



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

# MO HealthNet Comprehensive Review

## Short-term Cost Containment Opportunities

November 30, 2009

Revised Version 1/07/10

# Scope of Report

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- The purpose of this report is to present strategies for containing costs for Medicaid services in Missouri's Medicaid program, MO HealthNet
- This report includes short-term cost containment opportunities, as well as opportunities for operational improvement
- 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

# State budgets nationally are in critical condition

“These are the worst numbers we’ve ever seen...States have been forced to lay off and furlough employees, raise taxes, drain rainy day funds and sharply cut state spending in ways that impact every part of state government.” — Scott D. Pattison, NASBO Executive Director, Nov. 2009

- Mid year shortfalls have opened up in 35 states<sup>1</sup>
- Economic projections indicate that 2011 will be even worse
- At the same time, Medicaid growth is surpassing expectations
  - Total Medicaid spending growth averaged 7.9% across states in FY09, the highest rate in six years
  - Enrollment is expected to grow by 6.6% in FY10<sup>2</sup>
- Federal Medicaid assistance has helped, but is scheduled to end in December 2010
  - The assistance has strings attached, as “maintenance of effort” requirements prevent states from tightening Medicaid eligibility
- Missouri is experiencing the same revenue shortfalls and unexpected Medicaid growth as other states
- Medicaid represents nearly 20% of total GR appropriations in the Missouri FY10 budget

<sup>1</sup> “Recession continues to batter state budgets; state responses could slow recovery,” Center on Budget and Policy Priorities. November 19, 2009.

<sup>2</sup> “The Crunch Continues: Medicaid Spending, Coverage and Policy in the Midst of a Recession,” Kaiser Commission on Medicaid and the Uninsured. September, 2009.

<sup>3</sup> Total GR of \$7.8B from [http://www.mobudget.org/files/Governor%20Restrictions%2010%2028%2009\\_summary.pdf](http://www.mobudget.org/files/Governor%20Restrictions%2010%2028%2009_summary.pdf). Medicaid appropriation of \$1.54B from MOHealthNet.

# Most States are Counting on Medicaid Savings

- Most states seek Medicaid savings through provider payments and pharmacy controls
- States turning to recipient benefit reductions increased between 2009 and 2010
- Few states have implemented recipient eligibility cuts, applications changes, or additional recipient copays
  - Requirements around state receipt of ARRA enhanced matching rates make eligibility cuts particularly undesirable
- States are beginning to look to long term care for cost savings

## State Program Changes Planned to Achieve Medicaid Cost Savings

	2009	2010
Rate cuts	33	39
Pharmacy controls	35	34
Benefit reductions	10	15
Eligibility cuts	1	0
Application changes	0	0
Copay increase	2	3
LTC	8	12

Source: "The Crunch Continues: Medicaid Spending, Coverage and Policy in the Midst of a Recession," Kaiser Commission on Medicaid and the Uninsured. September, 2009.

# 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)

	Opportunity	Total Savings (2009 dollars)			Priority	P-Tax Impact	Slide #
		FY10	FY11	Full Annual			
<b>Rate changes</b>							
1	Reprice NF Part A crossover claims	\$10M	\$40M	\$40M	1		Appx A
2	Don't increase rates under Medicare parity plan	--	\$67.7M	\$67.7M	1		10
3	Reduce fees >80% of Medicare to 80%	\$4.4M	\$13.3M	\$13.3M	1		12
4	Raise and re-impose NF occupancy standard	TBD	TBD	TBD by MHN	1	*	Appx A
5	Reprice Part B crossover claims (hospital)	TBD	TBD	TBD by MHN	1	*	14
6	Reduce personal care/homemaker rates	\$13M	\$40M	\$40M	1		Appx A
7	Implement site of service differential in facility settings	\$3.6M	\$10.9M	\$10.9M	2		16
8	Reduce ADHC rates	\$0.2	\$0.7M	\$0.5 - \$1M	2		Appx A
9	Reprice Part B crossover claims (physician)	\$6.3M	\$18.9M	\$18.9M	2		18
10	Lower unenhanced fill-fee to \$4.20	\$1.8M	\$5.4M	\$5.4M	2	*	Appx B
11	Lower brand ingredient price to WAC+6%	\$6.8M	\$20.5M	\$20.5M	2	*	Appx B
12	Specialty drug MAC pricing	\$3.0M	\$9.1M	\$9.1M	2	*	Appx B
13	Ceiling on inpatient unit cost for MCO enrollee admission	--	\$0.5-3.0M	\$0.5-3.0M	2	*	20

# Summary of Cost Containment Opportunities

	Opportunity	Total Savings (2009 dollars)			Priority	P-Tax Impact	Slide #
		FY10	FY11	Full Annual			
<b>Benefit Management</b>							
14	Expand review and management to psychotropics	--	\$27.2M	\$27.2M	1	*	Appx B
15	Recapture LTC intake and assessment	--	\$1.7M	\$3.4M	1		Appx A
16	Personal care limit - hrs/week	--	\$1 - 4M	\$1 - 4M	2		Appx A
17	Adult day health limit - hrs/week	--	\$0.1M	\$0.1M	2		Appx A
18	Electronic verification system for personal care	--	<\$0.1M	\$8M			Appx A
19	LTC high cost case review process	<\$0.1M	<\$0.1M	<\$0.1M	2		Appx A
20	Rx mgmt. of 3000+ selected participants	\$1.5M	\$14.9M	\$14.9M	2	*	Appx B
21	MCO Rx carve -in (if/when DRE passes)	--	--	\$2.9M	2	*	Appx B
<b>Provider Taxes</b>							
22	Maximize existing provider taxes	\$11M	varies	varies	1		22
23	Modify P-tax statutes to increase access to funds	\$45M	varies	varies	1		24
24	Implement provider taxes on physicians, dentists, other practitioners	--	\$190M	\$190M	3		26

# Summary of Cost Containment Opportunities

	Opportunity	Total Savings (2009 dollars)			Priority	P-Tax Impact	Slide #
		FY10	FY11	Full Annual			
<b>Program Integrity</b>							
25	Impose Post-Adjudication/Pre-Payment Overlay Edits to Enhance Program Integrity	--	\$8.9M	\$17.8M	1	*	28
26	Expand PARIS match	--	\$3.7M	\$11M	1		30
27	Strengthen/expand lock-in process	\$1.0M	\$5.1M	\$7.0M	2		32
<b>General Taxes</b>							
28	Increase cigarette tax	--	\$597M	\$597M	1		35
29	Increase alcohol taxes	--	\$34M	\$34M	1		37
30	Impose "sugar tax"	--	\$61M	\$61M	2		39
<b>Other</b>							
31	Pursue additional supplemental Rx rebates	\$1.0M	\$2.9M	\$2.9M	1		Appx B
32	Aggressively implement Money Follows the Person	--	\$0.2 - \$1M	\$0.3 - \$2M	1		Appx A
33	Require Medicare certification for NFs	--	\$0.1M	\$0.1M	3		Appx A
34	Increase co-pay amounts for selected services	--	\$5.6M	\$5.6M	3		41

