



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

MO HealthNet Long Term Care Review

Cost Containment Opportunities

November 30, 2009

Revised Version 1/7/2010

About This Report

- The purpose of this report is to present strategies for containing costs for long-term care (LTC) services in Missouri's Medicaid program, MO HealthNet.
- This report focuses on short-term cost containment opportunities, but it also previews longer-term opportunities for improving the long term care system.
- This report is a deliverable under MO HealthNet's contract with The Lewin Group. However, all opinions and recommendations reflect those of The Lewin Group, not MO HealthNet or any of its sister agencies.

Where Missouri Ranks

(data is for elderly and people with physical disabilities)

- **Proportion of Medicaid LTC spending for HCBS**

- On this measure, MO has been consistently higher than the national average and was trending higher through 2005

	1995 % HCBS	2005 % HCBS	% Point Change
MO	12.8	27.9	15.2
U.S.	11.8	23.7	11.9

- **Medicaid NF census per 1,000 people 65+**

- Nursing facility utilization has been consistently higher than the national average, and MO is making less progress in reducing those numbers

	1995	2005	% Change
MO	35.3	30.9	-12.5
U.S.	30.2	25.7	-15.2

- **Total Medicaid LTC spending per person 65+**

- Missouri is spending less per Medicaid enrollee than the rest of the country, but spending trended higher through 2005.

	1995	2005	% Change
MO	\$768	\$1,452	6.6%
U.S.	\$1,024	\$1,696	5.2%

• Sources: Lewin analysis of CMS 64 (compiled by Medstat), OSCAR (compiled by Mick Cowles), and Census data

• We use data through 2005 due to technical factors related to the national data

■ **Takeaway:** Over the long term, MO has done a good job *funding* home and community-based services (HCBS) but – relative to the rest of the U.S. – has further room for decreasing nursing facility utilization

Where Missouri Ranks, continued

■ Nursing facility (NF) bed supply

- As of 2007, MO had the 5th highest number of beds per 1,000 people age 65+ (66 versus a national average of 45)
- As of 2007, occupancy was far below the national average (74% versus a national average of 85%)
 - See AARP Public Policy Institute. *Across the States: Profiles in Long-Term Care and Independent Living, 2009*. (http://assets.aarp.org/rgcenter/il/d19105_2008_atl.pdf)

■ NF use by “low care” residents

- MO had the 2nd highest rate of “low care” residents among long-stay residents
 - 10.1% versus U.S. average of 5.1%
 - Low care is defined here as not requiring assistance in any of the four late-loss activities of daily living (bed mobility, transferring, using the toilet, and eating) and being in the two lowest RUG groups. By an alternate definition of low care, MO is 5th highest.
 - See Mohr, et al. *Prospects for Transferring Nursing Home Residents to the Community*. Health Affairs, 26, no. 6, 2007.

■ **Note:** On many measures, Missouri looks similar to its neighboring states, even where it differs from the national average. We include regional comparisons in the appendix.

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

- Manage and Limit Service Utilization
- Nursing Facility Right-Sizing Initiative
- Maximize Medicare SNF Benefit
- Reduce Selected HCBS Payment Rates
- Pursue Structural Changes

Table of Contents

	Slide No.		Slide No.
Manage and Limit Service Utilization		Reduce Selected HCBS Rates	
Recapture intake and assessment	9	Reduce personal care/homemaker rates	40
Establish a high cost case review process	12	Reduce adult day health care rates	42
Limit personal care hours/week	14	Pursue Structural Changes	
Limit adult day health care days/week	16	Realign LTC budgets and oversight - global budgeting	46
Aggressively implement Money Follows the Person initiatives	18	Build a case management/service coordination infrastructure	47
Electronic verification system for personal care	20	Establish NF case mix reimbursement system	48
Raise the nursing facility level of care criteria	22	Remove adult day health care from the State Plan	49
Nursing Facility Right-Sizing Initiative		Monitoring LTC - executive dashboards	50
Raise and re-impose NF occupancy standard	27	Re-evaluate fiscal management services	51
Adjust CON rules	29	<i>Acronyms Used in this Report</i>	58
Selective contracting for NF services	31		
Maximize Medicare SNF Benefit			
NF Part A crossover claims	35		
Require Medicare certification for NFs	37		

Prioritized Cost Containment Recommendations

(does not include the longer-term structural changes)

Opportunity	Full Annualized Savings (TF)	FY10	FY11	Priority scale (1-3)	Slide No.
NF Part A crossover claims	\$35m - \$40m	\$10m	\$35m - \$40m	1	35
Recapture intake and assessment	\$3.4m*	-	\$1.7m*	1	9
Reduce personal care/homemaker rates	\$40m	\$13m	\$40m	1	40
Raise and re-impose NF occupancy std	TBD by MHN	-	TBD by MHN	1	27
Aggressively implement MFP	\$350k - \$2m*	-	\$175k - \$1m*	1	18
Reduce adult day health care rates	\$500k - \$1m	\$170k	\$750k	2	42
Personal care limit - hrs/week	\$1m - \$4m	-	\$1m - \$4m	2	14
Adult day health limit - days/week	\$100k	-	\$100k	2	16
High cost case review process	Nominal	Nominal	Nominal	2	12
Raise the nursing facility level of care criteria	TBD	-	TBD	2	22
Selective contracting for NF services	Nominal until 2014	-	-	2	31
Adjust CON rules	Unquantifiable	-	-	2	29
Electronic verification system for personal care	\$8m	-	Nominal	2	20
Require Medicare certification for NFs	\$100k	-	\$100k	3	37

* For two recommendations, actual GR savings would be disproportionately lower due to FMAP issues. See later slides.

Manage & Limit Utilization

- ***Currently, there are only a few constraints on the utilization of Medicaid LTC services in Missouri.*** The current system is primarily funded on a fee-for-service basis with little systematic cost monitoring and minimal case management. Our analysis of Medicaid claims data suggests that some people use extraordinarily high amounts of community services, while some nursing facility residents could be better served at lower cost in community settings.
- ***Ideally, policies to limit HCBS utilization should still allow relatively high levels of service to the people with the highest levels of need.*** Titrating the amount of services based on need helps to promote true substitution of HCBS for nursing facility care. However, blunt tools for limiting utilization may be necessary while developing more person-centered means of utilization control. We created the next set of recommendations in recognition of the operational realities in Missouri. Most (though not all) can be implemented with only modest additional administrative effort.

Recapture the Intake & Assessment Process - Summary

Opportunity summary:

Terminate the 'community partner' method of intake and assessment for the LTC system; consolidate the process with State control

Projected Savings:

\$3.4m*

(total funds over 12 months)
(\$500k GR due to FMAP issues)

Savings First Realized:



Rationale:

- The intake and assessment process is currently driven by providers who have an inherent conflict of interest. Changes to this process are critical.
- See following slide for additional discussion.

Impact on beneficiaries/providers:

- More rigorous enforcement of level of care criteria and development of care plans through an objective party would modestly increase future denial rates and reduce future care plan costs, but these would not affect many current beneficiaries
- Incremental revenue loss for providers

Key Implementation Tasks:

- Statutory change
- Make 'build' v. 'buy' determination
- Develop protocols and/or specifications for RFP

Administrative Considerations:

- DHSS does not have the staffing to manage this process currently. It would likely require administrative time to develop an RFP and conduct a procurement process, plus costs to pay the vendor.
- Costs would be partially offset by decrease in provider billing for nurse assessments, and they may be fully offset by other factors (see following slides).
- Statutory change at 208.895, RSMo.

