day Health Care benefit (In-Home)	*$100,000*
Increase PFRA Tax and increase Dispensing Fee (Pharmacy)	$21,753,506
Increase Generic Utilization (Pharmacy)	$1,456,200
MAC Pricing for Specialty Drugs (Pharmacy)	*$3,000,000*
Manage Psychotropic Medications (Pharmacy)	*$9,700,000*
Better Manage High Cost Clients (Pharmacy)	*$5,424,622*

FY 2011 MO HealthNet GR Savings

Items in italics suggested by Lewin	**Governor Recommendation**
Reprice Medicare Part B Crossover Claims (Hospitals)	*$8,000,000*
Restructure Outpatient Methodologies (Hospitals)	$11,500,000
Reduce fee schedule to 90% of Medicare (Physicians)	*$3,000,000*
Reduce rates to 90% of Medicare (DME)	*$533,276*
Reduce rates to 90% of Medicare (Optical, Dental, Audiology, Lab and Radiology)	*$1,437,299*
Eliminate Dual Eligibles from CCIP	*$3,567,690*
Enhance Third Party Liability Efforts	$3,786,120
SSI/SSDI/Medicare Eligible Identification	$1,500,000
Managed Care Contracts with Hospitals	*$3,000,000*
Managed Care Efficiencies	$25,171,809
Total Recommended Savings	$121,468,769

MO HealthNet Comprehensive Assessment
Summary of Deliverables and Due Dates

Deliverable	Due Date
1. Project Management Work Plan	Within 2 weeks of Task Order execution
2. Pharmacy Review	November 1, 2009
3. Prioritized List of Short-Term Cost Containment Savings	November 30, 2009
4. Other Clinical Service Area Review	December 1, 2009
5. Long-Term Care Short-Term Cost Savings	December 15, 2009
6. Provider Assessment	January 31, 2010
7. Long-Term Care Longer-Term Cost Savings	February 28, 2010
8. High-Cost Beneficiaries and High-Volume Providers Analysis	February 28, 2010
9. Metrics and Dashboards	February 28, 2010
10. Finance and Budget Assessment	February 28, 2010
11. Final Medicaid Program Assessment	February 28, 2010
12. Non-Emergency Medical Transportation	February 28, 2010

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MO HealthNet Comprehensive Review

The Lewin Group: Project Team

Project Directors

Terry Savela & Kathy Kuhmerker

Project Team

Lisa Alecxih Joel Menges Erika Ange Moira Forbes Jessica Boehm

Tim Engelhardt Cindy Gruman Chris Park Jim Teisl David Zhang

Josh McFeeters Mary Pohl Roger Auerbach Deborah Van Houten

Joan Johnson Suzanne Love Colleen Ryan Jim Gartner

Supporting Consultants

Doug Brown Maik Schutze Jessica Maley Samantha Flanzer Chris Robinson

The Lewin Group
2009-2010 Project Team

Terry Savela
Managing Director

Ms. Savela has worked for The Lewin Group since 1985. Ms. Savela's career has focused on Medicaid policy analysis and modeling; program development, implementation, administration, and evaluation for public payers; cost-effectiveness analyses, rate setting, and reimbursement model design; and research on the impact of managed care on safety net providers. Ms. Savela has worked with state and federal agencies, legislators, and stakeholder representatives to assist in introducing new delivery system models for state projects involving Medicaid, children's health insurance, general assistance populations, and health benefits for public employees, as well as for the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). Ms. Savela's role on these and other projects includes developing and implementing methodologies for calculating payment rates and designing risk sharing arrangements; developing recommendations for benefit packages, geographic areas, beneficiary populations and other program design components; drafting RFPs and developing, negotiating, and evaluating provider contracts; developing the administrative rules and procedures required to operate the program; designing program monitoring tools for payers; performing extensive on-site evaluations of managed care organizations and providers; and identifying and documenting new administrative systems-related requirements needed to operate the program. For the past several years, she has functioned as the Chief Information Officer in Lewin's role as the Statistical Contractor for the 2006-2008 cycles of PERM administered by CMS. In this role, Ms. Savela oversaw Lewin data managers and provided guidance to all 50 states and the District of Columbia in their efforts to submit complete and accurate Medicaid and SCHIP claims universes. She is currently directing a large independent study for CMS, at the behest of Congress, to assess the underlying issues and projected impact of four proposed regulations on the Medicaid programs of all 50 states and D.C. This project resulted in a report to Congress delivered in December 2009.

Ms. Savela has also worked for HRSA on projects relating to the managed care readiness and viability of Community Health Centers and on other issues affecting the nation's safety-net providers Prior to 1992, Ms. Savela's work focused on supporting the Office of the Assistant Secretary of Defense for Health Affairs on a series of projects that involved designing and implementing new health care delivery programs and evaluated programs for increasing the productivity and effectiveness of military hospitals and clinics. Ms. Savela earned her BA in Economics and Political Science from Wellesley College.

Kathy Kuhmerker
Managing Director

Ms. Kuhmerker joined The Lewin Group in February 2008. Ms. Kuhmerker has extensive experience with pay-for-performance (P4P) and value-based purchasing programs, health care for the uninsured, long-term care, and Medicaid program design, management and implementation. Since joining Lewin, she has worked with the Minnesota Medicaid program to analyze its personal care services program, the Medi-Cal program in California to assist them in the design and development of the program's Electronic Health Record Incentive Plan, and with the New York State Health Foundation to develop a roadmap for cost containment for the State.

Ms. Kuhmerker served as Director of New York State's $46 billion Medicaid program, responsible for managing the Medicaid program and its relationships with all levels of government and numerous advocacy and interest groups, for over six years. During her tenure as Medicaid Director, Ms. Kuhmerker implemented New York State's 1115 waiver, which established the Family Health Plus program for low-income adults; led the Department of Health's efforts to rebalance the State's long-term care system; implemented the State's replacement Medicaid Management Information System; reinvigorated the Medicaid program's focus on identifying and eliminating fraud, waste, and abuse; and, directed the Medicaid program's innovative response to the September 11 attack on the World Trade Center.

Prior to becoming the Medicaid Director, she spent more than two decades working for the NYS Division of the Budget, which gave her broad knowledge of issues in the areas of Medicaid, health care, housing, mental retardation and developmental disabilities, transportation and state financing. Ms. Kuhmerker has also operated her own consulting firm, The Kuhmerker Consulting Group, which allowed her to work with most state Medicaid programs. Prior to joining The Lewin Group, Ms. Kuhmerker served as a Vice President at Affiliated Computer Services (ACS) where she focused on improving state, local and federal health care programs with an emphasis on the appropriate use of information technology.

Ms. Kuhmerker received her Master's degree in Health Systems Administration (MBA) from Union College and her BA in Anthropology from the State University of New York at Binghamton.

Joel Menges
Managing Director

Mr. Menges joined Lewin in 1993. His career focus has been on the design, development, and improvement of Medicaid initiatives, with most projects involving financial and other quantitative analyses. He has twenty years of experience in the analysis and development of Medicaid initiatives, and has worked directly with twenty-five states (AZ, CA, CO, CT, DE, FL, IA, IL, IN, KS, MA, MD, MI, MN, MO, NC, NM, NY, OH, OR, PA, SD, TX, WA and WV) and the District of Columbia in this area. He has conducted and led dozens of engagements that involved working with Medicaid claims data and developing an actuarial framework for estimating/ensuring program savings. He has developed capitation rates for several states' Medicaid managed care programs and conducted more than 100 cost impact analyses in the Medicaid arena over the course of his career at Lewin. Mr. Menges' first Medicaid engagement involved establishing capitation rates for Missouri's Medicaid managed care program during the late 1980's. Prior to joining Lewin, Mr. Menges held an executive position with a New York Medicaid health plan, and prior to that directed a national managed care consulting practice. He is closely familiar with the dynamics of managed care from the perspectives of states, employers, health plans, and providers. Mr. Menges received his BA in Economics from Kalamazoo College and his MPA in Health Policy Studies from Syracuse University.

Lisa Alecxih
Vice President

Ms. Alecxih joined The Lewin Group in 1987. Her training is in public policy analysis and public administration with an emphasis on health and human service issues. Ms. Alecxih has a background in the quantitative analysis of survey research data, the manipulation of large data bases (including health claims data), instrument design, health communication, and microsimulation modeling. She has particular research experience with long-term care, disabilities, and health insurance coverage. She graduated magna cum laude with a BS in Social Work from the University of Dayton and holds a Masters in Public Affairs from the University of Texas at Austin.

Erika Ange
Managing Consultant

Ms. Ange joined The Lewin Group in 2006 with close to fifteen years of experience in the health care industry. Ms. Ange specializes in working with payers and providers in the development of health care delivery systems, the design, implementation, and evaluation of public sector managed care programs, and compliance and program integrity. She has managed Medicaid engagements for several States, including Colorado, Florida, Kentucky, Maryland, North Carolina, Pennsylvania, and Texas. Ms. Ange has also managed operational and litigation engagements for both public and private sector clients, including health plans, public payers, and providers. She supervised several engagements involving the review of billing and coding practices for compliance with federal and state billing regulations. Prior to joining The Lewin Group, Ms. Ange worked in the payer practice at Navigant Consulting, Inc. and the national strategy practice at KPMG. She has been a Director at both the Maryland Hospital Association and the National Institute for Health Care Management Foundation, and has held positions at Strong Memorial Hospital and the University of Rochester Medical Center. Ms. Ange holds a BS from Cornell University and an MHA from The University of North Carolina at Chapel Hill.