# Additional areas investigated for short-term savings

Area	Reason not included as short-term opportunity
Reducing hospital/nursing facility rates	Provider tax implications for both; low rates for NFs
Revisit provider tax exempt status for public benefit	Not likely to yield short-term benefit; IL case currently before State Supreme Court
More restrictive PDL	Other than adding psychotropics to PDL, review indicated current PDL appropriately restrictive
90-day supply of maintenance meds	Provider tax impact eliminated savings potential
Monthly drug limit	Felt that high users could be managed more appropriately with other initiatives
Eliminate duplicate capitation payments	Data did not indicate significant problem
Tightening eligibility requirements / groups	Prevented by ARRA maintenance of effort (MOE) requirements
Call center staff realignment	Current staffing appropriately distributed between state staff and vendor
Implement National Correct Coding Initiative (NCCI) edits	Staff report NCCI edits implemented in 2007
Conduct provider education to limit claims volume to avoid additional MMIS contract payments	Limited savings associated with issue



# Lewin Does Not Recommend Cutting Optional Benefits

- Federal statute permits a number of optional benefits, many of which are covered by state Medicaid programs
- Although states are not required to include these services in their Medicaid program, many optional services allow states to maximize federal revenues (e.g. ICF-MR services) which states would otherwise need to cover with state-only dollars
- EPSDT statutory requirements ensure that all medically necessary services are provided to children, regardless of whether services are optional or are excluded from Medicaid state plan

## Examples of Medicaid Optional Benefits:

- |  |  |                                |
|--|--|--------------------------------|
| ■ Prescribed drugs   | ■ Dental services                            | ■ HCBS Waivers if cost-neutral |
| ■ Physical, occupational, speech therapy                   | ■ Prosthetic devices                         | ■ Respiratory care services    |
| ■ Licensed practitioners' svcs (e.g., podiatrists, psych.) | ■ Diagnostic, screening, preventive services | ■ Hospice care services        |
| ■ Private duty nursing                                     | ■ Nurse practitioner                         | ■ Optometric services          |
| ■ Clinic services  | ■ Personal care services                     | ■ ICF/MR services              |
|  |  | ■ Case management services     |

- Lewin does not recommend cuts to optional benefits
  - Savings potential is limited, particularly when conventional wisdom is that at least 50% of spending shifts to other services (e.g., using ER for serious dental issues resulting in higher ER utilization) and some services substitute for more expensive mandatory services
  - Beneficiaries will delay uncovered care, while also seeking other service delivery options to obtain needed care
  - Alternative sources of care may ultimately be more costly to the State
  - Aside from cuts, benefit limitations may also be considered
- Dire budget situations have compelled some states to cut optional benefits
  - 2009:<sup>1</sup>
    - MI eliminated all dental, hearing aids, chiropractic, podiatry, eyeglasses and associated vision services
    - NE placed limits on dental, therapies, hearing aids, eyeglasses, and chiropractic
    - UT eliminated audiology, therapies, eyeglasses, and chiropractic for non-pregnant adults
  - 2010:<sup>1</sup>
    - CA eliminating acupuncture, dental (with exceptions), audiology, optometry, podiatry; psychology, chiropractic services and incontinence supplies (for both FFS and MC non-institutionalized, non-pregnant adults)
    - NM has considered eliminating all optional benefits

# Do Not Implement Increases to Rates for which SB577 Required Medicare Parity - Summary

Priority - 1

## Opportunity summary:

- Do not increase provider rates expected to increase under Medicare parity plans required by SB577

## Projected Savings:

FY11 - \$67.7M

## Savings First Realized:



## Rationale:

- Under current budget climate, rate increases would require significant cuts to other program appropriations

## Impact on Beneficiaries/Providers:

- Providers will not receive increases anticipated under four-year plan

## Key Implementation Tasks:

- Work with the Governor's office and General Assembly to ensure that rate increases are not funded through appropriation process

## Administrative Considerations:

- MO Revised Statutes §208.152.1(23) requires that MO HealthNet propose rate increases pursuant to its four-year Medicare parity plan
- Recommendation is more appropriately directed to Governor and General Assembly
- Moving forward with parity plan may be considered in future fiscal years once budget climate improves

# Do Not Implement Increases to Rates for which SB577 Required Medicare Parity - Estimate Detail

- Assumptions:
  - Estimates based on MO HealthNet calculations of the increases required in year one of the four year Medicare parity plan
  - Estimates include reduction of fees to 100% of parity if applicable

	FY11 Appropriation Increase
Physician Related Services	\$44.5 million
Dental	\$11.2 million
Ambulance	\$7.8 million
Optical	\$2.5 million
DME	\$0.95 million
Rehab Center Therapy	\$0.40 million
Hospice	\$0.22 million
Audiology	\$0.13 million
TOTAL	\$67.7 million

# Reduce Fees That Exceed 80% of Medicare Allowed - Summary

Priority - 1

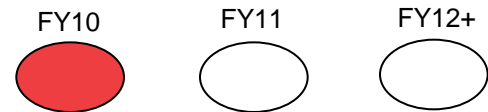
## Opportunity summary:

- Reduce all fees that currently exceed 80% of Medicare fees to 80% of Medicare allowable amount

## Projected Savings:

FY10 - \$4.4M  
FY11 - \$13.3M

## Savings First Realized:



## Rationale:

- MO fees for physician services were approximately 72% of Medicare in 2008, equal to the U.S. average\*
- States with lower average fees include OH, MI, IL, IN
- Reducing fees that exceed a ceiling is preferable to a percent reduction of all fees regardless of their current level

## Impact on Beneficiaries/Providers:

- No direct impact; however, providers are likely to claim that reduced fees will result in reduced access
- Fees are highest for radiology, lab, and DME relative to Medicare, and these areas account for the majority of savings

## Key Implementation Tasks:

- Relatively easy to implement requiring only a provider bulletin and updates of fee schedules

## Administrative Considerations:

- MMIS fee schedule updates
- Provider bulletin
- Reduced fees likely to result in strong negative reaction from providers, particularly when coupled with the fact that planned increases will be postponed

# Reduce Fees That Exceed 80% of Medicare Allowed - Estimate Detail

## Assumptions:

- MO HealthNet compared Medicaid fee schedule to Medicare non-facility fees for the St. Louis metro area
- Only includes codes with a comparable Medicare fee
- Based on SFY09 utilization, SFY10 MO HealthNet fees and 2009 Medicare fees
- Potential FY10 estimate assumes 4 months of savings based on 2 month claims lag