Recapture the Intake & Assessment Process - Rationale

- ***The intake and assessment process is the front door to the LTC system.*** In Missouri, half of the applicants for HCBS get an assessment and draft care plan from a provider. Although state officials have oversight of the assessments and care plans, staff shortages prevent adequate monitoring, and it does not change the fact that the front door is largely controlled by parties who have a vested interest in “upcoding” and proposing generous care plans. Those parties also have no incentive to counsel Medicaid beneficiaries about their full range of HCBS options.
- ***The states that have won the greatest accolades for reforming their LTC systems -*** Maine, Oregon, Washington, Wisconsin - all maintain a high degree of control over the intake and assessment processes. We believe that this is one of the most important parts of the LTC infrastructure and that investments pay off over the long run.
- ***A state preference to “build” or “buy”*** would shape any serious reform of the intake & assessment process. For example, Oregon, Washington, and Wisconsin have built strong networks of state, AAA, and ADRC staff to manage the intake and assessment processes. Maine, on the other hand, has contracted with a vendor to handle assessment and initial care planning functions. Our sense is that there is little appetite for expanding the state workforce in Missouri, making the Maine model a better fit. Contracting with a Quality Improvement Organization for this function may qualify for 75 percent federal match.
- ***The benefits:*** Greater control over the front door into the LTC system, opportunities for a neutral party (i.e., not a provider) to counsel applicants on their options, more consistent care planning, improved program integrity, and a high probability that per person HCBS costs would decline because providers would no longer be in a position of conducting assessments and developing care plans from which they stand to directly benefit.
- ***In Missouri, contracting to a private entity could free up staff*** who currently work on aspects of the medical/functional eligibility process. These staff should be redeployed to critical functions that need more attention, including (1) oversight of the new contract, including review of initial care plans; (2) high cost case review; (3) providing direct case management/service coordination; (4) assignment to specific nursing facilities to provide transition assistance to people who could return to the community; and (5) quality assurance work. (See our later recommendation on case management in the ‘structural changes’ section.)

Recapture the Intake and Assessment Process - Estimate Detail

- Savings from this proposal are inherently difficult to quantify. They could include savings from:
 - More LOC denials (see MI example)
 - Lower per person costs
 - More people choosing HCBS over institutional services
 - Elimination of payments to providers for conducting the assessments (\$40 per assessment)
- Assumptions/calculation:
 - Savings assumptions: Increase LOC denial rates by 0.5% for NF and 2% for HCBS, decrease per/person HCBS costs by 1%, divert 1% of new admissions that would have stayed for 90+ days from NF to HCBS, eliminate 10,000 \$40 evaluations
 - Cost assumptions: \$172/assessment, 29,000/year at 50% FMAP
 - Savings: \$3.4m TF, but \$500k GR due to FMAP issues (would be \$1.8m GR if admin costs could obtain 75% match through QIO)
- Example:
 - Medicaid providers in Michigan have historically been responsible for assessing nursing home level of care, with state officials periodically auditing a sample of assessments. In November 2007, Michigan shifted the responsibility for the LOC assessments in four regions of the state away from providers to new not-for-profit “single entry point” organizations. The denial rate for people seeking nursing facility care almost immediately increased from 0.29 percent to 1.04 percent. On the surface, this does not appear dramatic, but evaluators note that the savings from this modest change would reach into the millions. See Health Management Associates, *Cost Effectiveness of Michigan’s Single Point of Entry or Long term Care Connection Demonstration*. April 30, 2009.

Establish a High-Cost HCBS Case Review Team - Summary

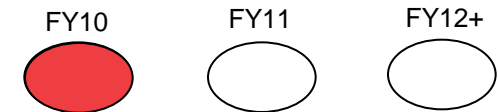
Opportunity summary:

Establish a clinical review team to monitor and investigate high cost cases among users of HCBS

Projected Savings:

nominal
(total funds over 12 months)

Savings First Realized:



Rationale:

- Lack of a systematic process for assessing the high cost cases
- The interagency team would intervene where appropriate on a case-by-case basis
- Team would also identify broader policy problems/solutions

Impact on beneficiaries/providers:

- Some immediate reductions in services, which will lead to potential access issues for beneficiaries, but only where justifiable under current rules and regulations
- It may also lead to substitution of more cost effective alternatives, rather than direct reductions in services

Key Implementation Tasks:

- Identify team members
- Identify support staff
- Establish meeting schedule

Administrative Considerations:

- Need to devote staff time by personnel with clinical expertise, plus time for an analyst to prepare cases and other staff to investigate and follow-through on team's case-specific recommendations.
- Establish mission, identify priorities, and develop workplan with roles and responsibilities
- No legal/regulatory issues. The team would operate in concert with existing rules and regulations for various programs.

Establish a High-Cost HCBS Case Review Team - Estimate Detail

■ Example:

- There are many examples of high service use. Some may be justified, but they warrant careful attention. As an example: for one participant, during FY09 Medicaid paid for 231 days of full-day adult day health care and - on those same 231 days - also paid for an average of over 7 hours per day of day habilitation services.
- In a case like this, the team might:
 - Contact the beneficiary's waiver case manager/service coordinator and primary care provider to review the beneficiary's plan of care and clinical information.
 - Contact the ADHC and day habilitation providers to determine how they coordinate services and what types of special services may be in place for this individual (team should check with program integrity staff to be sure the case is not under investigation before contacting providers).
 - If all services appear to be appropriate, the review may end without further action. Otherwise, the team may recommend changes to the care plan, further investigation/monitoring, and/or refer the case to program integrity staff.
 - Team would consider relevant policy issues. In this example, adequacy of case management and care planning processes, whether ADHC and day habilitation should be allowed on the same date, etc.

■ Recommendations:

- The review team should include reps from DSS, DHSS, and DMH and could be augmented by reps from contractors. Although the team requires some level of clinical expertise, policy and program integrity staff should participate as well.
- To keep the process moving, assign capable support staff to plan meetings, identify cases, follow through on team recommendations, and report to leadership.

Cap Allowable Personal Care/Homemaker per Week - Summary

Opportunity summary:

Establish caps on the allowable personal care and homemaker services. Options:

(a) Set a hard cap per day on number of units

(b) Set hard caps that vary by LOC score or other assessment data

(c) Reduce the levels for the current caps (based on percent of NF costs)

(d) Explore caps or other rules specific to beneficiaries in residential LTC programs

Projected Savings:

\$1m - \$4m, initially

(total funds over 12 months)

Savings First Realized:

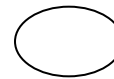
FY10



FY11



FY12+



Impact on beneficiaries/providers:

- For some, a decrease in access to paid in-home services
- Decline in revenue for small number of providers

Rationale:

- Many states impose caps on personal care and related services. Missouri regulations limit the total amount of PC to 60% of NF costs (or 100% for advanced PC or consumer directed services), although some waiver programs allow additional hours. The top user of personal care services received 5,741 hours of PC in 2009. That's over 15 hours, every day, for an entire year.

Key Implementation Tasks:

- Explore options
- Publicize change among providers and recipients
- Establish MMIS edits

Administrative Considerations:

- The admin challenges depend on the options above.
- All options would require regulatory and state plan amendments
- Our preferred option (b) would require some analytic work to determine reasonable thresholds for setting caps tied to assessment info – it could be very sophisticated but could also stay simple (e.g., below a 36 on the level of care assessment, limit to 40 hours per week)

Cap Allowable Personal Care/Homemaker per Week - Estimate Detail

■ Analysis:

- We analyzed claims data for FY 2009 to test the number of hours that exceeded either 40 hours in a week or 56 hours in a week.
- Based on that analysis, we conservatively estimate that a 40 hr/week limit would save \$3.6m TF while a 56 hr/week limit would save \$1m TF.
- The analysis is complicated by the fact that personal care providers can currently bill with date ranges that don't allow us to know how many units were delivered on which days. We created weekly averages based on FY09 claims for recipients with any date range claims.

- **Considerations:** We don't advocate for any draconian caps. However, even a cap of 56 hours per week (8 hrs/day) would have an impact (see above). Tying caps to the level of care score seems like a wise and viable option, but it may require some interface between the LOC score and the MMIS edits.
- As an adjunct to this recommendation, an instrument like the Texas 2060 or the CARES system in Washington could help limit the number of hours based on person-specific assessment information.

- **Example:** In Aug 2009, Colorado proposed to limit personal care and homemaker services to a combined maximum of 5 hrs per day. They expect to save \$1.1m total funds. Arkansas caps homemaker services at 43 hours per week.

Cap Allowable Adult Day Health Care per Week - Summary

Opportunity summary:

Limit the adult day health care benefit to no more than five days per week

Projected Savings:

\$100,000
(total funds over 12 months)

Savings First Realized:



Rationale:

- This would not make a huge dent in overall ADHC spending, and it is not a substitute for good utilization management, but it would prevent current and future excessive use.