Moira Forbes
Managing Consultant

Ms. Forbes works closely with private, state, and federal clients on Medicaid and CHIP policy. Her areas of focus include program integrity, managed care program development, implementation, and evaluation, eligibility policy, and federal and state regulation compliance. She has worked with all state Medicaid and CHIP programs on issues relating to program integrity, eligibility quality control, claims processing, and medical policy as Deputy Project Director of the federal Payment Error Rate Measurement program. Ms. Forbes has extensive familiarity with Medicaid laws and regulations and performs ongoing monitoring of the development of new federal policies for several public health programs. She received her BA in Russian from Bryn Mawr College and an MBA with a concentration in Finance from the George Washington University.

Jessica Boehm
Senior Consultant

Ms. Boehm joined the Lewin Group in 2002. She has extensive knowledge and understanding of Medicaid managed care and Primary Care Case Management (PCCM) programs. She has worked with several state Medicaid agencies as they evaluate and explore the feasibility and potential benefits of managed care, PCCM, and care management programs. Ms. Boehm also recently managed a large Knowledge Transfer (KT) project for Agency for Healthcare Research and Quality (AHRQ) on Medicaid care management. Through this project, AHRQ worked with 17 Medicaid programs, to measure performance and improve quality in their care management programs, and to share best practices across programs. Prior to joining The Lewin Group, Ms. Boehm worked at The Center for Health Care Strategies (CHCS) in Princeton, NJ. At CHCS, Ms. Boehm worked with state Medicaid and SCHIP agencies, through training and technical assistance opportunities, on topics including quality monitoring, performance incentives, primary care case management, and strategic planning. Ms. Boehm holds a Bachelor's degree and a Masters in Public Policy, both from Georgetown University.

Tim Engelhardt
Senior Consultant

Mr. Engelhardt joined the Lewin Group in 2006. Mr. Engelhardt's area of concentration is long term care for older adults and persons with disabilities. He works with a variety of federal, state, local, and private-sector clients, focusing on services for older adults, people with disabilities, and other vulnerable populations. He has led federal work on state health reform (for the Health Resources and Services Administration, HRSA), Medicaid cost containment (for CMS), and long term care reform (for the U.S. Administration on Aging) and supported state and local agencies and Medicaid health plans in California, Hawaii, Massachusetts, New Mexico, Ohio, Rhode Island, Texas, and West Virginia.

Prior to joining The Lewin Group, Mr. Engelhardt was the Deputy Director for Long Term Care Financing in Maryland's Department of Health and Mental Hygiene, where he oversaw Medicaid reimbursement for nursing facility and other institutional services, a multi-million dollar utilization control contract, and the state's PACE program. He received BA in Sociology from the University of Notre Dame and a MHS in Health Policy from the Johns Hopkins Bloomberg School of Public Health.

Cindy Gruman, PhD
Senior Consultant

Dr. Gruman joined the Lewin Group in 2008. Since 1989, she has been involved in planning, designing and conducting program and process evaluations with an emphasis on vocational rehabilitation programs, school-to-work transition, benefits counseling, home and community based direct service workforce issues, mental health disparities, and Medicare/Medicaid financing. She has extensive experience conducting and overseeing primary and secondary data collection, and analyzing qualitative and quantitative data. In addition, she has been actively involved with many technical assistance centers over the years. Prior to joining Lewin, Dr. Gruman was the lead evaluator on several Centers for Medicare and Medicaid Services' System Transformation grants where she provided ongoing technical assistance for state recipients of the Aging and Disability Resource Center grants, Nursing Home Diversion grants, and Veteran's Home and Community Based Services grants. The technical assistance she has provided include performance measures, information and referral technology, customer service standards, cost-effectiveness of home and community based services, organizational assessment and project sustainability. Dr. Gruman assisted in maintaining the technical assistance research center to help strengthen the research and data capacity of the Medicaid Infrastructure Grant state awardees as they monitored Medicaid Buy-In enrollees. She served as project liaison with the external co-directors of the center to coordinate activities and communicate work progress with the project director and oversaw an interactive web-based data exchange that was available to the research team and the broader-based research community. For the last 15 years, Dr. Gruman served as Assistant Professor/Adjunct in the Department of Medicine at the University of Connecticut. Her classes encompass issues related to disability policy, workplace integration, benefits counseling, and employment policy.

She has developed multiple public policy, program evaluation, and education projects from the following funding sources: CMS, Social Security Administration (SSA), Robert Wood Johnson Foundation (RWJF), Administration on Aging (AoA), and numerous state agencies.

Chris Park
Senior Consultant

Mr. Park re-joined The Lewin Group in July 2006. Mr. Park previously worked at The Lewin Group from 1999 to 2004. While at Lewin, Mr. Park has expertise providing quantitative modeling and financial analyses for private and public sector clients. He has worked extensively on Medicaid policy analyses, including Medicaid managed care capitation rate setting, the design, implementation, and cost projections of Medicaid managed care program expansions, the evaluation of Medicaid cost containment initiatives, and cost effectiveness analyses for 1915(b) waiver approval. Mr. Park has also been involved in extensive analyses of the Medicare Part D benefit, focusing on benefit design, drug pricing, and formulary analysis. He also has experience in analyzing pharmaceutical benefit design and cost containment

initiatives (e.g., preferred drug list, mandatory generics) and evaluating Medicaid drug rebate equalization and pharmacy carve-in/carve-out options for state Medicaid programs. He has worked on modeling the impact and benefits of an electronic application program for Medicaid and other county-based programs. In addition, he developed a web-based calculator to help states and other key stakeholders estimate potential Medicaid bonus payments made available through the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). Mr. Park also has prior experience analyzing operational variability in the hospital setting. Mr. Park has a BS in Chemistry from the University of Virginia and an MS in Health Policy and Management from the Harvard School of Public Health.

Jim Teisl
Senior Consultant

Mr. Teisl's experience includes health care policy development, provider operations improvement, Medicaid reimbursement reform, claims analysis, and financial projections. Since joining Lewin in 2008 Mr. Teisl has worked on a variety of projects including a market assessment for a behavioral health organization and a pilot project to improve the CMS Payment Error Rate Measurement (PERM) process. Mr. Teisl has interviewed Medicaid officials in all 50 states and D.C. regarding Medicaid financing, including intergovernmental transfers and certified public expenditures, and assessing conformance with the provisions of a proposed CMS regulation regarding payments to public providers. Prior to joining Lewin, Mr. Teisl was a Senior Consultant at Nexera, Inc., a consulting subsidiary of the Greater New York Hospital Association where he was responsible for managing a variety of projects to identify and implement operational improvements in heath care facilities.

Prior to his work at Nexera, Mr. Teisl was a Manager of Policy and Program Development for the Medicaid agency of the State of Ohio, where he helped to manage the reform and operations of the State's $3 billion dollar long-term care facility reimbursement system. Mr. Teisl holds an MPH in Health Finance and Management from The Johns Hopkins School of Public Health and a BA from The Johns Hopkins University.

David Zhang
Senior Programming Consultant

Mr. Zhang joined The Lewin Group in November 1988. Mr. Zhang has twenty years of experience in software engineering. He has done a variety of projects in numerical analysis, software product development, database design and application, systems administration and maintenance. His expertise and demonstrated skills include computing algorithm implementation, mathematical analysis, software systems development methodology, operating system and compiler design, database implementation and application, and computing systems architecture. Mr. Zhang is proficient in a variety of programming languages, including FORTRAN, SAS,

Ada, C, Pascal, and Assembly languages. Mr. Zhang's experience includes computer programming development for Medicaid managed care analyses. He has been responsible for the entire computer programming development of Medicaid managed care analyses for the State of Iowa, Connecticut, West Virginia, Montana, New Mexico and District of Columbia. His basic programming work includes developing a series of algorithms to investigate and clean up the raw claims database and eligibility database, checking the data for accuracy and completeness, analyzing the data and designing functional data structure, linking population data and claims data, choosing efficient programming tools, and implementing all logic and requirements in programming to meet each analysis. He has also been involved in a number of analytical projects, providing computer programming support for numerical analysis, model design and algorithm implementation based on CPS, CACI, ARF, CHAMPUS, and HCFA claims data (both Part A and Part B), BMAD, MEDPAR. Mr. Zhang earned an MS in computer science from George Washington University and a BS in computer science from The Northeastern University of Technology in Shengyang, China.