	Savings if Reduced to 100% Medicare	Savings if Reduced to 90% Medicare	Savings if Reduced to 80% Medicare	Savings if Reduced to 75% Medicare
Anesthesia	\$0	\$0	\$0	\$0
Psychologists	\$0	\$811	\$2,453	\$5,530
Nurse Midwife	\$397	\$576	\$1,335	\$1,956
Podiatry	\$3,104	\$11,510	\$19,994	\$26,243
X-ray	\$2,462,599	\$3,222,841	\$4,372,416	\$5,064,797
Lab	\$1,596,390	\$2,672,785	\$4,387,510	\$5,361,186
Surgery	\$863,624	\$1,223,981	\$1,728,424	\$2,119,053
Medical	\$1,272,744	\$1,621,720	\$2,093,902	\$2,549,216
Ambulance	\$0	\$0	\$96	\$150
Rehab Center Therapy	\$0	\$0	\$7	\$11
Audiology	\$79,049	\$86,680	\$94,312	\$98,128
Dental	\$0	\$0	\$0	\$0
DME	\$521,547	\$1,204,496	\$2,371,690	\$3,098,515
Optical	\$4,755	\$8,731	\$38,165	\$71,395
Total (without copays)	\$6,804,208	\$10,054,131	\$15,110,304	\$18,396,180
<b>Savings (after copays)</b>	<b>\$5.0 million</b>	<b>\$8.3 million</b>	<b>\$13.3 million</b>	<b>\$16.6 million</b>

- Federal legislation impacting Medicare rates should be monitored for impact on savings estimate

# Reprice Part B Hospital Crossovers - Summary

Priority - 1

## Opportunity summary:

Reprice Part B crossovers to limit total hospital payments to no more than the MO HealthNet fee schedule amount

## Projected Savings:

TBD by MHN

## Savings First Realized:



## Rationale:

- 1902(n)(2) of the SSA provides that a state is not required to provide payment to the extent that payment under Medicare would exceed the payment amount under Medicaid
- A review of 20 state plans determined that more than half of states limit payment to the amount that Medicaid would have paid

## Impact on Beneficiaries/Providers:

- No impact on beneficiaries
- Reduction in provider revenue mitigated by bad debt collection from Medicare

## Key Implementation Tasks:

- Meet with provider groups to review change
- Work with General Assembly to modify statute
- Update State Plan to reflect policy change
- Update MMIS with revised pricing logic

## Administrative Considerations:

- Likely requires state plan amendment and regulation (assuming statute change)
- MMIS changes required to implement repricing; however, logic was reportedly programmed previously
- Assume staging of statutory change and MMIS coding would take at least 6 months
- Any net reduction in revenue would reduce provider tax base
- Prior attempt to reprice Part B crossover claims resulted in MO Revised Statutes §208.010 requiring that Part B crossovers be paid in full

# Reprice Part B Hospital Crossovers - Estimate Detail

- Preliminary data run shows outpatient crossover payments of nearly \$80 million (based on CY2008 incurred dates)
- Missouri statute §208.010 currently requires full payment of Medicare Part B coinsurance and deductibles for dual eligibles
- 1902(n)(2) of the SSA provides that a state is not required to provide payment to the extent that payment under Medicare would exceed the payment amount under Medicaid
  - Many states exercise this right and limit total payment to the amount Medicaid would pay
- Reimbursement methodologies and system limitations result in a variety of repricing strategies
- Provider impact is mitigated by the ability to claim bad debt from Medicare

# Implement Site of Service Professional Payment Differential - Summary

Priority - 2

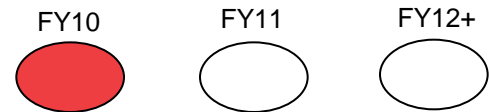
## Opportunity summary:

- Implement fee differential for professional services provided in an office setting versus a facility-based setting

## Projected Savings:

FY10 - \$3.6M  
FY11 - \$10.9M

## Savings First Realized:



## Rationale:

- Unlike Medicare, current fee schedule provides the same reimbursement regardless of where the service is performed
- When services are performed in a facility, overhead expenses are billed by the facility in addition to the physician claim
- May consider both an office increase and facility decrease

## Impact on Beneficiaries/Providers:

- Reduces incentive for physicians to provide services in outpatient hospital setting and may increase proportion of services provided in clinics/offices
- Advocates contend that incentive to move to office-based settings compromises patient safety

## Key Implementation Tasks:

- Calculate differential and update fee schedule
- Update MMIS with revised fees and payment logic
- Work with providers to ensure that site of service is reported consistently and accurately

## Administrative Considerations:

- Physician groups have consistently raised safety concerns related to site of service differential on the grounds that certain procedures are more safely done in hospitals
- Fees can be set through provider bulletin without statutory or regulatory action



# Implement Site of Service Payment Differential - Estimate Detail

- Methodology:
  - Identified procedure codes for which Medicare applies a site of service differential
  - Calculated percent difference in Medicare Relative Value Units
  - Applied Medicare RVU differential to FY08 MO HealthNet payments with a facility-based site of service
  - Potential FY10 estimate assumes 4 months of savings based on 2 month claims lag
  - Estimate does not account for anticipated shift by physicians from facility-based to office-based settings
    - Net savings could be higher based on commensurate decline in facility claims for these services
    - 2008 hospital claims for clinic services (rev. codes 0150-0159) totaled \$22 million
- Differential could be applied along with an overall fee increase for these codes to achieve overall budget neutrality for physician payments
  - Savings decrease by 50% (net savings of \$2 million vs. \$4 million in state share) if fees for these codes are increased by 5%, assuming no change in site of service distribution
  - No net savings if fees for these codes are raised by 10% accompanied by site of service differential, assuming no change in site of service distribution
- Policy makers could also limit the codes to which differential would apply (e.g., Ohio applies 80% reduction only to facility-based office visits, consults, and psychotherapy)
- A number of other states have adopted site of service differential including:
  - Virginia
  - South Carolina
  - Washington
  - Montana

# Reprice Part B Physician Crossovers - Summary

Priority - 2

## Opportunity summary:

Reprice Part B crossovers to limit total physician payments to no more than the MO HealthNet fee schedule amount

## Projected Savings:

FY10 - \$6.3M

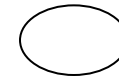
FY11 - \$18.9M

## Savings First Realized:

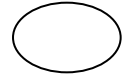
FY10



FY11



FY12+



## Rationale:

- 1902(n)(2) of the SSA provides that a state is not required to provide payment to the extent that payment under Medicare would exceed the payment amount under Medicaid
- A review of 20 state plans determined that more than half of states limit payment to the amount that Medicaid would have paid