Impact on beneficiaries/providers:

- Fewer days of service for a small number of beneficiaries.
- Decline in revenue for a small number of providers

Key Implementation Tasks:

- Review state plan issues (see the 'structural changes' section of this report).
- Propose regulatory amendments
- Establish MMIS edit

Administrative Considerations:

- Would require a new edit in MMIS
- Minor regulatory and state plan amendments
- However, the state plan amendment process would raise important technical considerations that we will discuss in later deliverables.

Cap Allowable Adult Day Health Care per Week- Estimate Detail

■ Notes:

- Only 15 out of 99 centers are open more than five days per week
- We analyzed claims data for SFY 2009 and found \$100,000 in total payments for services beyond five full days/week

■ Notes on the beneficiary impact:

- It seems hard to argue that recipients would be greatly harmed by being limited to five days per week. Indeed, for the outliers we have identified (e.g., an individual with 355 days of ADHC in FY09), it seems highly dubious that any individual would actually freely choose to attend that many days

■ State examples:

- Arkansas limits its ADHC waiver service to no more than 40 hours per week. California has historically limited its comparable state plan benefit to 5 days per week

Real-life MO examples

- Here are the numbers of days of ADHC for the top four clients in SFY 2009 for an ADHC provider in the St. Louis area:
 - Client A - 355 days of ADHC
 - Client B - 354
 - Client C - 352
 - Client D - 352
- Another provider had eight different clients for whom Medicaid paid between 270 and 275 days of service in SFY 2009 (in addition to different clients for whom Medicaid covered 265 and 262 days). The provider was always paid the full day rate of \$70.20.

Aggressively Implement the MO Money Follows the Person Program - Summary

Opportunity summary:

- Prioritize and aggressively implement MO's Money Follows the Person demo and other efforts to help people move out of nursing facilities
- See discussion on the next slide

Projected Savings:

\$350k - \$2m*
(total funds over 12 months)
(\$70k-\$700k GR due to FMAP issues)

Savings First Realized:



Rationale:

- Helping people move out of nursing facilities leads to immediate savings, facilitates *Olmstead* compliance, and captures enhanced FFP in MO for people who qualify under the Money Follows the Person demo

Impact on beneficiaries/providers:

- More chances for beneficiaries to live in the settings of their choice
- Modest revenue decline for NFs; revenue increase for community providers

Key Implementation Tasks:

- Review current MFP operational protocol
- Assess adequacy of that process
- Assess ways to dedicate additional resources to identifying and assisting individuals who want to return to the community

Administrative Considerations:

- No new regulations or statute required
- May warrant new inclusion of one-time transition costs as a 1915(c) waiver service

Aggressively Implement the MO MFP Program- Estimate Detail

■ Calculation:

- Conservative assumptions: assume ½ of 1% of ~15,000 long-stay NF residents transition to HCBS, average monthly savings of \$800 TF, offset by admin costs of \$5,000 TF per transition (at 50% FMAP) = savings of ~\$350k TF over a year (but \$70k GR after factoring for service and admin FMAP rates). The monthly savings of \$800 is 1/3 of the difference between the average NF and average HCBS costs in MO. We used this figure based on the assumption that individuals leaving NFs would require a more expensive mix of services than the average HCBS user.
- Less conservative assumptions: 1% of ~15,000 long-stay NF residents transition to HCBS, average monthly savings of \$1,600 TF, offset by admin costs of \$5,000 TF per transition (half at 50% FMAP and half at 64% FMAP) = savings of ~\$2m TF over a year (but \$700k GR after factoring for service and admin FMAP rates).
- We did not factor for small NF provider tax loss, nor did we assume enhanced FMAP under MFP demo.

■ Discussion/options:

- Escalate and aggressively monitor the Money Follows the Person demo. This is a federal initiative that offers an enhanced FFP rate for certain people who move out of institutions. MO is among the states selected by CMS to participate in the demo. MO is achieving some early successes, and its implementation needs to be a high priority. (See <http://www.cms.hhs.gov/DeficitReductionAct/Downloads/MFPReportNo3Nov09.pdf>)
- Immediately implement the assisted living waiver for people transitioning out of nursing facilities. The assisted living waiver, as we understand it, has been approved by CMS but left unfunded. However, budget language/statute already authorizes money to follow people into community programs. Although the practical ramification of this is limited for other community programs (there are no waiting lists), it is justification to bring funds into the new waiver.
- Consider either (a) contracting with an entity to identify and assist NF residents to move to the community or (b) creating a targeted case management program specific to deinstitutionalization. If possible, pay per successful transition, rather than on an hourly basis. This will create strong incentives while limiting Medicaid's financial exposure.
- Example: Oregon and Washington assign case managers to specific nursing facilities to begin working with individuals immediately on admission to plan for returning to the community. *A person newly admitted to a NF is roughly twice as likely to stay in the NF beyond 90 days in MO than in OR.* (See Mor, et al. 2007)

Electronic Verification System for Personal Care - Summary

Opportunity summary: Implement electronic verification and program management system for personal care services

Projected Savings:

\$8m

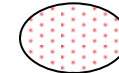
(total funds over 12 months)

Savings First Realized:

FY10



FY11



FY12+



Rationale:

- Cost savings due to more accurate billing
- System provides case managers and PC agencies with up-to-date information concerning care delivery (type, frequency) by requiring that PCAs call a voice-interactive system to report attendance and work performed

Impact on beneficiaries/providers:

- Should improve care to beneficiaries as personal care agencies are better able to monitor delivery of care at home.

Key Implementation Tasks:

- Enroll all personal care assistants as MO HealthNet providers
- Pilot implementation in select areas to allow resolution of implementation issues
- Schedule statewide implementation

Administrative Considerations:

- Would require development of PCA enrollment form and systems and staff to enroll PCAs.
- State would need to issue RFP for a vendor to implement necessary systems and train personal care provider agencies.
- Possible 90%/75% administrative funding from CMS if considered to be tied to MMIS development.
- Adopt regulations requiring all personal care providers to use an electronic system approved by the State for billing.
- Regulations likely necessary to require PCAs to enroll in MO HealthNet and to require PC agencies to use specific electronic system.

Electronic Verification System for Personal Care - Estimate Detail

■ Assumptions:

- No immediate contracting costs since vendors appear willing to implement on a contingency basis.
- PCA enrollment will require 6-12 months to complete, once authorization to require is in effect.
- RFP will require 6 months to procure, and an additional 6 months to set up systems, coordinate with MMIS and begin roll-out to providers; full implementation could occur in FY 2012.
- Will want to start with larger providers first to obtain greatest savings.

■ Calculation:

- Assume potential savings of 5% of personal care spending, although probably could be achieved in late FY11 at the earliest. Assume first-year contingency fee of 50% for vendor ($5\% \times \$313\text{m} \times 50\% = \7.8m); subsequent maintenance fees would be much lower.
- Savings offset by first year costs of enrolling personal care assistants in MO HealthNet (staff costs)

■ Several states are implementing similar systems:

- Oklahoma recently awarded contract to move from pilot to full implementation
 - Tennessee is requiring its managed care plans to use electronic billing systems for these services
 - South Carolina implemented a system several years ago.
- Can be extended to other non-institutional services (e.g., homemaker)

Increase the Level of Care Threshold - Summary

Opportunity summary:

Increase the nursing facility level of care standard by three points each year for three years

Projected Savings:

TBD

(total funds over 12 months)

Savings First Realized:

FY10



FY11



FY12+



Rationale:

- This would incrementally tighten the functional/medical eligibility criteria for nursing facility services and most HCBS options, thus preserving services for those in greatest need
- See next slide for additional discussion

Impact on beneficiaries/providers:

- This would reduce access to LTC services for beneficiaries
- MHN may have some alternatives for providing either Medicaid- or state-only-funded services for people who lose access to services, but this would reduce potential savings

Key Implementation Tasks:

- Analyze potential numbers of individuals affected (we have requested data from DHSS to begin this analysis)
- Develop transition strategy for those individuals who are already receiving services but would no longer qualify

Administrative Considerations:

- Modest admin effort up front. Biggest challenges may be dealing with more appeals and hearings
- We are not aware of any regulatory changes
- State plan change would probably be necessary
- If MHN wanted to set up some limited supports for people who lose access to services, the new administrative effort could be considerable
- *MHN cannot implement this change until ARRA maintenance of effort rules expire*

Increase the Level of Care Threshold - Estimate Detail

- Analysis:

- We have requested from DHSS the data necessary to begin to model the savings for this recommendation.