Joshua McFeeters
Consultant

Mr. McFeeters joined the Lewin Group in August, 2007. His work focuses on access and eligibility issues for Medicaid and SCHIP, Medicare and Medicaid reimbursement for physicians and hospitals, the cost of health care, and the evaluation of new public health insurance initiatives. Current projects include the evaluation of a state program assisting individuals with serious mental illness maintain independence and employment, and a CMS-sponsored project to measure the accuracy of claims payment in Medicaid. Prior to joining Lewin, Mr. McFeeters worked at the Urban Institute, studying the effects of premium increases on enrollment in SCHIP, analyzing Medicaid and Medicare payment issues, and examining how insurance coverage affects out-of-pocket health care spending. Mr. McFeeters has also worked as a computer programmer and quality assurance tester for EDS on the Wisconsin Medicaid Title XIX Account. In addition to working on Medicaid claims processing, Mr. McFeeters provided programming support to several Medicaid related programs including the Wisconsin Chronic Disease Program and Wisconcare, a limited health insurance program for people who are unemployed. Mr. McFeeters received his Masters of Public Policy from the University of Chicago, and has a BS in Food Science from the University of Wisconsin-Madison.

Mary Beth Pohl
Consultant

Ms. Pohl has ten years experience working with state Medicaid programs and state claims data. For several years, Ms. Pohl served as the data manager with the CMS Payment Error Rate

Measurement (PERM) project where she worked with nearly all 50 States and the District to Columbia to facilitate and review the states' PERM data submissions. Ms. Pohl has also has significant experience with legislation and regulation at the state and federal level, including developing impact and fiscal assessments of proposed legislation. Prior to joining the Lewin Group, Ms. Pohl served an advisor to Maryland Medicaid's Executive Director where she focused on a range of policy areas, primarily in long-term care and home and community-based services waivers. Ms. Pohl developed an expertise for developing solutions to bridge Medicaid program needs and operational implementation and served as the Department lead for developing MMIS solutions for HIPAA and NPI implementation. Ms. Pohl has also developed quantitative analysis of public insurance expansion programs for uninsured populations and created several large modeling programs to produce health coverage estimates. Ms. Pohl has an undergraduate degree in Public Health from The Johns Hopkins University.

Roger Auerbach
Consulting Director

Mr. Auerbach joined Lewin in 2001 after leaving his position as Administrator of Oregon's Senior and Disabled Services Division where he was responsible for all long-term care programs for older adults and persons with physical disabilities, including Medicaid institutional and home and community-based waiver services, licensure, and regulation of providers. At Lewin he has worked on research and evaluation of existing community-based service models for people with disabilities of all ages, making recommendations for improving existing programs and implementing new programs. Mr. Auerbach also has significant experience in preventive, primary and acute care services from his work as Senior Policy Advisor to the Governor for Health primarily focused on health reform (1991-94).

Deborah Van Houten, RN
Consulting Director

Ms. Van Houten is a health care nurse executive with extensive experience leading multiple organizations and departments in multimillion-dollar corporations. She is an expert in identifying operational efficiencies and reducing expenses for healthcare plans. In her current role with Caring Solutions Inc., she has worked with various entities including McKesson, Denver Hospice, Colorado Clinical Guideline Collaborative, UnitedHealth Group, and the Colorado Department of Health Care Policy and Financing, on delivery system and business design/model analysis.

Previously Ms. Van Houten served as the Product Lead for UnitedHealth Group's Evercare where she was responsible for site expansion planning and execution, competitive intelligence, product design, marketing and sales, clinical model innovation, medical expense management, quality, compliance, and operational improvement. She has also worked as the Executive

Director of Evercare Colorado where she successfully positioned Evercare for future product and location expansion working with nursing facility owners and operators, physicians, hospitals, senior support organizations, and CMS. Ms. Van Houten holds a BS in Nursing from the Brockport State College, and an AD in Nursing from Alfred State College. She is a Colorado State Registered Professional Nurse.

Joan Johnson
Consulting Director

Ms. Johnson has worked extensively with the New York Departments of Health (DOH) and Social Services over the past 30 years. She recently served as the Director of Medicaid Fraud Control and Program Integrity in the Department of Health's Office of Medicaid Management, managing provider relations and program integrity for the State's $46 billion Medicaid program. Ms. Johnson is also a subject matter expert in health systems management. Her work as New York's Director of Medicaid Systems included large-scale projects within DOH, such as developing the Replacement Medicaid Systems reprocurement for the Medicaid Management Information System (MMIS) and the Electronic Medicaid Eligibility Verification System (EMEVS). She has managed systems applications, handling their maintenance and operations, for State agencies such as the Offices of Children and Family Services (OCFS) and Temporary and Disability Assistance (OTDA), as well as their local department of social services counterparts. She is a graduate of State University College at Cortland.

Suzanne Love
Consulting Director

Ms. Love has extensive experience in the implementation of initiatives to contain Medical Assistance (MA) Program costs through improved management and more efficient and effective use of budgetary resources. She has worked closely with the Pennsylvania Department of Welfare, serving in multiple roles including the Director of Bureau of Policy, Budget and Planning, the Director of the Bureau of Outpatient Programs, the Division Director of Policy and Program Development, and the Section Chief of Pharmacy and Ancillary Services. Ms. Love has been a key player in the development, implementation and maintenance of the regulatory and operational base for all federally and state funded public assistance programs in PA. Through her work she has been involved in analyses of legislation and federal directives, development of procurement documents, federal waivers, state plan amendments, and regulations for cost saving initiatives such as Preferred Drug List with Supplemental Rebates, and Selective Contracting for specific MA Program services such as specialty pharmacy drugs. She received her Bachelor of Arts from the University of Pittsburgh.

Colleen Ryan
Consulting Director

Ms. Ryan currently serves as a Senior Consultant in Health and Technology Innovation at Ingenix Consulting. She is a clinical and business development advisor to health plans and

pharmacy benefit management clients, with a particular expertise in medical management operations, strategic marketing, and new business development. In her twenty-six years in the healthcare industry, she has developed clinical criteria for medical management programs employed across the nation, designed and implemented disease management programs, directed health plan medical management operations, and designed Pharmacy Audit solutions for Medicare Part D and commercial clients. She is an inventor on two U.S. Patents for Medication Adherence and the Disease Management process flow. Ms. Ryan received an MBA from the University of Phoenix and a BSN from Boston University.

Jim Gartner RPh, MBA
Consulting Director

Mr. Gartner has vast experience in the pharmacy arena serving as the Director of Pharmacy for a leading Consumer Directed Health Plan (CDHP), a specialty Pharmacy Program Manager for large national retailer in their Pharmacy merchandising area, and a Senior Account Director for Fortune 100 companies within a large national PBM. Over the years he has managed several large client product implementations, including large hospital employer implemented choices in pharmacy benefits with internet capabilities to help in selection process. Through his experiences, Jim provides expertise in the pharmacy industry from the point of dispensing to the processing of claims at the PBM with the ability to understand the pharmacy business from the point of view of the consumer, pharmacist and plan. Mr. Gartner has served on the Academy of Managed Care Pharmacy's Professional Practice Committee. He has spoken at their national conference as well as Medco's National Trend Conference. Mr. Gartner holds a BS in Pharmacy from Ohio Northern University and an MBA with concentration in Healthcare Administration from Cleveland State University.

The LEWIN GROUP®



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

Presentation to the MO HealthNet Oversight Committee

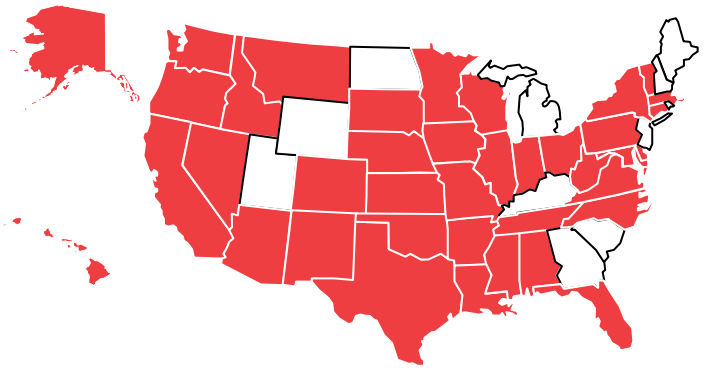
Terry Savela, Managing Director

Kathy Kuhmerker, Managing Director

February 2, 2010

The Lewin Group - Who We Are

- The Lewin Group, founded in 1970, is a premier national health care and human services policy research and consulting firm
- Our clients are federal, state and local agencies, legislatures, and commissions that oversee and operate Medicaid, public health, mental health, aging, HIV/AIDS, human services and insurance programs
- Lewin was purchased by Ingenix, a wholly-owned subsidiary of UnitedHealth Group, in 2007
- Throughout its history, The Lewin Group has maintained firm principles to preserve the integrity and editorial independence of our work. These principles are strongly supported by both Ingenix and UnitedHealth Group.



Red represents states with which Lewin has worked since 2000

"The Lewin Group is the gold standard of health policy analysis..."

- The Wall Street Journal, October 17, 2008.