## Impact on Beneficiaries/Providers:

- No direct impact on beneficiaries; however, the reduction in payments to physicians could potentially create access concerns
- Overall reduction in physician revenue

## Key Implementation Tasks:

- Meet with provider groups to review change
- Work with General Assembly to modify statute
- Update State Plan to reflect policy change
- Update MMIS with revised pricing logic

## Administrative Considerations:

- Likely requires state plan amendment and regulation (assuming statute change)
- MMIS changes required to implement repricing; however, logic was reportedly programmed previously.
- Assuming staging of statutory change and MMIS coding would take at least 6 months
- Prior attempt to reprice Part B crossover claims resulted in MO Revised Statutes §208.010 requiring that Part B crossovers be paid in full

# Reprice Part B Physician Crossovers - Estimate Detail

- Repricing analysis was performed by MO HealthNet staff. According to MO HealthNet summary report:
  - The following criteria were used to identify the universe of claims to be considered:
    - Paid crossover claims for state fiscal year 2009 with a paid amount greater than \$0.00
    - Only claims for physicians (provider types 20 and 24) and clinics with a physician as a performing provider (provider types 50 and 55, excluding FQHCs)
    - Excluded institutional crossovers
    - Excluded claims for anesthesia procedures codes (0-01999) and J Codes
    - Excluded claims for QMB eligibles
  - The following criteria were used to determine the amounts applicable for each procedure code from the universe of claims identified above:
    - The Medicare paid amount, coinsurance, deductible, PR122 (Psych deductible), blood deductible, spenddown amount, and TPL amount were taken from the crossover claims
    - The procedure code on the crossover claim was compared to the MO HealthNet fee schedule in determining the MO HealthNet allowable
    - The MO HealthNet fee schedule amount was multiplied by the units from the claim form to calculate the MO HealthNet allowable for the detail line
  - For the claims identified above, the MO HealthNet payment amount was \$21.7 million. Based on the criteria outlined, the MO HealthNet payment amount, after repricing, would have been \$2.8 million. The difference is \$18.9 million.
- Estimate may not include repricing for codes that are not on the MO HealthNet fee schedule. This will need to be explored further.
- Potential FY10 estimate assumes 4 months of savings based on 2 month claims lag

# Establish Ceiling On Inpatient Unit Cost for MCO Enrollee Admissions - Summary

Priority - 2

## Opportunity summary:

Establish ceiling that MCO payments will not exceed “x” % (e.g., 105%) of Medicaid fee-for-service unit cost for inpatient services rendered to Medicaid beneficiaries.

## Projected Savings:

**FY11 - \$0.5 - \$3.0M**  
(requires encounter data analyses and MCO input)

## Savings First Realized:



## Rationale:

- Out of network payments to hospitals are often well above Medicaid FFS payment levels; MCOs and hospitals must “haggle” their way to a mutually acceptable payment for each out-of-network claim
- State policy intervention is needed to prevent excess payments

## Impact on Beneficiaries/Providers:

- No direct beneficiary impact
- Would result in lower provider revenues

## Key Implementation Tasks:

- Work with Governor’s office and legislature to develop support
- Conduct encounter data analysis to establish ceilings
- Modify MCO contract language
- Reduce MCO capitation rates to reflect savings
- Modify provider reimbursement manual and administrative code

## Administrative Considerations:

- Decreased hospital revenue would impact provider tax
- May require statutory language

# Establish Ceiling On Inpatient Unit Cost for MCO Enrollee Admissions

- More detailed estimate requires encounter data analysis and MCO input
- For in-network care, policy might be best applied across entire book of an MCO's annual Medicaid admissions at a given hospital. Some MCOs may, for example, negotiate DRG payments that result in reasonable overall costs but that result in payments well above Medicaid for certain short-stay admissions
- MCOs may be reluctant to share the full degree to which “excess” payments are occurring (as this will accordingly reduce their capitation rate)
- Several states have put these types of protections in place. Georgia, for example, requires its MCOs to pay hospitals only 90% of FFS for out-of-network care if MCO can demonstrate that good faith efforts to contract with the hospital at 100% of FFS have failed.

# Maximize Existing Provider Taxes - Summary

Priority - 1

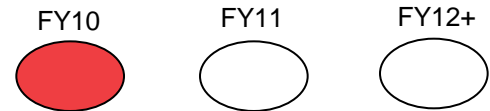
## Opportunity summary:

- Increase provider taxes for hospitals and nursing facilities to 5.45%

## Projected Revenue:

FY10 - \$11M  
(GR equivalent)

## Savings First Realized:



## Rationale:

- 42 CFR 433.68 limits provider tax rates to 5.5% of net patient revenue for the period 1/1/08 - 9/30/11
- FRA is currently at 5.4% and the NFRA is at 5.33%

## Impact on Beneficiaries/Providers:

- No direct beneficiary impact
- Increased tax rate for providers could create cash flow issue

## Key Implementation Tasks:

- Tax rate can be adjusted administratively
- Requires notification to CMS

## Administrative Considerations:

- Current statutes limit flexibility to use tax revenues in other parts of the program
- Maintains minimal "cushion" in the event that provider revenues fall short of projections.
- Increase remains within federal statutory limits and should be approvable by CMS

# Maximize Existing Provider Taxes - Estimate Detail

- Calculation:
    - Estimates based on MO HealthNet budget staff analysis
    - FRA tax increase from 5.4% to 5.45%
      - For FY10 MO HealthNet estimates \$884 million at 5.45%, an \$8 million increase over 5.4%
    - NFRA tax increase from 5.33% to 5.45%
      - For FY10 MO HealthNet estimates \$139 million at 5.45%, a \$3 million increase over 5.33%
- 
- While federal tax limit is 5.5%, it is prudent to maintain a .05% “cushion” in case provider revenues fall short of expectations potentially jeopardizing permissibility of tax
  - Pharmacy provider tax could also be increased; however, current reimbursement system does not include a vehicle to repay pharmacies for tax
  - ICF-MR tax is already near maximum

# Modify Provider Tax Statutes - Summary

Priority - 1

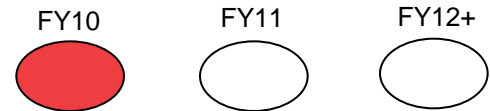
## Opportunity summary:

- Modify provider tax statutes to eliminate or ease limits on use, and carry-over of balances

## Projected Revenue:

FY10 - \$8M (FRA)  
\$37M (NFRA)  
(GR equivalent)

## Savings First Realized:



## Rationale:

- Provider taxes provide state-share eligible for FMAP
- Statutory restrictions limit State flexibility to use funds effectively, even in cases where providers are already paid more than they are taxed.