- Discussion:

- This is not a feel-good proposal. Fewer people will qualify for services. However, it preserves limited Medicaid resources for those with the greatest needs.
- One of the biggest challenges is the prospect of people losing eligibility for nursing facility or HCBS services that they already receive (we do not believe CMS would allow any “grandfathering”). This would be greatly mitigated by gradually increasing the LOC threshold as we propose here. However, this reduces the immediacy of savings as well.
- An 1115 demonstration could allow for grandfathering cases, but this would be a major administrative undertaking and CMS approval is uncertain.

Nursing Facility Right Sizing Initiative

- ***Nursing facility occupancy rates in Missouri are among the lowest in the nation.*** Low occupancy creates two main problems:
 - Medicaid indirectly subsidizes inefficiency by covering a portion of the additional overhead costs associated with extra beds
 - Incentive for providers to fill as many beds as possible, instead of actively assisting residents to return home when they are ready

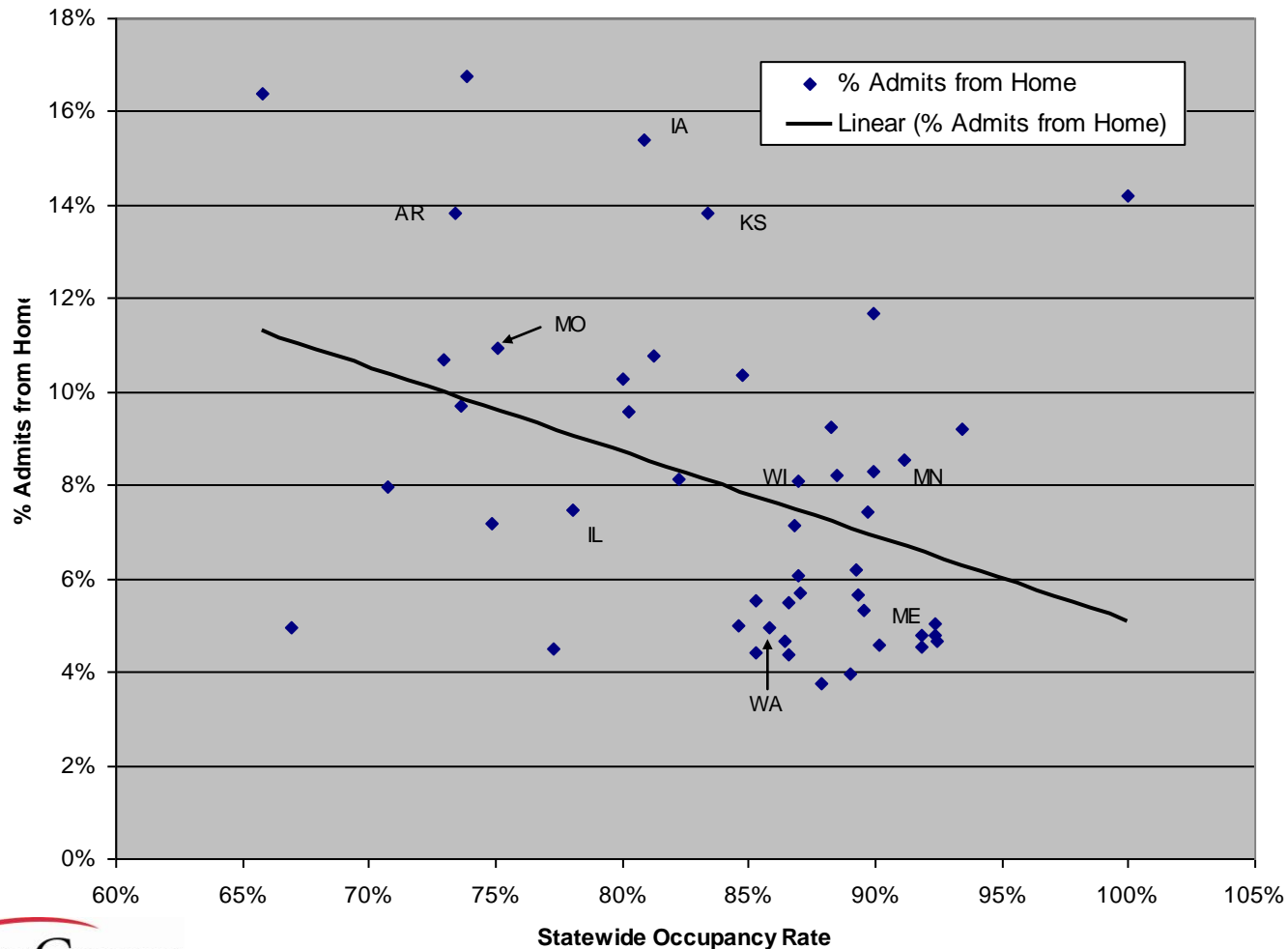
- ***The Nursing Facility Right-Sizing Initiative*** is our proposed package of initiatives intended to move the occupancy rate closer to the national average while reducing (or leveraging) the excess supply through smart purchasing strategies. The initiative includes three different elements:
 - Re-imposing and increasing the Medicaid occupancy standard
 - Adjusting the certificate of need requirements
 - Selective contracting for nursing facility beds in urban areas

Occupancy Rates and Admits from Home, 50 States, 2007

Lewin analysis of data from the Shaping Long Term Care in America Project at Brown University funded in part by the National Institute on Aging (1P01AG027296).

A high rate of admissions from home suggests that NFs are acting like traditional “old folks homes”