States Struggling with Medicaid Costs Nationwide

- National budget crisis varies by state only in degree of intensity
- Medicaid represents a large proportion of discretionary spending, thus nearly all states have targeted it for savings
- ARRA maintenance of effort provisions require states to maintain eligibility levels to receive enhanced matching funds
- Weak economy combined with high unemployment create increased demand for Medicaid services while reducing state revenues

State of the Medicaid Program Nationally

- Most states seek short-term Medicaid savings through provider payments and pharmacy controls
- Number of states turning to recipient benefit controls increased between 2009 and 2010
- Few states have implemented recipient eligibility cuts, application changes, or additional recipient copays (due to ARRA)
- States are increasingly looking to long-term care for cost savings

Administration's Vision for Lewin's Role

- Top priority was to identify cost containment opportunities for SFY10 and SFY11
- Then, equally important, to conduct a comprehensive assessment of the program to identify improvements in efficiency, structure, policies, and strategy
- Review includes a drill-down into specific areas (e.g. long-term care, pharmacy, high-cost participants and providers, non-emergency medical transportation)
- Our scope of work excluded in-depth analyses of managed care or hospital reimbursement systems

Estimated Budget for Lewin Review

Task	Approximate Hours	Approximate Cost
Project planning, meetings, travel	700	$160K
Pharmacy review	580	$140K
Short-term savings	870	$190K
Clinical services	940	$200K
Long-term Care	400	$90K
High cost/volume	200	$50K
NEMT	200	$40K
Program-wide Recommendations	670	$150K
Total	4560	$1.02M

Preliminary Observations

- MO HealthNet has emerged as a leader in several key areas:
  - Implementation of health information technology
  - Commitment to care management of participants with chronic conditions
- Missouri has used provider taxes to maximize the amount of federal funding for the program
  - This minimizes general revenue commitment but also limits program flexibility
- Reimbursement systems generally do not account for acuity but rather, are based on units of care (days, hours)
- Overall assessment and recommendations will be provided in an upcoming deliverable

Assessment Focus Areas

- **Short-term Cost Containment**
- **Long-term Care – Short-term Opportunities**
- **Pharmacy**
- **Other Clinical Services**
- **Pending Deliverables**

Cost Containment Opportunity Summary

- Short-term cost containment opportunities are grouped into the following general categories:
  - Rate changes
  - Benefit management
  - Provider taxes
  - Program Integrity
  - General taxes
  - Other

- Additional opportunities in each of these areas are included in the long-term care and pharmacy sections that follow
  - A complete list of short-term cost containment opportunities from all three deliverables is included on slides 14-16

Cost Containment – Rate Change Opportunities

- Cap fees paid to providers at 80% of Medicare fees
- Reduce rates for personal care and adult day health care
- Reprice Medicare crossover claim payments so that providers are paid no more than if participants were fully covered by MO HealthNet
- Impose a "site-of-service" differential to reduce physician payments for services performed in facility settings (e.g. hospitals) where overhead is paid to the facility
- Establish a ceiling for MCO inpatient payment rates based on MO Healthnet rates for fee-for-service participants
- Implement "maximum allowable cost" pricing for specialty drugs

Cost Containment – Benefit Management Opportunities

- Expand review and management of psychotropics
- Restructure the intake and assessment process for the LTC system
- Impose limits on use of personal care services, ideally based on individual participants' needs
- Impose limits on use of adult day health care
- Implement an electronic verification system for personal care
- Establish a LTC high-cost case review process to realize savings while ensuring quality of care
- Aggressively manage the pharmacy utilization of 3000+ selected participants

Cost Containment – Provider Taxes Opportunities

- Increase nursing facility and hospital provider taxes to 5.45% of revenue
- Modify provider tax statutes to permit MO HealthNet to utilize funds to achieve program-wide policy objectives
- Consider provider taxes on physicians, dentists, other practitioners
  - States have been largely unsuccessful in implementing taxes on physicians and dentists, as it is difficult to limit the impact of taxes on providers that may have few or no Medicaid patients

While short-term budget issues necessitate the continued maximization of provider taxes, such financing mechanisms are not an ideal long-term strategy

Cost Containment – Program Integrity Opportunities

- Apply additional edits prior to making provider payments, possibly though a contingency arrangement with a contractor
- Improve third-party liability offsets using the Public Assistance Reporting Information System (PARIS) match with MOHealthNet beneficiaries
- Expand the existing lock-in program

Cost Containment – Opportunities for General Taxes with Public Health Benefits

- Increase cigarette tax from $0.17 to national average ($1.34)
- Establish sales tax of 5% on soft drinks and earmark for Medicaid
- Increase the State beer excise tax from $0.06 to $0.24 per gallon; increase State liquor excise tax from $2.00 to $3.00 per gallon.

Summary of Cost Containment Opportunities

- Savings amounts are total computable (state and federal) presented in constant (2009) dollars
- For revenue opportunities, revenue amounts are for 12 months of GR or GR equivalent
- Opportunities are ranked from 1 to 3 based on savings potential, beneficiary and provider impact, and feasibility
- Savings in each fiscal year depends on actual date of implementation
- Savings are not additive (e.g. reduction in fees would reduce the impact of Part B crossover repricing)

		Total Savings (2009 dollars)				
	Opportunity	**FY10**	**FY11**	**Full Annual**	**Priority**	**P-Tax Impact**
Rate Changes						
1	Reprice NF Part A crossover claims	$10M	$40M	$40M	1	
2	Don't increase rates under Medicare parity plan	--	$67.7M	$67.7M	1	
3	Reduce fees >80% of Medicare to 80%	$4.4M	$13.3M	$13.3M	1	
4	Raise and re-impose NF occupancy standard	TBD	TBD	TBD by MHN	1	*
5	Reprice Part B crossover claims (hospital)	TBD	TBD	TBD by MHN	1	*
6	Reduce personal care/homemaker rates	$13M	$40M	$40M	1	
7	Implement site of service differential in facility settings	$3.6M	$10.9M	$10.9M	2	
8	Reduce ADHC rates	$0.2	$0.7M	$0.5 - $1M	2	
9	Reprice Part B crossover claims (physician)	$6.3M	$18.9M	$18.9M	2	
10	Lower unenhanced fill-fee to $4.20	$1.8M	$5.4M	$5.4M	2	*
11	Lower brand ingredient price to WAC+6%	$6.8M	$20.5M	$20.5M	2	*
12	Specialty drug MAC pricing	$3.0M	$9.1M	$9.1M	2	*
13	Ceiling on inpatient unit cost for MCO enrollee admission	--	$0.5-3.0M	$0.5-3.0M	2	*

Summary of Cost Containment Opportunities, cont.

		Total Savings (2009 dollars)				
	Opportunity	**FY10**	**FY11**	**Full Annual**	**Priority**	**P-Tax Impact**
Benefit Management						
14	Expand review and management to psychotropics	--	$27.2M	$27.2M	1	*
15	Recapture LTC intake and assessment	--	$1.7M	$3.4M	1	
16	Personal care limit – hrs/week	--	$1 - 4M	$1 - 4M	2	
17	Adult day health limit – hrs/week	--	$0.1M	$0.1M	2	
18	Electronic verification system for personal care	--	<$0.1M	$8M		
19	LTC high cost case review process	<$0.1M	<$0.1M	<$0.1M	2	
20	Rx mgmt. of 3000+ selected participants	$1.5M	$14.9M	$14.9M	2	*
21	MCO Rx carve –in (if/when DRE passes)	--	--	$2.9M	2	*
Provider Taxes						
22	Maximize existing provider taxes	$11M	varies	varies	1	
23	Modify P-tax statutes to increase access to funds	$45M	varies	varies	1	
24	Implement provider taxes on physicians, dentists, other practitioners	--	$190M	$190M	3	

Summary of Cost Containment Opportunities, cont.

		Total Savings (2009 dollars)				
	Opportunity	**FY10**	**FY11**	**Full Annual**	**Priority**	**P-Tax Impact**
Program Integrity						
25	Impose Post-Adjudication/Pre-Payment Overlay Edits to Enhance Program Integrity	--	$8.9M	$17.8M	1	*
26	Expand PARIS match	--	$3.7M	$11M	1	
27	Strengthen/expand lock-in process	$1.0M	$5.1M	$7.0M	2	
General Taxes						
28	Increase cigarette tax	--	$597M	$597M	1	
29	Increase alcohol taxes	--	$34M	$34M	1	
30	Impose “sugar tax”	--	$61M	$61M	2	
Other						
31	Pursue additional supplemental Rx rebates	$1.0M	$2.9M	$2.9M	1	
32	Aggressively implement Money Follows the Person	--	$0.2 - $1M	$0.3 - $2M	1	
33	Require Medicare certification for NFs	--	$0.1M	$0.1M	3	
34	Increase co-pay amounts for selected services	--	$5.6M	$5.6M	3	

Assessment Focus Areas

- Short-term Cost Containment
- **Long-term Care – Short-term Opportunities**
- Pharmacy
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- Pending Deliverables

Five-Point Plan for a More Cost Effective LTC System in Missouri

1. Manage and Limit Service Utilization
2. Nursing Facility Right-Sizing Initiative
3. Maximize Medicare SNF Benefit
4. Reduce Selected HCBS Payment Rates
5. Pursue Structural Changes

Manage & Limit Utilization

- Currently only a few constraints on the utilization of LTC services
  - Primarily fee-for-service
  - Minimal cost monitoring and case management
  - Data suggest that some beneficiaries are receiving very high amounts of community services, while some nursing facility residents could be better served in community settings
- Policies to limit HCBS utilization should still allow higher levels of service to the people with the highest levels of need
  - Limits based on need help promote true substitution of HCBS for nursing facility care

Nursing Facility Right Sizing Initiative

- Nursing facility occupancy rates in Missouri are among the lowest in the nation

- The Nursing Facility Right-Sizing Initiative is intended to move occupancy toward the national average while reducing (or leveraging) the supply through smart purchasing strategies including:
  - Re-imposing and increasing the Medicaid occupancy standard
  - Adjusting the certificate of need requirements
  - Selective contracting for nursing facility beds in urban areas

Maximizing Medicare SNF Benefits

- Missouri has vigorously pursued mechanisms for maximizing the federal financial contribution to Medicaid funding.