## Impact on Beneficiaries/Providers:

- No direct impact; additional flexibility could benefit other provider types

## Key Implementation Tasks:

- Work with General Assembly to modify statutes
- Modify budget to apply excess funds to appropriate areas

## Administrative Considerations:

- Current statutes were passed with provider support to ensure that funds are used primarily for the benefit of providers that are taxed
- Modification is likely to be opposed by taxed providers



# Modify Provider Tax Statutes - Estimate Detail

- Calculation:
  - Estimates based on MO HealthNet analysis
  - Current estimates assume a \$5.50 FY10 NF rate increase to offset the tax increase; additional balance of \$16 million could be available without rate increase
  - Estimates include settlements for UPL overpayments and DSH audits

# Implement Additional Provider Taxes - Summary

Priority - 3

## Opportunity summary:

- Implement additional provider taxes on eligible service providers

## Projected GR Equivalent:

FY11 - Physician/Clinical: \$144 M  
Dental Services: \$27M  
Other Prof : \$19.5M

## Savings First Realized:



## Rationale:

- A number of service providers other than those currently taxed are eligible for provider taxes
- Significant revenue could be generated to help fund the state share of Medicaid including rate increases

## Impact on Beneficiaries/Providers:

- Potential for decline in access due to provider loss; but could benefit high Medicaid providers
- If tax is accompanied by rate increases, overall access could actually improve.

## Key Implementation Tasks:

- Work with Governor's office, General Assembly, and provider groups to gain buy-in
- Work with CMS to obtain provider tax and state plan approval

## Administrative Considerations:

- Medicaid volume may be insufficient to permit offsets, thus subjecting tax to Article X, Section 18(e) of the Missouri Constitution
- Ensure that limitation language is not included with new taxes
- Consider sunset language to limit duration of tax program

# Implement Additional Provider Taxes - Estimate Detail

- Assumptions:
    - Estimate based on National Health Expenditures data for 2004 with tax rate of 2% (<http://www.cms.hhs.gov/NationalHealthExpendData/downloads/nhestatespecific2004.pdf>)
    - Physician/Clinical includes services billed independently by physicians and physician operated establishments as well as freestanding lab services
  - Other Professional includes services provided in establishments operated by health practitioners other than physicians and dentists
    - E.g. private-duty nurses, chiropractors, podiatrists, optometrists, and physical, occupational and speech therapists, among other
    - Ambulance services paid under Medicare are also included here.
- 
- Highly contentious issue. Provider taxes are common for institutional providers that are able to recoup the majority of the tax through Medicaid reimbursement. Medicaid represents a far smaller proportion of the business for individual practitioners who are likely to vigorously oppose a tax.
  - Likely resistance and constitutional limits resulted in a low priority ranking for this opportunity
- 
- Such taxes are not widespread.
    - West Virginia taxes physicians as well as freestanding labs/radiology. The physician tax is slated to end in FY11.
    - Michigan recently proposed a 3% physician tax that passed the House, but failed in the Senate. Cuts were imposed, reducing MI rates to about 50% of Medicare.
    - Florida taxes freestanding labs/radiology.

# Apply Post-Adjudication/Pre-Payment Overlay to Existing MMIS System to Enhance Program Integrity - Summary

Priority - 1

## Opportunity summary:

- Contract with a vendor to apply post adjudication/pre-payment edits to existing InfoCrossing MMIS payments.

## Projected Savings:

FY11 - \$8.9M  
Full Annual - \$17.8M

## Savings First Realized:



## Rationale:

- Improves alignment between policy and practice ensuring that providers are paid appropriately for services
- Existing MMIS system is in the process of being re-engineered; thus the ability to make substantive changes to the current system is limited. Applying a post-adjudication review avoids this issue

## Impact on Beneficiaries/Providers:

- No impact on beneficiaries
- Providers may express concern about loss of revenue, but editing should only reduce payment for inappropriate claiming

## Key Implementation Tasks:

- State will need to issue RFP and then work with winning vendor to implement
- Notify providers of nature of changes

## Administrative Considerations:

- State should consider issuing an RFI to solicit information from various vendors and generate vendor interest
- Savings are not expected to accrue until one year from release of an RFP (three months to issue, three months from release to award, and an additional six months to implement).
- State may want to consider performing "dry runs" to alert providers to the impact of the changes so that they are able to correct inadvertent errors

# Apply Post-Adjudication/Pre-Payment Overlay to Existing MMIS System to Enhance Program Integrity- Estimate Detail

- Missouri's MMIS system does not incorporate as many up-to-date edits as it could (e.g., cross-invoicing edits)
- Due to the fact that the system is in the process of being re-engineered, it is not practical for the State to try to implement a broad array of new edits ahead of its current schedule (e.g., the State is planning to add the Fair Isaac<sup>1</sup> rules engine as part of its re-engineering process)
- However, as identified by the provider "dashboards" produced by Thomson, additional editing could produce increased savings
- Vendors are available who can conduct post-adjudication/pre-payment claims reviews which can overlay on existing MMIS systems
  - Iowa recently contracted with a vendor to conduct this type of review for a large variety of edits, including the NCCI edits. Iowa reimburses the vendor based on a 10 percent contingency contract. Vendor required 90 days from start-up to edit implementation.
  - Reported saving in other states have ranged from 2.4% to 5.6%
- We estimate that Missouri can avoid expenditures totaling approximately \$18M on a full annual basis
  - Assume a 1% savings offset by a 10% contingency payment
  - Assume that edits will apply to nursing facility, inpatient, outpatient, and laboratory/x-ray services
  - Savings begin in January 2011 to reflect time needed for RFP process and project implementation

<sup>1</sup>Fair Isaac provides software that helps payers detect fraud, abuse and error in healthcare claims before payment and identify suspicious providers as soon as aberrant behavior patterns emerge.