Admits from Home v. Occupancy

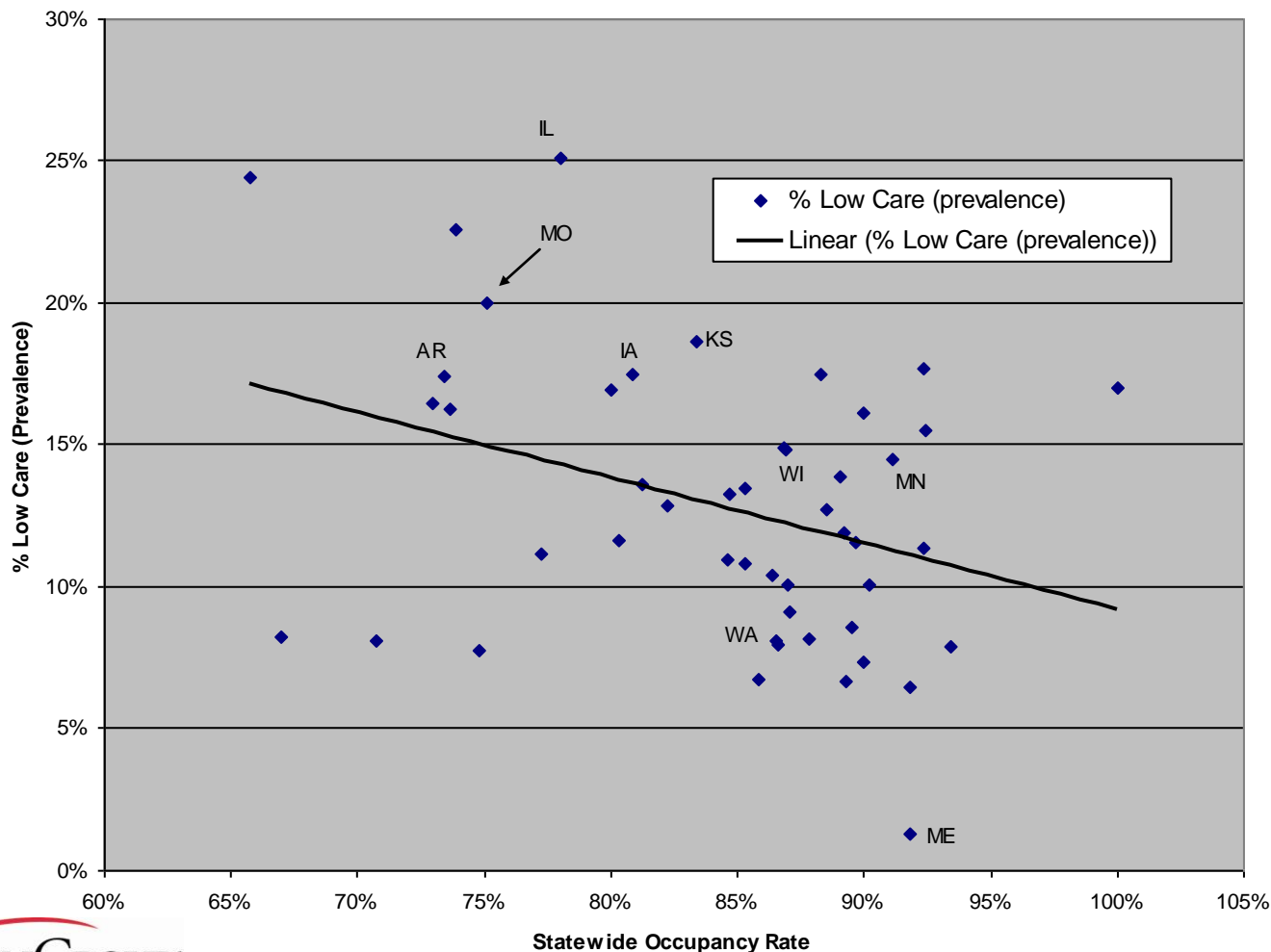


Occupancy v. Prevalence of “Low Care” Residents, 50 States, 2007

Lewin analysis of data from the Shaping Long Term Care in America Project at Brown University funded in part by the National Institute on Aging (1P01AG027296).

A low care resident is defined as a resident who does not require physical assistance in any of the four late-loss ADLs—bed mobility, transferring, using the toilet, and eating—and is not classified in either the “Special Rehab” or “Clinically Complex” Resource Utilization Group

Low Care Prevalence v. Occupancy



■ Note: this metric differs from a similar one earlier in this report. The earlier measure only applied to long-stay residents and was from an earlier year.

Re-impose and Increase the Medicaid Occupancy Standard - Summary

Opportunity summary:

In setting Medicaid NF rates for SFY 2011, use current occupancy data to re-calculate NF rates. Increase the applicable occupancy standard to 90%.

Projected Savings:

TBD by MHN staff
(total funds over 12 months)

Savings First Realized:



Rationale:

- Current Medicaid NF rates include an occupancy standard set at 85%. However, this was last implemented based on occupancy data from 2001 and has not been updated since.
- Therefore, the occupancy standard may be unfairly applied to any NF that has experienced an increase or decrease in occupancy. If the standard is never re-applied, providers have no incentive to adjust the number of licensed beds.
- Increasing the standard to 90% would strengthen the incentive associated with the occupancy standard.

Impact on beneficiaries/providers:

- Limited and indirect impacts on beneficiaries in those facilities that choose to retain licensure for a high number of empty beds, thereby leading to a reduction in Medicaid revenue.
- Any loss in revenue for providers would be avoidable if they reduce bed capacity.

Key Implementation Tasks:

- NF rate setting team obtains current occupancy data, models potential impacts
- Share information with NF industry. They should have time to plan for implementation (in some case, delicensing beds)
- Target implementation with FY2011 rates

Administrative Considerations:

- Additional admin effort, but would still be far less than actual re-basing of rates.
- MHN should also communicate the policy change and explain to providers how they would be affected as early as possible. DHSS would likely experience an increase in requests for changes in bed capacity.
- The change to the occupancy standard would require a regulatory amendment.
- SPA may be necessary as well.

Re-impose and Increase the Medicaid Occupancy Standard - Estimate Detail

- Assumptions: TBD by MHN staff

- Calculation: TBD by MHN staff

- Option:
 - Exempt providers from the occupancy standard if they agree to something else of value to MHN (e.g., making unused space available for a dental clinic that accepts Medicaid clients)

Adjust CON Rules - Summary

Opportunity summary:

Amend CON regulations and bed need formula

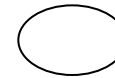
Projected Savings:

unquantifiable

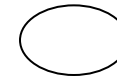
(total funds over 12 months)

Savings First Realized:

FY10



FY11



FY12+



Rationale:

- See following slide

Impact on beneficiaries/providers:

- No impact on beneficiaries
- Some potential providers might be disadvantaged in the future, but this actually protects existing providers from new competition entering the market

Key Implementation Tasks:

- Discuss with DHSS CON staff. They own the process and would need to propose changes to regulations, CON Rulebook, etc.

Administrative Considerations:

- Would require that DHSS pursue changes to regulations, CON Rulebook, etc
- Might reduce the number of CON requests they process in the future

Adjust CON Rules - Estimate Detail

■ Discussion:

- The current CON regulations allow approval of new NF beds where average occupancy within the county and within 15 miles exceeds 90%. *However, recent approvals for new facilities in St. Charles County do not appear to have been held to these requirements.* (See MO Health Facilities Review Committee Application Decisions)
- Furthermore, DHSS and the MO Health Facilities Review Committee base bed need projections on a standard of 53 beds per 1,000 people age 65 and older. We recommend immediately reducing it to the national average of 45 beds/1,000. Better yet, with large numbers of baby boomers hitting age 65 in the coming years, a standard based on beds/1,000 people age 85+ might more appropriately reflect NF demand. It seems unreasonable to assume there is bed need anywhere in Missouri as long as occupancy rates in existing facilities remain so low.
- These changes would have little, if any, immediate impact on Medicaid spending. However, they are important changes as part of a comprehensive approach to right-sizing this industry.

Selective Contracting Pilot for NF Services - Summary

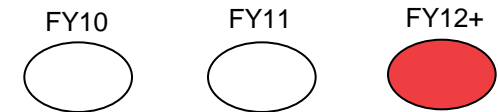
Opportunity summary:

- Seek 1915(b) waiver authority to pilot a new program in St. Louis and KC metro areas to exclude from Medicaid participation the worst performing nursing facility in each area in 2012, 2013, and 2014

Projected Savings:

nominal until 2014
(total funds over 12 months)

Savings First Realized:



Rationale:

- This proposal could reduce excess bed supply while incentivizing quality of care improvements
- See following slide for discussion

Impact on beneficiaries/providers:

- Some number of nursing facility residents would need to relocate to other nursing facilities or to community placements in 2011. By definition, this relocation would be toward a higher performing facility, but every relocation is disruptive and upsetting to those directly involved.
- One provider in each pilot area would likely go out of business, unless it changed its business model

Key Implementation Tasks:

- Inform industry representatives and engage them in the planning process
- Informally discuss with CMS regional office
- Complete 1915 (b) waiver template
- Work with DHSS and industry reps on performance measures

Administrative Considerations:

- This would require CMS approval through a 1915(b) waiver
- Waiver development and reporting will require significant staff time and attention, especially during the initial development phase
- The program should be codified with regulatory language

Selective Contracting Pilot for NF Services - Rationale

■ **Missouri has too many nursing facility beds.**

- Indirectly, Medicaid subsidizes this inefficiency (although an occupancy standard imposed for Medicaid payment rates mitigates this somewhat). Occupancy is low in urban areas, where geographic distance between facilities is relatively limited (e.g., St Louis City and Jackson Co (KC) have 75% occupancy, and St Louis County is at 81%).
- What better way to downsize than by refusing to pay the worst performing facilities? Removal of Medicaid payment would almost certainly lead to closure for a low-performing facility and a reduction in total bed capacity.
- As an alternative, MHN could refuse to pay for new Medicaid residents in those facilities but continue to cover those already receiving Medicaid-funded services. This approach would mitigate both the benefits and costs of selective contracting. Note that many people become newly eligible for Medicaid *after* NF admission.