- Other opportunities to maximize the use of Medicare benefits and payment rules
  - Eliminate/reduce payment for Medicare SNF co-payments
  - Require Medicare certification for all nursing facilities

Reduce Selected HCBS Payment Rates

- Payment rates for some home and community-based services appear to be higher than necessary
  - Reduce rates for personal care & homemaker services
  - Reduce rates for adult day health care

Critical Structural Changes

- Re-align LTC budgets and oversight in one agency – global budget for LTC
- Build a case management/service coordination infrastructure
- Establish a nursing facility case mix reimbursement system
- Remove adult day health care from the state plan and shift into 1915(c) authority
- Re-evaluate fiscal management services for consumer-directed personal care

Assessment Focus Areas

- Short-term Cost Containment
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Missouri Has an Innovative Medicaid Pharmacy Program

- Pharmacy leadership has an exceptional level of expertise and stand out nationwide
- Smart PA program maximizes efficient use of Missouri's preferred drug list and avoids adverse drug interactions
- Medication Therapy Management pilot is now operational and can be expanded
- Specialty MAC program has been implemented and is being expanded
- CyberAccess is used by Missouri providers to enhance their knowledge and facilitate interaction with MO HealthNet

Missouri's Pharmacy Reimbursement is Structured to Support its Provider Tax

- Missouri's ingredient payment is WAC plus 10% which is among the highest in the nation
- Missouri's dispensing fee of $9.66 due to tax program is nation's highest by more than $2.00
- Rates are high as a direct result of Missouri's pharmacy provider tax and any reduction would impact the amount of revenue generated by the tax and potentially jeopardize the tax itself under existing statute

Controls on Psychotropic Drugs

- State statute currently prohibits psychotropic medications from being reviewed/managed in same manner as other medications
  - Ideal policies balance providing access with avoidance of excessive and unnecessary services
- MO HealthNet has developed a thoughtful approach to improving management of psychotropics that is supported by the Department of Mental Health
  - Emphasis on assessing unapproved and inappropriate utilization
  - Incorporation of Evidence Based Medicine (EBM) guidelines
  - Safety is key concern (e.g. avoidance of potentially dangerous drug interactions, grandfathering to minimize disruption of regimens, etc.)
- MO HealthNet staff project no savings during FY2010 due to ramp-up time needed for this initiative; savings of $27.2 million were projected (in gross Medicaid funds) for FY2011, with higher savings projected for subsequent years

High Cost Beneficiaries Getting Much Costlier

Time Period	1,000 Costliest Persons	10 Costliest Persons	Costliest Individual Person
CY2005	$58,990,607	$6,579,689	$1,395,713
CY2006	$56,249,374	$6,547,913	$1,297,471
CY2007	$62,747,466	$8,052,296	$1,582,630
CY2008	$68,233,349	$11,609,120	$3,422,294
CY2009 (estimated)	$85,365,931	$14,742,535	$4,200,000
Share of Total 2009 Rx Costs	11.8%	2.0%	0.6%

Costliest 1,000 persons expected to account for 11.8% of CY2009 claims costs, up from 5.0% in CY2005 and 10.3% in CY2007.

Approach to Management of High-Cost Persons

- Year 1: Intervene with high-volume users
  - Focus on improving patients' medication regimens and eliminating unnecessary and duplicate therapies
  - Objectives will be to achieve improved safety and cost savings
- Closely evaluate the program upon implementation and throughout first year
- Modify and/or broaden the initiative to maximize its longer-term effectiveness

MCO Carve-Out/Carve-In Dynamics

- Prescription drugs were recently removed from the Medicaid MCO benefit package and are now managed directly by MO HealthNet
  - Provides access to rebates not available under the "carve-in" approach
- Lewin estimates annual savings of up to 15% above current levels if Drug Rebate Act is enacted
- If not enacted, there may be ways to strengthen savings that occur under the carve-out approach (e.g., MCO bonus/penalty clauses tied to effectiveness of medication management)

Specialty Pharmacy Management Strategies

- Consider selective contracting with specialty management organization(s) in targeted areas that can access lower average unit costs and safely deliver drugs to patients
- Identify the magnitude of waste and, if indicated, design a drug distribution strategy to decrease waste for unused drugs
  - Require patient confirmation of drug delivery and/or administration of drugs included in the prior authorization
- Member and physician education and monitoring to:
  - Review appropriate dosing schedules
  - Manage side effects and identify barriers to compliance
  - Promote proper storage and use of specialty medications

Assessment Focus Areas

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Inpatient Hospital: Approaches to Potential Cost Containment and Operational Efficiencies

- Decrease length of stay
- Decrease avoidable admissions
- Monitor and maximize contractor performance
- Restructure reimbursement methodology
- Transition to care management
- Monitor inpatient metrics
- Coordinate care coordination program and inpatient review services

Outpatient Hospital: Approaches for Potential Cost Containment and Operational Efficiencies

- Target ER programs to minimize inappropriate usage
- Ensure effective enforcement of outpatient prior authorization program for imaging services
- Restructure outpatient reimbursement methodology to promote quality and efficiency
- Shift routine physician care from outpatient hospital setting to less costly office/clinic settings

CCIP: Approaches for Potential Cost Containment and Operational Efficiencies

- Exclude dual eligibles from program
  - Immediate annual savings of $14.3 million
  - Explore opportunities with CMS to manage and coordinate care for dual eligibles through a shared Medicare savings initiative
- Focus on high-risk/high-cost members amenable to intervention
- Enhance effectiveness of physician incentive payments by promoting active engagement in program

CCIP: Approaches for Potential Cost Containment and Operational Efficiencies

- Initiate hospital admission alert system to enable care coordination to extend to transitions in and out of hospitals
- Strengthen care coordination program contract procurement and payment terms to enhance program effectiveness
- Tailor care coordination approaches to client situation (e.g., in person vs. telephonic)

DME: Approaches for Potential Cost Containment and Operational Efficiencies

- Explore additional contracting mechanisms to improve cost effectiveness
  - Preferred provider contracting for estimated savings of $835K (assuming a 5% savings rate)
  - Competitive bidding, looking to current CMS competitive bid pilot project as an example
- Remove the 12% add-on payment made for certain rent-to-own items
- Monitor OIG initiatives surrounding appropriate payment levels, and potential fraud and abuse
- Expand PA list to review and control high cost areas

Hospice: Approaches for Potential Cost Containment and Operational Efficiencies

- Reduce length of stay as appropriate, focusing on MO HealthNet only recipients (non-duals)
- Strengthen certification and recertification requirements to ensure appropriate use of program
- Closely Monitor MedPac recommendations for potential program modifications
- Enhance claims monitoring
  - Increase plan of care oversight and certification of terminal illness requirements
  - Ensure nursing facilities are not receiving double payments
  - Review services received outside hospice to ensure appropriateness
  - Ensure not paying for duals beyond NF per diem

Assessment Focus Areas

- Short-term Cost Containment
- Long-term Care – Short-term Opportunities
- Pharmacy
- Other Clinical Services
- **Pending Deliverables**

Future Deliverables

- Non-Emergency Medical Transportation (NEMT) assessment is focused on the appropriateness of using actuarially sound rates and potential areas for service modifications
- Analysis of high-cost beneficiaries and high-volume providers in various counties/regions of the State
- Final Assessment Report

Our Comprehensive Review is Still Ongoing

- Final report will include potential performance metrics and overall recommendations for improving efficient delivery of high-quality care

- Questions that we will address will focus on cost, quality and access:
  - How can MO HealthNet maximize access to high quality providers in the most appropriate settings?
  - What is the best approach to managing care for the elderly and disabled?
  - How should MO HealthNet coordinate care management for other high-cost participants with chronic conditions?
  - What additional approaches can be taken to promote program efficiency, coordination and accountability?
  - What opportunities exist for improving the fiscal integrity and cost effectiveness of the program?