# Increase Efforts for PARIS Matches - Summary

Priority - 1

## Opportunity summary:

- Begin reviewing the Federal File and Veterans File of the Public Assistance Reporting Information System (PARIS) match with MOHealthNet beneficiaries

## Projected Savings:

FY11 - \$ 3.7M  
Full Annual - \$11M

## Savings First Realized:



## Rationale:

- Missouri currently only using PARIS Interstate File
- Other states found significant cost avoidance when reviewing matches in PARIS Federal File and Veterans File

## Impact on Beneficiaries/Providers:

- Veterans File: State will notify VA to develop Veterans benefits, VA benefits will offset Medicaid payments
- Federal File: CHAMPUS eligibles will be asked to enroll in DEERS to obtain health benefits for themselves and dependents through TRICARE

## Key Implementation Tasks:

- State will need additional staff to validate matches and conduct necessary file updates; VA staff will also be needed to develop Veterans benefits
- Developing Veterans benefits is slow, state experiences indicate often one year until State sees associated savings from matches from the Veterans File

## Administrative Considerations:

- Staff required to validate matches, update TPL file, and refer to VA
- PARIS run quarterly (Feb, May, August and November)
- State must ask CHAMPUS eligibles to enroll in DEERS to obtain health benefits

# Increase Efforts for PARIS Matches - Estimate Detail

## ■ Assumptions:

- Cost calculations based on Washington State's experiences of matches to total cost avoidance
- Assumes the same staff construct as Washington: 2 staff for MO HealthNet and 4 staff in the Department of Veterans Affairs; assumes DVA staff to support the effort
- Assumes earliest savings from February 2010 PARIS match; savings not recognized until FY 2011 due to staff hiring, training, and work to validate matches.
- Loading TRICARE third party coverage to the recipient file will allow Medicaid to avoid costs by exhausting third party payments before paying through Medicaid. The Veterans File also contains information that would allow development of benefits for veterans that in turn may offset expenses or add to income that may be used in the eligibility determination process.

## ■ Calculations:

- Full annual savings of \$11M; first year savings of \$ 3.7M
- Cost Avoidance/Savings Calculation:
  - Based on Washington State's experience, in SFY09 gross savings of \$1181 per beneficiary matched.
  - Missouri has 9500 potential matched beneficiaries.
  - Recognizing slow start, length of time to develop VA benefits (12 months) and recoupment timeframes, only 1/3 of the savings will be realized in the first year: \$3.74 (Gross). (1/3 x 9500 x \$1181)
- Administrative Costs:
  - \$31,716 plus E & E and fringe/ State staff person X 2 = \$63,432 +E & E/fringe
  - \$2.00/indiv for postage, paper, Xeroxing, filing X 3,166 matched beneficiaries = \$6,322

# Increase Number of Participants in Lock-In - Summary

Priority - 2

## Opportunity summary:

- Expand the existing lock-in program by increasing the number of beneficiaries identified, notified and controlled by lock-in.

## Projected Savings:

FY11 - \$1.0M; FY12 - \$5.1M  
Full Annual - \$7M

## Savings First Realized:



## Rationale:

- Current staffing too low to work case volume of prospective lock-in participants
- Increasing lock-in requires only additional staff; no regulatory or system changes required

## Impact on Beneficiaries/Providers:

- Single provider/pharmacy responsible for services for the locked-in participant; Missouri will not pay other providers for services for the locked-in participant except for emergency or authorized referral services

## Key Implementation Tasks:

- Hire and train two additional staff for lock-in

## Administrative Considerations:

- Additional state staff needed to support the required work to identify and place a participant in lock-in
- Savings assume 6 months to hire and train staff and additional 3 months to begin to see lock-in savings
- Missouri staff will need to identify sufficient providers willing to participate in lock-in
- State may consider process improvements for lock-in
- No regulatory or systemic changes required to increase the number of participants in lock-in



# Increase Number of Participants in Lock-In - Estimate Detail

## ■ Assumptions:

- Savings calculation based on hiring 2 new state staff by March 2010 and training over 3 month period
- Following training, additional 2-3 months to complete required notifications to enroll participant in lock-in
- 9 months of savings in FY 2011; 12 months of savings in FY 2012; staff costs represent full year
- Current lock-in staff expenses: \$31,716 annual salary without E&E or fringe; assume same staffing qualifications
- Some additional administrative costs will be necessary to address required notifications (\$2/participant)
- Currently two staff manage 1400 lock-in participants; assumes each new staff enrolls 40 participants each month; 10-participant attrition each month, for an attained number of lock-in participants of approximately 1400 at end of second year
- Staff will assign additional lock-in participants at same rate by provider type as is currently assigned
- Participants locked-in for two years
- It may be necessary to consider provider incentives to encourage participation; no costs attributed to this at this time

## ■ Calculation:

Projected savings (including offset of \$65,000 for annual costs of 2 additional staff and miscellaneous expenses):

FY2011:	\$1.0M
FY2012:	\$5.1M
Full Annual:	\$7.0 M

Calculation assumes savings of \$420/participant/month and reflects accumulating savings as participants in the lock-in program grow from 80 to 1410 participants at the end of FY 2012. Full annual savings reflect ongoing savings of maintaining the additional 1410 participants in the lock-in program.

# Missouri Taxes on Cigarettes, Liquor, and Beer Are Among the Nation's Lowest

State Cigarette, Liquor, & Beer Taxes (as of July 1, 2009)			
	Cigarette Tax (Per Pack)	Spirits Tax (Per Gallon)	Beer Tax (Per Gallon)
Alabama	\$0.425	\$18.78	\$1.05
Alaska	\$2.00	\$12.80	\$1.07
Arizona	\$2.00	\$3.00	\$0.16
Arkansas	\$1.15	\$2.58	\$0.21
California	\$0.87	\$3.30	\$0.20
Colorado	\$0.84	\$2.28	\$0.08
Connecticut	\$2.00	\$4.50	\$0.20
Delaware	\$1.15	\$3.75	\$0.16
Florida	\$1.339	\$6.50	\$0.48
Georgia	\$0.37	\$3.79	\$1.01
Hawaii	\$2.60	\$5.98	\$0.93
Idaho	\$0.57	\$10.96	\$0.15
Illinois	\$0.98	\$8.55	\$0.185
Indiana	\$0.995	\$2.68	\$0.115
Iowa	\$1.36	\$12.47	\$0.19
Kansas	\$0.79	\$2.50	\$0.18
Kentucky	\$0.60	\$6.46	\$0.08
Louisiana	\$0.36	\$2.50	\$0.32
Maine	\$2.00	\$5.21	\$0.35
Maryland	\$2.00	\$1.50	\$0.09
Massachusetts	\$2.51	\$4.05	\$0.11
Michigan	\$2.00	\$10.91	\$0.20
Minnesota	\$1.504	\$5.08	\$0.15
Mississippi	\$0.68	\$6.75	\$0.427
Missouri	\$0.17	\$2.00	\$0.06