■ **Benefits**

- Provides major incentive for NF operators in the area to improve performance; better quality for Medicaid beneficiaries; more efficient use of facilities (by improving occupancy in the rest of them when the worst one closes)

■ **Costs**

- This would be controversial, in part because performance measures always leave room for debate. In the short term, NF staff could lose their jobs, and residents would need to move. These costs could only be mitigated by providing intensive assistance relocating people and helping displaced staff find jobs in other NFs or community LTC programs.
- DHSS and MHN would need to dedicate a SWAT team to deal with the closure process. The analysis of the performance measures would also require staff time, although MHN could build from the performance measurement work in other states.

Selective Contracting Pilot for NF Services - Estimate Detail

- Sample Calculation:
 - Starting in 2012, terminate Medicaid participation for one 100 bed NF each year
 - At 80% occupancy and 65% Medicaid utilization, 52 Medicaid recipients would need to move to another setting
 - Assume cost/day is no different, in aggregate, at the other nursing facilities in the area
 - If all 52 individuals transfer to other nursing facilities, \$2.5m in Medicaid payments would now go to other area providers ($\$130 \times 52 \text{ people} \times 365 \text{ days} = \2.5m), no immediate savings
 - For any of the 52 individuals who move to the community, MHN will likely experience some cost savings (e.g., with 5 people at savings of \$10,000, MHN would save \$50,000 TF per year)
 - When the nursing facilities that accept those incoming residents providers submit cost reports covering 2012, per person costs will be marginally lower, as fixed costs are spread over a greater number of resident-days
 - Future rate-setting would reflect this efficiency, but savings would not materialize until 2014

Maximizing Medicare SNF Benefits

- ***Opportunities to maximize federal responsibility for dual eligibles:*** Missouri has vigorously pursued mechanisms for maximizing the federal financial contribution to Medicaid funding. However, there are 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
- We also address potential changes to provider taxes in a separate deliverable

NF Medicare Crossover Claims - Summary

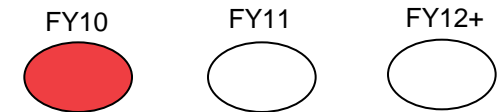
Opportunity summary:

Limit total payment to the NF to the amount MO HealthNet would pay

Projected Savings:

\$35m - \$40m
(total funds over 12 months)

Savings First Realized:



Rationale:

- Repricing permitted by federal reg and done by many other states
- Medicare permits NFs to claim shortfall as bad debt and receive federal reimbursement, reducing impact on providers

Impact on beneficiaries/providers:

- No impact on beneficiaries
- Providers that appropriately document bad debt will get any loss of revenue covered by Medicare, although with some cash flow delay

Key Implementation Tasks:

- Meet with provider groups to review change
- Update State Plan to reflect policy change
- Update MMIS with revised pricing logic

Administrative Considerations:

- Effort to modify MMIS pricing logic
- Modify provider payment notices
- Ensure repricing efforts are also reflected correctly in spenddown requirement
- Update State Plan to reflect policy change

NF Medicare Crossover Claims - Estimate Detail

- Assumptions:

- For 80% - 90% of Part A claims, NFs receive Medicare payments that exceed the MHN per diem (based on the national average RUG-III distribution and MHN average rate)

- Calculation:

- Total NF Part A crossover claim value = \$44.5M (Based on 2008 paid claims)
- $\$44.5 \times 80\% = \35.6M
- $\$44.5 \times 90\% = \40.0M

- A majority of states already use this methodology for pricing SNF Part A co-payments.

Require Medicare Certification for all Medicaid NFs - Summary

Opportunity summary:

Require that all Medicaid-participating nursing facilities also be certified as Medicare SNF providers.

Projected Savings:

\$100,000
(total funds over 12 months)

Savings First Realized:



Rationale:

- There are 13 nursing facilities (678 Medicaid beds) in Missouri that accept Medicaid, but not Medicare. From what we understand, the Medicare certification requirements are not dissimilar from the Medicaid standards. Without Medicare certification, these facilities may be billing Medicaid even when the resident qualifies for the Medicare SNF benefit.

Impact on beneficiaries/providers:

- Probably minimal direct impact on beneficiaries
- 13 providers would be affected

Key Implementation Tasks:

- Discuss with licensing and certification staff at DHSS
- Propose to NF industry; give them a chance to justify why this proposal might hurt certain facilities
- Propose regulations

Administrative Considerations:

- Minimal, although it may require new regulatory language
- Possibly establish a mechanism to exempt rural facilities that cannot meet Medicare certification due to geographic issues.

Require Medicare Certification for all Medicaid NFs - Estimate Detail

■ Analysis:

- This initiative can achieve savings by incenting use of the Medicare Part A SNF benefit in those 13 facilities that do not currently have Medicare certification.
- We assume - although we have not yet confirmed - that some residents in these 13 facilities could have qualified for Medicare SNF benefits, but the facility instead billed Medicaid.

■ Sample Calculation:

- The Medicare SNF benefit covers 100% of the costs of the first 20 days, and if MO pursues the recommendation to re-price Medicare Part A SNF co-payments, Medicare could fully cover up to 100 days after a qualifying hospital stay. Even if that applies to only one resident at each of the 13 facilities per year, the savings could add up (example: $13 \times 100 \text{ days} \times \$130/\text{day} = \$169,000 \text{ TF}$)
- Since this would not decrease revenue in the NF industry, this would have no negative impact on provider taxes. It might nominally help by increasing revenues.

Reduce Selected HCBS Payment Rates

Payment rates for some home and community-based services appear to be higher than necessary, especially in the current fiscal climate. We recommend that MHN and DHSS:

- Reduce rates for personal care & homemaker services
- Reduce rates for adult day health care
- We did not analyze rates for the 1915(c) waiver services that account for smaller overall spending (e.g, home-delivered meals), but some may present other opportunities for modest savings

Reduce Payment Rates for Personal Care and Homemaker Services - Summary

Opportunity summary:

Reduce Medicaid payment rates for personal care and homemaker services by 10%

Projected Savings:

\$40m

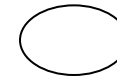
(total funds over 12 months)

Savings First Realized:

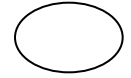
FY10



FY11



FY12+



Rationale:

- Relative to other state Medicaid programs, Missouri appears to pay high rates to personal care agencies. DHSS reports no access problems for people seeking personal care services. We have no evidence on how much of the rate is passed on to direct care workers.

Impact on beneficiaries/providers:

- Comparisons to rates in other states, overall MO utilization trends, and anecdotal evidence on the entry of new providers to the marketplace suggest that beneficiary access to care is not a problem today and would not significantly decrease under this proposal
- Provider revenue will decline

Key Implementation Tasks:

- Communicate with stakeholders
- Revise payment schedule in MMIS
- Potentially review cost report data (see next slide)

Administrative Considerations:

- Minimal

Reduce Payment Rates for Personal Care and Homemaker Services - Estimate Detail

- Assumptions: See the appendix for Medicaid payment rates in other states

■ Calculation: Projected FY 2010 Cost (from MHN documents):

- Personal care: $\$329\text{m} \times 10\% = \33m TF savings
- Homemaker: $\$66\text{m} \times 10\% = \6.6m TF savings
- Sum: $\$40\text{m}$ TF savings

■ Other Considerations:

- We are unaware of any data on how much of the hourly payment to the agencies is ultimately passed through to the personal care workers. DHSS and DSS should consider either requiring cost reports or using some small portion of the savings to fund an evaluation of rates v. costs. The results could justify further cuts, demonstrate why high rates are necessary, or illuminate more efficient purchasing strategies (e.g., shift differentials).
- Another option: require cost reports for high-volume providers and cost settle in future years, allowing the agency to keep some fraction of difference between costs and payment.