Additional Resources

- Each of the Lewin deliverables can be found at:
  http://www.dss.mo.gov/mhd/oversight/resources.htm

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February 2, 2010

MO HealthNet Managed Care Cost Avoidance

State of Missouri

Angela WasDyke, ASA, MAAA

Michael Cook, FSA, MAAA

Managed Care Cost Avoidance
Overview

- Results
- Model Goals
- Managed Care Savings Considerations
- Questions

Managed Care Cost Avoidance
Results

- Managed care program is consistently showing savings relative to projected costs for the same population absent managed care
- SFY 2009 Results

FFS Benchmark Costs	$1.430 billion
Managed Care Costs	$1.392 billion
SFY 2009 Savings	$38 million
Percentage Savings	2.7%

Managed Care Cost Avoidance
Results – SFY 2009 Detail

SFY 2009 FFS Benchmark PMPMs		SFY 2009 Managed Care PMPMs	
Inpatient	$85.57	Medical Capitation	$201.61
Outpatient	$56.04	FFS Costs	$53.52
Professional	$105.73		
Pharmacy	$40.93		
TPL	($15.28)		
Medical Adjustments[1]	$8.63	Medical Adjustments[2]	($2.26)
Medical Total	**$281.63**	**Medical Total**	**$252.88**
		Medical Savings	**$28.75**

[1] Includes mass adjustments and geographic adjustment.

[2] Includes mass adjustments.

Managed Care Cost Avoidance
Results – SFY 2009 Detail

SFY 2009 FFS Benchmark PMPMs		**SFY 2009 Managed Care PMPMs**	
Medical Total	**$281.63**	**Medical Total**	**$252.88**
State Administration	$12.97	Health Plan Admin	$23.21
		Target Profit	$6.11
		State MC Oversight	$4.48
Grand Total	**$294.60**	**Grand Total**	**$286.68**
		Total Savings	**$7.92**

Managed Care Cost Avoidance
Model Goals

- Model goal is to answer the following question:

  If the MC program did not exist, what would the cost of the existing MC eligibles be in the FFS delivery system?

- Historical financial analysis of MC program
- Not a direct comparison between the existing FFS and MC populations and delivery systems
  - Tool for historical financial performance of MC program
  - Not a depiction of anticipated savings associated with MC expansion opportunities
- Development of Benchmark population and cost to compare to MC costs
- Comparison done on a per member per month (PMPM) basis

Managed Care Cost Avoidance

Managed Care Savings Considerations

- Level of savings experienced through MC varies based on many factors
  - Rural versus urban population
  - TANF versus ABD population
  - Level of provider acceptance of managed care
  - Effectiveness of managed care organizations
  - Maturity of managed care program
  - Sophistication of existing FFS care management
- Typical long-term savings for a TANF-like population are 3 – 6%
- States experience a wide range in MC savings based on their actual environment in regards to the factors above

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February 2, 2010

MO HealthNet Chronic Care Improvement Program (CCIP) Financial and Clinical Evaluation

State of Missouri

Angela WasDyke, ASA, MAAA

Michael Cook, FSA, MAAA

CCIP Financial and Clinical Evaluation
Financial Results

	SFY 2008		CY 2008	
Total CCIP – All Conditions	**Dollars**	**Percent**	**Dollars**	**Percent**
Gross Cost/(Savings)	($15.7M)	(1.4%)	($14.0M)	(1.2%)
Net Cost/(Savings)	$0.9M	0.1%	$5.8M	0.5%
Net ROI	0.94 : 1		0.71 : 1	
CCIP Excluding Dual Eligibles – All Conditions				
Gross Cost/(Savings)	-	-	($27.1M)	(3.2%)
Net Cost/(Savings)	-	-	($16.7M)	(2.0%)
Net ROI	-		1.6 : 1	
CCIP Excluding Dual Eligibles				
Asthma Net Cost/(Savings)	-	-	($3.5M)	(2.6%)
Net ROI	-		1.6 : 1	
Diabetes Net Cost/(Savings)	-	-	($8.1M)	(3.6%)
Net ROI	-		3.0 : 1	

CCIP Financial and Clinical Evaluation
Financial Observations

- CY 2008 increase in CCIP enrollment and resulting fees not offset by increased medical savings (across entire CCIP program)
- Dual eligibles comprise 48% of CCIP Population in CY 2008
- Care management efforts for the duals result in cost savings for services that are mainly the financial responsibility of Medicare
- CY 2008 observations on other conditions where Non-CCIP population not of credible size (excluding dual eligibles)
  - Heart Failure likely producing good savings
  - At-Risk Cardiac may be producing limited savings
  - COPD appears to be breaking even at best
  - GERD and Sickle Cell Anemia not likely generating program savings

CCIP Financial and Clinical Evaluation
Clinical Results (Excluding Dual Eligibles)

		Condition Metrics			
		Enrolled Population		Non-Enrolled Population	
Condition	**Metric Description**	**Sample Size**	**Metric Percentage**	**Sample Size**	**Metric Percentage**
Asthma	Inhaled Corticosteroid Medications	18,483	45.8%	4,218	39.5%
At-Risk Cardiac	At least one fasting lipid profile	17,318	57.7%	1,967	61.1%
At-Risk Cardiac	At least two fasting lipid profiles	17,318	25.3%	1,967	27.7%
Heart Failure	Treated with an ARB or ACEI	3,204	67.3%	320	65.9%
Heart Failure	Treated with Beta Blockers	3,204	62.4%	320	65.6%
Heart Failure	Treated with a diuretic	3,204	69.2%	320	72.2%

CCIP Financial and Clinical Evaluation
Clinical Results (Excluding Dual Eligibles)

		Condition Metrics			
		Enrolled Population		Non-Enrolled Population	
Condition	**Metric Description**	**Sample Size**	**Metric Percentage**	**Sample Size**	**Metric Percentage**
COPD	Treated with bronchodilator therapy	7,736	49.1%	1,062	50.7%
Diabetes	At least one fasting lipid profile	14,041	61.8%	1,895	68.3%
Diabetes	At least two fasting lipid profiles	14,041	30.1%	1,895	34.6%
Diabetes	At least one A1c measurement	14,041	68.8%	1,895	74.0%
Diabetes	At least two A1c measurements	14,041	43.8%	1,895	46.0%

Includes individuals with given condition and continuously enrolled for 12 months, excludes dual eligibles.

CCIP Financial and Clinical Evaluation
Clinical Observations (Excluding Dual Eligibles)

- Asthma metric for percentage of individuals treated with inhaled corticosteroids at 46% for CCIP and 40% for Non-CCIP Population
- Diabetes, with nearly credible sample sizes, did not show improvement in any of 4 metrics
- For other metrics where sample sizes were not credible, the percentage results between CCIP and Non-CCIP Populations were generally similar
- Improved clinical outcomes and associated cost savings are oftentimes minimal or not realized at all in initial year of DM program due to time it takes to engage members and change behaviors
- Contained ER and IP utilization trends within a reasonable level, driving the $16.7 million in net financial savings
  - ER visits per 1,000 trended at an annual rate of 4.0%
  - IP admissions per 1,000 trended at an annual rate of 0.7%

MERCER

MARSH MERCER KROLL
GUY CARPENTER OLIVER WYMAN

Missouri Alliance for HOME CARE
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MO HealthNet Oversight Committee

February 2, 2010

1. Bring MO into compliance with federal law: Eliminate the "Homebound" requirement to qualify for Home Health Services.
2. Specific recommendations related to the Lewin Group Report: MO HealthNet Long Term Care Review – Cost Containment Opportunities, 1/7/10

Mary Schantz
Executive Director

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 East 12th Street, Suite 235
Kansas City, Missouri 64106

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Division of Medicaid and Children's Health Operations

October 30, 2009

Ronald J. Levy, Director
Missouri Department of Social Services
Broadway State Office Building
P.O. Box 1527
Jefferson City, MO 65102

Dear Mr. Levy:

By this letter, I am providing notice of the preliminary determination by the Centers for Medicare & Medicaid Services (CMS) that Missouri appears to be out of compliance with Federal Medicaid requirements by requiring Medicaid beneficiaries to be "confined to the home" as a condition for receipt of home health services. As discussed in more detail below, this restriction does not comply with the requirements of section 1902 of the Social Security Act (the Act) as implemented by applicable Medicaid regulations and relevant CMS interpretative policy. Therefore, at this time, I am requesting your cooperation with resolving this issue by submitting a State plan amendment (SPA) which removes this requirement from your State plan. Your response to our request should be received in our office within 30 days from receipt of this notice. Unless the State submits a SPA to come into compliance, CMS intends to commence a compliance action which could result in financial penalties as permitted under section 1904 of the Act.

Section 1902(a)(10)(D) requires that State plans provide for the coverage of home health services for any individual who, under the State plan, is entitled to nursing facility services. Nursing facility services are a required service for categorically needy populations under section 1902(a)(10)(A), as defined in section 1905(a)(4)(A).

Under CMS regulations, a service included as a covered benefit under a State plan must be "sufficient in amount, duration and scope to reasonably achieve its purpose" (42 CFR 440.230(b)) and, for required services, cannot be denied or reduced to an eligible beneficiary "solely because of the diagnosis, type of illness, or condition" (42 CFR 440.230(d)). It is not consistent with these requirements to deny home health services to eligible individuals who need such services on the basis that they are not homebound.