State Cigarette, Liquor, & Beer Taxes (as of July 1, 2009)			
	Cigarette Tax (Per Pack)	Spirits Tax (Per Gallon)	Beer Tax (Per Gallon)
Montana	\$1.70	\$8.62	\$0.14
Nebraska	\$0.64	\$3.75	\$0.31
Nevada	\$0.80	\$3.60	\$0.16
New Hampshire	\$1.78		\$0.30
New Jersey	\$2.70	\$5.50	\$0.12
New Mexico	\$0.91	\$6.06	\$0.41
New York	\$2.75	\$6.44	\$0.14
N. Carolina	\$0.35	\$13.39	\$0.53
N. Dakota	\$0.44	\$2.50	\$0.16
Ohio	\$1.25	\$9.04	\$0.18
Oklahoma	\$1.03	\$5.56	\$0.40
Oregon	\$1.18	\$24.63	\$0.0839
Pennsylvania	\$1.35	\$6.54	\$0.08
Rhode Island	\$3.46	\$3.75	\$0.11
S. Carolina	\$0.07	\$4.97	\$0.77
S. Dakota	\$1.53	\$3.93	\$0.27
Tennessee	\$0.62	\$4.46	\$0.14
Texas	\$1.41	\$2.40	\$0.20
Utah	\$0.695	\$11.41	\$0.41
Vermont	\$2.24	\$0.68	\$0.265
Virginia	\$0.30	\$20.13	\$0.2565
Washington	\$2.025	\$26.45	\$0.26
West Virginia	\$0.55	\$1.85	\$0.18
Wisconsin	\$2.52	\$3.25	\$0.06
Wyoming	\$0.60		\$0.019
D.C.	\$2.00	\$1.50	\$0.09

# Increase Cigarette Tax - Summary

Priority - 1

## Opportunity summary:

- Increase the State cigarette tax from \$0.17 to \$0.34 per 20-pack; or
- Increase the state cigarette tax from \$0.17 to \$1.34 per 20-pack (national average)
- Use 50% of revenues to offset current expenditures and 50% to increase smoking cessation or other public health activities

## Projected Additional Revenue:

Full Annual -

\$0.34 tax/pack: \$99M

\$1.34 tax/pack: \$597M

## Savings First Realized:



## Rationale:

- At \$0.17, Missouri has the nation's second lowest cigarette tax
- According to the NCSL, the national average cigarette tax is \$1.34 per 20-pack
- Increasing smoking cessation activities will decrease health care needs in the future
- MO has the 48th lowest price per pack of cigarettes (\$4.08) and the 3rd highest adult smoking rate (25%)

## Impact on Beneficiaries/Providers:

- Increased revenues could be used to increase access to services
- Increases in cigarette taxes will likely lead to decreased smoking rates, especially among low income individuals

## Key Implementation Tasks:

- Work with General Assembly and Governor's Office to garner support for an increase

## Administrative Considerations:

- Requires statute change (Missouri Statute, §149.015)
- Article X, Section 18(e) of the Missouri Constitution could force popular vote; alternatively, tax could be phased in over several years to avoid triggering vote
- Several attempts have been made to raise the cigarette tax in MO with no success
- Politically, this option is a "hard-sell" in the State
- Identification of politically popular public health programs should make increased tax rate more acceptable

# Increase Cigarette Tax - Estimate Detail

- Calculation:<sup>1</sup>
  - Price elasticity was taken into account in developing additional revenue estimates
  - For every 10% increase in the cost of a pack of cigarettes, consumption declines by 4%
  - In FY2008, Missouri had \$97,150,388 in cigarette tax revenue off the sale of 589,147,289 packs of cigarettes
  - Doubling the cigarette tax to \$.34 /20-pack would result in a 4% increase in the cost/pack of cigarettes leading to ~2% decrease in consumption, resulting in 11 million fewer packs of cigarettes sold; state revenues would total \$196 million (\$99M higher than current revenue)
  - Increasing the cigarette tax to the national average of \$1.34 would result in a 29% increase in the cost/pack of cigarettes, resulting in ~70 million fewer packs of cigarettes sold; state revenues would total \$694 million (\$597M higher than current revenue)
- There has been a trend across states to increase the cigarette tax in order to create additional state revenue
  - Missouri is one of four states that has not increased cigarette taxes since 1999
  - In 2007, Tennessee tripled its cigarette tax from \$.21 per 20-pack to \$.63 per 20-pack, resulting in \$239 million in new state revenue for FY2008<sup>2</sup>
  - In 2009, Arkansas increased its cigarette tax to \$1.15 and Kentucky doubled its tax to \$.60
  - The South Carolina House and Senate agreed on a \$.50 cent increase of their \$.07 tax, but couldn't agree on health care programs to fund with the revenue
  - Additional information can be found at: <http://www.ncsl.org/default.aspx?TabId=13862>

<sup>1</sup> Missouri Department of Revenue. Annual data tabulations. [http://www.dmh.mo.gov/ada/rpts/c12\\_000.pdf](http://www.dmh.mo.gov/ada/rpts/c12_000.pdf), Sources: Chaloupka F, The-Wei Hu, Warner K, Jacobs R, Yurekli (2000). "The taxation of tobacco products", Report found at <http://www1.worldbank.org/tobacco/tcdc/237TO272.PDF>, State Cigarette Tax Rates & Rank, Date of Last Increase, Annual Pack Sales & Revenues, and related data. Found at: <http://tobaccofreekids.org/research/factsheets/pdf/0099.pdf>

<sup>2</sup> National Conference of State Legislatures, November, 2009. <http://www.ncsl.org/IssuesResearch/Health/StateCigaretteExciseTaxes/tabid/14349/Default.aspx#State>

# Increase Liquor and Beer Taxes - Summary

Priority - 1

## Opportunity summary:

- 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.

## Projected Revenue:

Full Annual - \$34M

## Savings First Realized:



## Rationale:

- MO beer tax (\$0.06) is lowest in US and liquor tax is 5<sup>th</sup> lowest US
- MO beer excise tax was last changed in 1971 and has lost 81% of its value; if it had kept pace with inflation, it would now be \$0.32
- Wine excise tax was increased in 2008 from \$.36 per gallon to \$.42 per gallon
- Raising alcohol taxes reduces rates of alcohol consumption and heavy drinking<sup>1</sup>

## Impact on Beneficiaries/Providers:

- Increased revenues could be used to increase access to services
- Raising alcohol taxes has potential to help reduce rates of alcohol-related health problems, particularly among underage drinkers

## Key Implementation Tasks:

- Work with General Assembly and Governor's Office to garner support for an increase

## Administrative Considerations:

- Requires statute change (Missouri Statute, §311.550)
- Article X, Section 18(e) of the Missouri Constitution could force popular vote
- Attempt to raise tax on beer, wine and liquor in 2004 did have bipartisan support, but overall lack of support in Committees.