Reduce Payment Rates for Adult Day Health Care - Summary

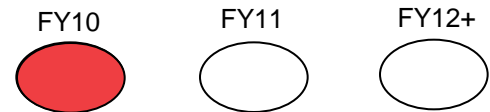
Opportunity summary:

Reduce payment rates for adult day health care by 5% over two years

Projected Savings:

Yr 1: \$500k, Yr 2: \$1m
(total funds over 12 months)

Savings First Realized:



Rationale:

- ADHC utilization has been increasing steadily in recent years, so (by this crude measure) there does not appear to be an access problem
- Several other states pay lower rates, especially relative to regional cost differences

Impact on beneficiaries/providers:

- Minimal, if any, impact on beneficiaries
- Revenue decline for providers

Key Implementation Tasks:

- Communicate with stakeholders
- Revise payment schedule in MMIS

Administrative Considerations:

- Minimal, as long as no state plan amendment is necessary (see later recommendation on moving ADHC out of the state plan)
- ADHC is included in capitation rates in managed care areas. Would you adjust capitation rates to reflect this rate reduction?

Reduce Payment Rates for Adult Day Health Care - Estimate Detail

■ Assumptions:

- Projected FY 2010 costs - \$19.2m TF
- Percent utilization growth - 6.5% (based on FY09 to FY10 only, because eligibility changes of the last several years confound the longer-term trend rates)

■ Calculation:

- Year 1: $\$19.2\text{m} \times 1.025 = \$480,000$ (times growth factor of 6.5% would net \$510,000)
- Year 2: $\$19.2\text{m} \times 1.05 = \$960,000$ ($\$960\text{k} \times 1.065 \times 1.065 = \1.1m)

■ Comparisons to other states:

- Missouri pays ADHC for a half day (3-5 hours) at \$35.60 and a full day (6-10 hours) at \$70.20
- Arkansas, ADHC in their Elderchoices Waiver, paid at \$10.16 per hour (FY 2010)
- Maryland, medical day care, various 1915(c) waivers, paid at \$71.80 per full day (FY 2010)
- Washington State pays between \$49.22 and \$57.44 per day (FY 2009) for adult day health, which includes nursing and therapy services, but not transportation

■ Consideration:

- We haven't studied the issue thoroughly, but a move to an hourly payment rate for ADHC (versus the current ½ day or full day rates) might be cost effective. It would better align the duration of services with payment. We suspect that some providers currently keep participants just long enough to hit the minimum time for full-day billing.

Critical Structural Changes

- *The following slides are not short-term cost containment proposals, but we present them here because (a) they provide important context for some of the cost containment actions, and (b) they require urgent attention, even if they do not tie to immediate savings.*

Critical Structural Changes

- ***There are currently several structural impediments to major improvement in the LTC system.*** The following recommendations begin to address those issues. Some will be more fully explored in future deliverables. We introduce them here to give MO HealthNet and its sister agencies context for the cost containment proposals.
 - Re-align LTC budgets and oversight in one agency - global budget for LTC
 - Build a case management/service coordination infrastructure
 - Establish a NF case mix reimbursement system
 - Remove adult day health care from the state plan and shift into 1915(c) authority
 - Monitoring LTC - executive dashboards
 - Re-evaluate fiscal management services for consumer-directed personal care

Re-align LTC budgets and oversight in one agency - global budget for LTC

■ Issue:

- Currently, MHN budgets for and oversees nursing facility services, DHSS budgets for and oversees HCBS for older adults and people with disabilities, and DMH budgets for and oversees the MR/DD system
- This arrangement fragments accountability and impedes planning and coordination

■ Recommendation:

- For services to older adults and people with disabilities, strongly consider re-aligning programmatic and budgetary responsibility for institutional and HCBS within the same agency
 - If not, the level of interagency collaboration and coordination needs to increase significantly beyond where it is today. Most importantly, there needs to be cross-agency budget planning/collaboration.
- Create a global budget for LTC services. The current legislative appropriations are service- or program-specific, and this does not allow executive authority to reallocate funds within the LTC system or leverage investments in one place to achieve savings in another. Several states have used budget flexibility and administrative consolidation as essential components to improving their LTC systems (e.g., OR, NJ, VT, WA, WI; OH is also beginning the process).

Build a case management/service coordination infrastructure

■ Issue:

- There is virtually no case management/service coordination infrastructure for older adults and people with physical disabilities
- This allows for misallocation of resources and inappropriate service utilization

■ Recommendation:

- Begin to build a case management/service coordination infrastructure, starting with high-cost cases
 - As we discuss earlier, contracting out the intake and assessment process could free up state staff to take on this function more aggressively
- Our earlier recommendation on establishing a high-cost case review team could be the starting point for a more robust case management/service coordination system that focuses on helping people stay in the community or re-establishing community supports after hospitalization or institutionalization
- Rather than assign an infinite caseload to a small number of case managers/service coordinators, assign each available case manager/service coordinator a manageable caseload of higher-need individuals on which to focus intensively. The new electronic platform may be a mechanism for efficiently identifying high-need individuals for case management interventions.

Establish a NF case mix reimbursement system

■ Issue:

- Each nursing facility is currently paid based on its costs in 2001, with flat per diem add-ons in some of the subsequent years. The same payment rate applies for all residents within a given facility, regardless of the intensity of services.

■ Recommendation:

- MHN must begin evaluating alternatives to the current payment model to move to a system that pays providers higher rates for higher-need residents.
- This is a critical step toward establishing payment incentives that (a) equip nursing facilities to serve people who might otherwise be in a hospital and (b) mitigate the current incentive to recruit and accept as many low-need residents as possible.
- As part of this process, MHN should continue exploring the possibilities for paying higher Medicaid rates to appropriately-certified special needs units (e.g., vent care, specialized wound care, etc).

■ Fiscal consideration:

- Contrary to assertions in MHN's December 2008 Provider Reimbursement Rate Study, moving to a Medicare-style RUGS payment system would not require that MHN pay Medicare rates. A new case mix system could be designed to be cost neutral.

Remove adult day health care from the state plan and shift into 1915(c) authority

■ Issue:

- ADHC is covered under the state plan rehab option. CMS has been pressing states to no longer allow adult day services under the rehab option, even when it is through a medical model. Maryland, Texas, South Carolina, and Washington either have or are in the process of moving adult day services out of the rehab option and into 1915(c) or 1915(i) authority.
- When CMS receives a SPA request in the rehab option section, the agency often initiates a review of all rehab option services. If CMS takes a similar view of ADHC as they have in other states, this could pose a barrier to approval of any SPA related to rehab - even those not directly related to ADHC. For example, issues on ADHC could prevent or delay DMH from adding additional substance abuse services under the rehab option. Other of our recommendations may require a SPA in the rehab option as well.

■ Recommendation:

- Create an ADHC benefit in the current 1915(c) waivers.
- However, many ADHC clients are not currently in waivers, even though they would all qualify. If MHN or DHSS is uncomfortable with the prospect of all current clients enrolling in the waiver programs, create a new stand-alone ADHC waiver in addition to adding ADHC to the existing waivers.
- For the MR/DD waivers, shift to the DMH budget an amount proportional to the current ADHC use by MR/DD waiver participants. As an added benefit, this will place utilization of day habilitation and ADHC by MR/DD waiver participants under the same system.
- Eliminate ADHC from the state plan. It is possible that CMS would approve a SPA if it contained language sunsetting ADHC (as a state plan benefit) at some future date certain.
- MHN, DHSS, and DMH would need to review or modify the existing plans for meeting CMS' quality assurance requirements under the waivers to be sure they encompass ADHC. May require more staff resources.

Monitoring LTC - Executive Dashboard

- **Issue:**

- Basic metrics on LTC need to be on the executive-level dashboard, updated on a regular basis
- MHN should monitor other aspects of LTC delivery

- **Recommended Metrics for Secretariat/Medicaid Director:**

- Medicaid nursing facility census - monthly

- **Recommended Metrics for MHN and DHSS Staff:**

- Medicaid nursing facility census - monthly
- Average and median LOC scores for the current caseload, by program
- Average and median cost of care plans, by program, by county/region
- Average and median actual expenditures, by program, by county/region

Re-evaluate Fiscal Management Services for Consumer-directed Personal Care

■ Issue:

- In the consumer-directed model of personal care, the Medicaid beneficiary is the employer of record for the personal care attendant. There are multiple models of consumer direction, but states typically arrange for fiscal management services (FMS) to help the beneficiary meet his/her fiduciary obligations as an employer (e.g., tax withholding and reporting, workers comp, etc).
- FMS functions are currently handled through personal care provider agencies. Recently, CMS has been pushing states to clarify and justify their FMS mechanisms as they apply to HCBS waiver services.