The CMS provided interpretive guidance indicating that these statutory requirements preclude denial of home health services to eligible individuals because they are not homebound. This guidance was issued in response to the June 22, 1999, Supreme Court decision in the case of *Olmstead v. L.C. & E.W.*, which reinforced the Americans with Disabilities Act by affirming the right of individuals with disabilities to live in their communities. Following this decision, CMS, then the Health Care Financing Administration (HCFA), issued a series of State Medicaid director letters (SMDL) to clarify Medicaid policy on issues impacted by the Olmstead decision.

On July 25, 2000, HCFA issued Olmstead Update #3 which clarified that the Medicare rule for home health services requiring an individual to be "homebound" did not apply to the receipt of Medicaid home health services. Specifically, Olmstead Update #3 states that the homebound requirement violates Federal regulatory requirements at 42 CFR section 440.230(c) and section 440.240(b).

The "homebound" requirement in Missouri was raised during the review of Missouri SPA 05-09. At that time, Missouri chose to withdraw the page containing the homebound language but did not reverse the policy. Since that time, there have been numerous discussions between CMS and Missouri regarding this issue. CMS believes that Missouri has had numerous opportunities to come into compliance with Federal requirements.

In accordance with regulations found at 42 CFR section 430.10, the State plan serves as a basis for Federal financial participation in the State Medicaid program. Section 430.12 states that the plan must provide that it will be amended whenever necessary to reflect changes in Federal law, regulations, policy interpretations, or court decisions; or material changes in State law, organization, or policy, or in the State's operation of the Medicaid program.

Since Missouri has not amended its State plan to reflect the statutory requirements discussed above and interpreted in Olmsted Update #3, CMS has reached the preliminary conclusion that the Missouri State plan is not in compliance with Federal requirements.

Therefore, if Missouri does not respond to this opportunity to correct this situation by submitting a SPA within a 30-day time frame which would bring the State into compliance, CMS intends to proceed with compliance proceedings in accordance with section 1904 of the Act. A compliance proceeding could result in withholding Federal funding for the all or part of the Missouri Medicaid program until the State comes into compliance. Such proceedings will be governed by the procedures set forth in CMS regulations at 42 CFR 430.35, with an opportunity for a hearing as set out at 42 CFR Part 430, Subpart D.

We hope you will agree to modify your policy to come into compliance with the law. If you have questions concerning this letter, please feel free to contact me at (816) 426-5925.

Sincerely,

Jackie Glaze

Jackie Glaze
Acting Associate Regional Administrator
for Medicaid and Children's Health Operations

cc:
Dr. Ian McCaslin
Joel Ferber

Missouri Department of
SOCIAL SERVICES
Your Potential. Our Support.

JEREMIAH W. (JAY) NIXON, GOVERNOR • RONALD J. LEVY, DIRECTOR

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December 31, 2009

James G. Scott
Associate Regional Administrator
Division of Medicaid and Children's Health
Centers for Medicare and Medicaid Services
Federal Office Building, Room 235
601 East 12th Street
Kansas City, MO 64106

Dear Mr. Scott:

This is in response to your October 30, 2009 letter regarding home health services for MO HealthNet participants.

State Plan Amendment 00-09 was approved by the Centers for Medicare and Medicaid Services on July 28, 2000. The requirements of Missouri's home health program are the same as those for the federal Medicare program.

If you have further comments please submit them to me in writing.

Sincerely,

Ronald J. Levy
Director

RJL:kp

Missouri Alliance for HOME CARE
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1/15/10

Cindy Mann, Director
Center for Medicaid and State Operations
Department of Health and Human Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850

Dear Ms Mann:

RE: Homebound Requirement for Home Health Services in Missouri

The state of Missouri was notified by CMS on October 30, 2009 that CMS had reached the preliminary conclusion that the Missouri State Plan is not in compliance with the Federal requirements related to the homebound requirement to qualify for Home Health. And further, the state has not been in compliance since 2000 when it was notified by then-HCFA to remove the homebound requirement to qualify for Medicaid Home Health. The state was given thirty days to submit a SPA to bring the state into compliance. On December 31st, 2009 the Director of the Department of Social Services, Ronald Levy, responded that the State Plan Amendment 00-09 was approved by HCFA in July 2000 and the Missouri home health program requirements are the same as Medicare.

Representing the home health industry in Missouri, we are concerned that Missouri did not comply with the 2000 directive to remove the homebound requirement nor has the state made any attempt to do so during the decade between then and now. Medicaid beneficiaries in Missouri who are eligible under Federal guidelines for home health are being denied access to home health services.

We are requesting that CMS continue their initiative to bring Missouri into compliance with Federal law.

Our intention is not to argue the financial merits of removing the homebound requirement; the state should be in compliance with the law. However we believe that the state will realize a reduction in overall Medicaid expenditures by allowing recipients to receive care from a home health agency rather than nursing home, emergency room or other more expensive provider.

If you have any questions or concerns do not hesitate to contact me. I look forward to hearing from you about what CMS intends as it relates to Missouri being out of compliance with Federal law on this issue.

Sincerely,

Mary Schantz

Cc: Jackie Glaze, Acting Associate Regional Administrator
MAHC Board of Directors
Ron Levy, Director, Missouri Department of Social Servies
Dr. Ian McCaslin, Director, Missouri Department of MO HealthNet

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January 25, 2010

Mr. Ron Levy, Director
Missouri Department of Social Services
Broadway State Office Building
P.O. Box 1527
Jefferson City, MO 65102

Dear Ron:

AARP Missouri is writing to urge your department to eliminate the illegal requirement denying a Medicaid service to the senior and disabled population in need of homebound services. In accordance with CMS regulations, the additional requirement of homebound status and skilled nursing or therapy services is not in compliance with CMS regulations and does not achieve a more cost effective way to deliver services to those persons who struggle to live independently.

Missouri is confronted with serious budget shortfalls. Allowing one of the most vulnerable populations to remain in their homes removes barriers to services that are critical to their survival. AARP is hopeful you will reconsider and respond appropriately to this request.

Sincerely,

Craig Eichelman, Senior State Director
ceichelman@aarp.org

cc: Dr. Ian McCaslin, Director, Missouri Department of MO HealthNet
Jackie Glaze, Acting Associate Regional Administrator

Medicaid Home Health Criteria By State:

State	Homebound	Skilled Care	Physician Order	Other Criteria
AZ	No	yes	yes	
CT	No	Yes	yes	Prior Auth
FL	No	Yes		
KS	No	Yes		
MO	Yes	Yes	Yes	Visit limit 100
MN	No	Yes	Yes	
NJ	No	Yes	Yes	
WV	No	Yes		
MT	No	Yes	Yes	Prior Auth
KY	No	?	Yes	
TN	?	Yes	Yes	Prior Auth
IN	No	Yes	Yes	
PA	No	Yes	Yes	
VT	No	Yes	Yes	
OH	No	Yes	Yes	
NM	N0	?	Yes	Prior Auth
NC	Almost HB	Yes	Yes	Visit limits
SC	Yes	Yes	Yes	Visit limit 75
AR	No	Yes	Yes	
OR	No	Yes	Yes	Prior auth
NH	No	Yes (except Katie Beckett type)	yes	
GA	No	No	Yes	50 Visits per yr
MD	No	Yes	Yes	
WA	No	Yes	Yes	

Source: MO Alliana for Home Care

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Mo HealthNet Long Term Care Review: Cost Containment Opportunities

Recommendations and Alternatives

1. Third Party Assessment:

   A. Home care provider nurses currently conduct assessments. This system is working and has reduced waiting time to receive service from months to days. Why add another layer of bureaucracy?
   B. Two (2) nurse visits are required annually for all in-home clients (state law). These visits are being utilized to conduct initial assessments and reassessments – adding no additional cost to state for the assessment.
   C. State spent millions to develop a web-based assessment tool for home and community based LTC. The tool will assess eligibility for the program (21 points). The original intent was to develop a web-based system that would also develop a plan of care appropriate for the individual's needs. That component was not developed. Develop that component, which will serve in essence as a third party assessment process. The development of this component will be a onetime cost as compared to the ongoing cost of a third party assessment system.
   D. If a third party assessment is needed, access to all LTC services should be controlled by the assessment vendor. Controlling access to the least expensive LTC services and not on the most expensive LTC will not reduce inappropriate usage of LTC services. MO's nursing homes have the fourth highest percent of "low care" residents based on occupancy vs prevalence. These low-care residents need to be considered for home care. If a third party vendor is used only to control access to home care many lower care need clients will end up as residents of nursing homes.
   E. A third party vendor will charge approximately $172 per assessment (Lewin Group). Nurse visits by in-home providers cost approximately $40.

2. High Cost Review Teams:
   A. The incentive should be to assure proper plans of care and not an arbitrary reduction of units goal.
   B. Current and accurate data must be used in making determinations.