■ Recommendation:

- As the Single State Medicaid agency, MHN needs to engage on this issue and partner with DHSS to help manage its resolution
- Collectively, DHSS and MHN should reach out to CMS and take advantage of its technical assistance contractors to assess (a) the current model of FMS, (b) compliance with IRS requirements, (c) liability issues for beneficiaries/employers, and (d) whether MO has opportunities to get a better financial deal on the FMS functions.
- If necessary, work with the CMS technical assistance contractors to identify viable alternatives to the current system.
- We believe that, as long as there is full transparency on this issue, CMS will be willing to reauthorize the waiver programs and give MO sufficient time to evaluate and address the FMS issues.
- We also believe that MO could start to be recognized as a national leader in consumer direction - very few states have such a high penetration of consumer direction.

Appendices

Where Missouri Ranks: A Six State Comparison

Proportion of Medicaid LTC spending for HCBS (for elderly and people with physical disabilities)

	1995 % HCBS	2005 % HCBS	% Point Change
MO	12.8	27.9	15.2
U.S.	11.8	23.7	11.9
AR	20.0	19.9	-0.1
IA	.6	11.0	10.4
IL	6.6	19.6	13.0
KS	11.8	29.9	18.1
MN	4.1	37.5	33.4
WI	11.5	34.3	22.8

Where Missouri Ranks: A Six State Comparison

Medicaid NF Census per 1,000 people age 65+

	1995	2005	% Change
MO	35.3	30.9	-12.5
U.S.	30.2	25.7	-15.2
AR	43.9	32.3	-26.8
IA	31.2	30.7	-1.5
IL	36.1	32.0	-11.4
KS	36.3	30.6	-15.7
MN	45.2	31.9	-29.3
WI	42.9	30.6	-28.8

Where Missouri Ranks: A Six State Comparison

Total Medicaid LT Spending Per Person 65+

	1995 % HCBS	2005 % HCBS	% Point Change
MO	\$768	\$1,452	6.6%
U.S.	\$1,024	\$1,696	5.2%
AR	\$984	\$1,599	5.0%
IA	\$596	\$1,112	6.4%
IL	\$858	\$1,155	3.0%
KS	\$714	\$1,372	6.8%
MN	\$1,818	\$2,214	2.0%
WI	\$1,303	\$2,041	4.6%

Payment Rates for Personal Care & Homemaker Services in Missouri, Other States

State	Hourly rate	Year	Service name
Missouri	(a) \$16.96 (b) \$21.00 (c) \$14.76 (d) \$16.40 - \$18.44 (e) \$16.96	2009	(a) Personal care (b) Advanced personal care (c) Personal care consumer directed and extended personal care in the Independent Living Waiver (d) Personal care in residential or assisted living facility (e) Homemaker/chore services

State	Hourly rate	Year	Service name	NF LOC ²	Labor cost comparison ³	Data Source
Arkansas	\$16.76	2009 (FY2010)	Adult companion, homemaker, and chore service in ElderChoices Waiver	X	Labor cost is 6% lower in AR than MO	AR Medicaid Elder Choices Fee Schedules
Illinois	\$16.23	2009 (FY2010)	In-home services (non-medical assistance with IADLs and ADLs)	X	Labor cost in IL is 13% higher than MO	IL Dept on Aging, FY 2010 Enacted Budget
Iowa	(a) \$13.47 (b) \$20.20	2009 (FY2010)	(a) Attendant care, individual providers (b) Attendant care, agency providers Both apply to multiple HCBS waivers	X	Labor cost in IA is 14% higher than MO	IA Bureau of Long Term Care, Program Manager, HCBS Waiver
Kansas	(a) \$12.68 (b) \$13.52 - \$14.92	2008 (FY2009)	(a) Self-directed attendant care (b) Provider-directed attendant care (higher level includes delegated nursing) Both in HCBS Frail/Elderly Waiver	X	Labor cost in KA is the same as MO	HCBS Frail and Elderly Provider Manual
Maryland	\$9.97 - \$16.61	2009 (FY2010)	Personal care in HCBS waivers for older adults and people with physical disabilities	X	Labor cost is 20% higher in MD than MO	State fee schedule
Massachusetts ⁴	\$13.16	2008	State plan personal care attendant program (consumer-directed)		Labor cost is 32% higher in MA than MO	MA 114.3 CMR 9.00, Final Adoption. (Independent Living Services for the PCA Program)

[1] There is no standardized data source for Medicaid personal care rates, nor do all states define personal care services in exactly the same way

[2] X indicates that service recipients must meet a nursing facility level of care (as is the case in MO). Each state's NF LOC criteria are unique.

[3] Comparison to MO based on mean hourly wages for home health aides from the U.S. Bureau of Labor Statistics.

[4] In MA, rates are subject to collective bargaining agreement. Does not include costs for fiscal management service vendor.

Payment Rates for Personal Care & Homemaker Services in Missouri, Other States (Continued)

State	Hourly rate	Year	Service name	NF LOC ²	Labor cost comparison ³	Data Source
Minnesota	(a) \$15.84 (b) \$17.40	2009 (FY2010)	(a) Personal care services (1:1 ratio) (b) Homemaker Rates and services apply in multiple HCBS waivers	X	Labor cost is 19% higher in MN than MO	State fee schedule
New Mexico	\$13	2008	Personal care (payment to agency for consumer-directed model)	X	Labor cost is 3% higher in NM than MO	Lewin report to state of MN on PCA program
Ohio	\$24.72 first hour, \$12.36 subsequent hours	2008 (FY2009)	Personal care and home health aide in the Home Care Waiver	X	Labor cost is 4% higher in OH than MO	Dept of Job & Family Services Press Release
Oregon	\$15 - \$19	2008	Home care/personal care		Labor Cost is 8% higher in OR than MO	Lewin report to state of MN on PCA program
Texas	\$11.47-12.47	2009	Primary Home Care, Family Care and Community Attendant Services		Labor Cost is 5% lower in TX than MO	TX Health & Human Health Services Commission, PHC, FC, CAS Payment Rates
Washington ⁷	(a) \$16.50 (b) -\$17	2008	(a) Cash & counseling personal care (b) State plan personal care	(a) X (b) no	Labor cost is 15% higher in WA than MO	Lewin report to state of MN on PCA program

[5] X indicates that service recipients must meet a nursing facility level of care (as is the case in MO). Each state's NF LOC criteria are unique.

[6] Comparison to MO based on mean hourly wages for home health aides from the U.S. Bureau of Labor Statistics.

[7] In WA, payment to workers is subject to a collective bargaining agreement. Agencies get to keep \$6 per hour from Medicaid payment for overhead, and the remaining \$10.50 must go to the worker.

Acronyms Used in this Report

- ADHC – adult day health care
- ARRA – American Recovery and Reinvestment Act of 2009
- CDS – consumer-directed personal care services
- DHSS – Department of Health and Senior Services
- DMH – Department of mental Health
- DSS – Department of Social Services
- FMAP – federal medical assistance percentage
- GR – general revenue (state \$)
- HCBS – home- and community-based services
- LOC – level of care
- LTC – long term care
- MFP – Money Follows the Person
- MHN – MO HealthNet
- MR/DD – mental retardation/developmental disabilities
- NF – nursing facility
- PC – personal care
- PCA – personal care assistance or personal care attendant
- PWD – people with disabilities
- RUG – resource utilization group
- SNF – Medicare skilled nursing facility benefit
- TF – total funds (state and federal)

[5] X indicates that service recipients must meet a nursing facility level of care (as is the case in MO). Each state's NF LOC criteria are unique.

[6] Comparison to MO based on mean hourly wages for home health aides from the U.S. Bureau of Labor Statistics.

[7] In WA, payment to workers is subject to a collective bargaining agreement. Agencies get to keep \$6 per hour from Medicaid payment for overhead, and the remaining \$10.50 must go to the worker.



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