3. Telephony:
   A. Currently, CDS vendors are not allowed to use telephony. Make telephony optional for CDS vendors.
   B. Good idea to use modern technology to get the most efficiency possible. Do not limit to current (possibly soon outmoded) technology by mandating a phone voice activated system.
   C. This requirement will be an added cost for the provider – cost range from $0.25 to call in and $0.25 to call out – these charges would be the same if they delivered a 30 minute task or a 3.5 hour task. Smaller agencies may have to pay more and larger agencies may have to pay less.
   D. Concern about clients/consumers who do not have land lines. Will the worker use the clients/consumers cell phone? What about the cost to the client?
   E. CDS Plans of Care are much different than for in-home clients. Often the worker is in and out many times during the day. For example, what happens when you pick up consumer and take to a dialysis appointment, then pick back up later and take home? This would be very costly to the provider or consumer (cell phone)
4. Utilization Management:
   A. Cuts recommended by governor far exceed the Lewin Group's recommendations (Lewin 40 hours a week/Governor 60 hours a month)
   B. Other states that have limited their PC hours are not nearly as severe:

Missouri	**60 per month**
Minnesota	275 hours per month*
Montana	160 hours per month
New Jersey	160 hours per month
North Carolina	60 hours per month
Kansas	360 hours per month
Arizona	As Needed
Vermont	As Needed
Arkansas	64 hours per month
New Hampshire	160 hours per month
Florida	As Needed

*changed weekly rates to monthly (all are approximate)

   C. Some clients/consumers will be forced into nursing homes. These caps are too severe and consumers could lose their right to choose where they receive their care and the right to live in the least restrictive environment.
   D. Will this result in a violation of the Olmstead Act? Will Missouri be subject to a legal challenge?

Other recommendations for cost savings:

1. Consider making requests for provider/vendor contracts a low priority based on budget constraints. Home Health has effectively done this and no new home health agencies are being approved because of the low priority given to that function.
2. The General Assembly passed a provider tax for the in-home industry in 2009. This tax has not been imposed. Work with CMS and the Missouri Congressional delegation to get the tax approved by CMS.

DCHR
Disability Coalition on Healthcare Reform
Building a Movement for Access and Choice

Public Comment for the MO HealthNet Oversight Committee
Submitted by
Megan Burke, mburke@paraquad.org

February 2, 2010

The Disability Coalition on Healthcare Reform (DCHR) believes that the healthcare and long term care systems should both create opportunities and remove barriers to allow full participation in education, employment, and all aspects of community life. We believe our communities benefit from the inclusion of every individual. Cost saving measures taken into consideration by this committee and the Governor must act in congruence with the Olmstead decision supporting choice and community supports and not place individuals with disabilities at risk of institutionalization.

Personal care hours should be determined by assessed need, and not and arbitrary cap.

The Governor recently recommended capping hours for the Consumer Directed Personal Attendant Services (CD-PAS) attendant program at 60 hours/month. This is significantly below cap of 40 – 56 hours/week suggested by the Lewin Group. DCHR is opposed to the proposed cap on CD-PAS hours as it will restrict the independence of many Missourians living with disabilities and put them at risk for institutionalization.

The CD-PAS program in Missouri is geared towards people with disabilities who require more than just chore services. Participants need assistance with personal care such as bathing, toileting, dressing, eating, and other activities of daily living to live independently, go to school, work and participate in their community. A study conducted by the University of Missouri – Columbia found that people enrolled in the CD-PAS program required more assistance with activities of daily living than participants in the DSS program. (2003 "Health Snapshot: Agency vs. Consumer-Directed PAS", Missouri Model Spinal Cord Injury System, University of Missouri-Columbia.) Therefore, participants in the CD-PAS program on average need more hours of personal care assistance than people who just need some respite for family members.

The assessment process must assure full informed choice and access to services and support.

DCHR believes every individual and family facing decisions about healthcare, long term care, community services and supports must be fully informed of all options and make their own

decisions. There are many gaps in the system that lead to people being inappropriately placed in a nursing home or going without necessary services. State employee lay-offs have led to challenges in conducting individualized assessments that take into account informal supports, providing full informed choice of all options and hospital discharge planning. The assessment process is key to assuring that people are getting the hours they need and using all available non-state funded resources.

If the state contracts with a third-party, the following must be a part of the framework to assure full informed choice and access to services and supports.

- The vendor shall have no conflict of interest.
- Assessments should be conducted face to face.
- There should be timelines for assessments and authorization of services to avoid lengthy waits. Participants should not have to wait more than a maximum of 20 calendar days from time of assessment to receive services.
- The staff conducting the assessments should have disability competencies that have been established in partnership with the disability community; and staff should receive training.
- Assessments should be based on the person-centered planning process that takes into account the individual's choices, independent living goals, informal supports, what people can do on their own and what they need help with.
- Plans of care should be based on the assessment and there should be no financial incentive to arbitrarily limit necessary attendant hours.
- The third-party should provide full informed choice of all options and all vendors available.
- Assessments should utilize existing paperwork requirements and not add a paper-work burden to the participant or the provider.
- The third-party vendor should work with hospital discharge planners to avoid delays in setting up services in the person's home.

Use of telephony for attendant reporting should not be mandatory.

DCHR is not opposed to the monitoring of services provided to participants. However, there are concerns with regard to how the system would work for people who do not have land lines or access to cell service. There are many questions that still need to be answered before such a program is implemented.

Utilization review and other oversight mechanisms should assure that people are receiving the services they need.

DCHR supports the review of services for program participants to ensure that services are not duplicated and that unused authorized hours are reduced if they are not needed. All of this must be done with accurate data and with attention paid to spenddown participants who may have unused hours because they could not quickly meet their spenddown. Any reductions in services should be based on an accurate assessment and not solely for cost containment.

Missouri long term care system should promote independent living and community access for people with disabilities.

The Lewin Group recommended a nursing facility right-sizing initiative. Missouri's nursing home industry may be over-built. The percentage of certified nursing home beds occupied in 2007 was 74.6%. In 2007, Missouri had 8.6 beds per 1,000 state residents of all ages, higher than the national rate of 5.6 (Nursing Home Data Compendium, 2008 ed.). We believe that all people with disabilities, no matter their age or disability, should have the choice to live in the community given adequate services and supports. There are people in nursing homes that could be targeted for immediate transition planning. Of the 78,232 people in Missouri nursing homes in 2007, 10,796 people were under the age of 65. Forty percent had no Activity of Daily Living limitations – meaning they had no limitations with getting in and out of bed, dressing, eating, transferring and toileting - and 14% had two or fewer ADL limitations (Nursing Home Data Compendium, 2008 ed.).

The Money Follows the Person (MFP) initiative has been successful in transitioning people from nursing homes to the community. DCHR supports the Lewin Groups recommendation for Missouri to aggressively implement MFP initiative. Missouri receives an enhanced federal match for the first year of Medicaid community services after the individuals transitions form an institution to the community. Missouri should take advantage of these additional federal dollars.

In addition to the recommendations presented by the Lewin Group, DCHR is requesting that the MO HealthNet Division remove the home-bound requirement from the Medicaid home health program. Missouri requires participants of Medicaid home health services to be "home-bound". This homebound requirement penalizes individuals with disabilities who try to function in their community rather than remain confined to their home by denying them medically necessary home health services. Missouri's illegal home health policies disregard the Olmstead requirement to ensure that people with disabilities receive services in the most integrated settings possible. Forcing Missourians to become homebound or need skilled nursing care in order to receive home health services increases social isolation and has serious adverse health consequences. By restricting community access for people with disabilities, the state is in violation of federal Medicaid law and the Americans with Disabilities Act.

The Olmstead decision requires states to provide services in the "most integrated settings", and DCHR supports initiatives that promote independence, informed choice, and community access. The state of Missouri can spend available funds in more effective ways, changing the system to support independent living, informed choice, and community access. Re-balancing the Medicaid long-term care system is important to the state and to people with disabilities.

February 2, 2010

I appreciate the opportunity to provide public comment on behalf of AARP Missouri. I am Norma J. Collins, advocacy director. AARP just recently became aware of the Lewin Reports, and reviewing them for content, both here in Missouri and at National Office in Washington, D.C. We appreciate the difficult fiscal situation the state is facing, and, unfortunately, the need to implement more cuts to critical services. Glad the state is approaching cuts carefully, and trying to consider various options for both short-term budget cuts, as well as for longer term systems reforms.

I have only had time to look at the recommendations related to LTC, and wanted to make a couple of brief comments this afternoon:

- Particularly struck by the Nursing Home over bedding and would encourage you to pursue some of the recommendations noted to "right size" the institutional capacity in the state. I would think a lot of the "low care" people in facilities should be in their homes or in community settings.
- As you might suspect, AARP Missouri would like any "savings" and more emphasis to be placed on expanding and improving HCBS.
- More work on suggestions in the Lewin report, improving the intake/process, more case management, finish developing our Single Point of Entry, and implementing an assisted living waiver all make sense.

We urge extreme caution about imposing hard caps on personal care services-- any caps need to be carefully tied to needed service use. AARP is also concerned about reducing rates to HCBS providers without more, careful study. We support many of the structural reforms discussed, like agency/program consolidation.

We will be monitoring progress, and am looking forward to the opportunity to working with you to make current delivery system more efficient...so that seniors and persons with disabilities can get access to the quality services they need so badly.