# Increase Liquor and Beer Taxes - Estimate Detail

- Estimate derived from Marin Institute online calculator: <http://www.marininstitute.org/site/tax-calculator.html?view=alcoholtax>
  - Calculation based on Missouri excise tax rates of \$0.06/gallon (beer), \$0.30/gallon (wine), \$2.00/gallon (spirits), and a sales tax rate of 4.23%
  - Underlying data is current as of October 2009
  - Excise and sales tax information from Federation of Tax Administrators, The Tax Foundation and available state data. Does not include local or special taxes
  - Consumption data from The Beverage Information Group's 2009 Wine and Spirits Industry Marketing Handbook, April, 2009. <http://www.adamsbusinessresearch.com>
  - Retail price estimates after a tax or fee increase assume the alcohol industry passes on 100% of the tax to consumers. This is a conservative estimate: Young D.J., Bielinska-Kwapisz A. Alcohol taxes and beverage prices. National Tax Journal. LV-1: 57-73. 2002
  - Alcohol prices elasticities: -0.46 (beer), -0.69 (wine), -0.80 (spirits). Alexander C. Wagenaar, Matthew J. Salois & Kelli A. Komro. Effects of beverage alcohol price and tax levels on drinking: a meta-analysis of 1003 estimates from 112 studies. Addiction, Volume 104, Issue 2, February 2009, (p 179-190)
- There has been a trend across states to increase alcohol taxes in order to create additional state revenue
- Montana has considered taking up to \$1 million a year from alcohol taxes help pay the state's share of mental health Medicaid benefits<sup>1</sup>
  - Taxes offset a million of the dollars the state pulls from its general fund for mental health Medicaid benefits
  - Current statute allows alcohol tax money to be spent on chemical dependency services, including chemical dependency Medicaid payments; the statute does not allow the state to use the money for mental health Medicaid benefits
- Illinois' 2010 budget raised the taxes on beer (25%), wine (90%, from \$0.73 per gallon to \$1.39 per gallon), and distilled spirits by (90%, from \$4.50 per gallon to \$8.55 per gallon)
- Kentucky's governor signed a measure that applies a 6% sales tax on packaged alcohol sales starting April 1, 2009 expected to generate \$51.9 million in FY 2010
- Additional information on these and other examples can be found at: <http://www.ncsl.org/default.aspx?tabid=17254>

<sup>1</sup> Montana Code Annotated 16-1-404. Also at: <http://data.opi.mt.gov/bills/mca/16/1/16-1-404.htm>

# Implement “Sugar Tax” - Summary

Priority - 2

## Opportunity summary:

- Establish a State sales tax of 5% on soft drinks and earmark revenues for Medicaid

## Projected Revenue:

Full Annual - \$61M

## Savings First Realized:



## Rationale:

- Nearly half of states impose a sales tax on soft drinks in vending machines and grocery stores
- Tax would be limited to a product that is linked to obesity and other negative health conditions

## Impact on Beneficiaries/Providers:

- No direct impact on Medicaid beneficiaries or providers

## Key Implementation Tasks:

- Work with General Assembly and Governor's Office to garner support for the tax

## Administrative Considerations:

- Would require statutory approval
- Article X, Section 18(e) of the Missouri Constitution could force popular vote
- Tax would be portrayed as regressive, falling most heavily on low-income individuals
- Strong lobby from soft drink manufacturers, distributors and wholesale dealers against the tax
- Obesity advocacy groups strongly favor soft drink taxes for potential to lower consumption
- Could consider an excise tax, but should prevent price increase from being “spread” across non-sugary drink as well

# Implement “Sugar Tax” - Estimate Detail

## ■ Calculation:

- Estimate derived from Center for Science in the Public Interest online calculator (<http://www.cspinet.org/liquidcandy/index.html>)
  - State sales of soft drinks are based on the fraction of the entire country’s population that lives in each state.
  - A price elasticity of -0.6 is used to estimate the reduction in sales due to price increases. (The -0.6 was based on a review of various estimates, some as high as -1.0). An elasticity of -0.6 means that a 10 percent price increase would lead to a 6 percent reduction in sales.
  - A sales tax would affect only non-diet soft drinks; in contrast, under an excise tax, bottlers and retailers will sell both diet and non-diet carbonated soft drinks at the same price, even though it’s only the non-diet beverages that would be taxed, thereby diminishing by about one-third the effect of the tax on non-diet soft drink consumption.
  - Low-calorie diet beverages represent 30.6 percent of all carbonated soft drink sales. The calculator assumes that no sports drinks, fruit drinks, “energy” drinks, and teas are diet beverages.
  - The average cost of soft drinks (both carbonated and non-carbonated) is 42 cents per 12-ounce serving (including sales from grocery stores, vending machines, restaurants, and other locations) and total sales amount to 14.416 billion gallons annually.

## ■ Example:

- Arkansas passed an excise tax on soft drinks in 1992 and has earmarked the additional revenue from the tax to the Medicaid program
- The Arkansas soda tax is about 2¢ per 12 ounces of soda. The fiscal year that ended on June 30 netted \$47.6 million in revenue from the tax
  - Soft Drink Syrup - \$2.00 per gallon of soft drink or simple syrup
  - Can Drinks - \$.21 cents per gallon of bottled or canned soft drink product; equals \$.02 cents per 12 oz. can of soda
  - Powders - \$.21 cents for each gallon produced by powders or base products

Source: Arkansas Code Annotated 26-57-901. Also at: [http://www.state.ar.us/dfa/excise\\_tax\\_v2/et\\_mt\\_descriptions.html](http://www.state.ar.us/dfa/excise_tax_v2/et_mt_descriptions.html)



# Increase Co-pays for Inpatient, Clinic, Physicians - Summary

Priority - 3

## Opportunity summary:

Increase co-pays for inpatient stays, physician services, and clinic services

## Projected Savings:

FY11 - \$5.6M

## Savings First Realized:



## Rationale:

- MO HealthNet's co-pay amounts for these services are low, both nationally and compared to neighboring states
- Will be portrayed by providers as a rate cut, but unlikely to result in providers leaving the program

## Impact on Beneficiaries/Providers:

- Direct financial impact; concern that higher co-pays could cause participants to forego needed primary care (although participants can decline to pay co-pays and still receive care)
- Providers may have difficulty collecting

## Key Implementation Tasks:

- Update required co-pay amounts
- Update MMIS with new amounts
- Notify providers and participants

## Administrative Considerations:

- Update participant manual and provider manuals
- Need to time increase to MMIS and regulatory changes
- Requires statute change to 13 CSR 70-4.050 "Copayment and Coinsurance for Certain Medicaid-Covered Services"

# Increase Co-pays for Inpatient, Clinic, Physicians- Estimate Detail

- Estimates based on FY09 co-pays; assume FY11 implementation after statute change
- Inpatient Hospital Services:
  - FY09 co-pays of \$10 totaled \$216K in participant out-of-pocket expenses; increase to \$50 would shift an additional \$900K from Medicaid expenditures to participants
  - Missouri's copay for non-emergent inpatient hospital services is significantly lower than neighboring states
  - Kansas has a copay of \$48 per admission, Kentucky has a copay of \$50 per admission, and Tennessee's copays range from \$100-\$200 per admission
- Physician Services:
  - FY09 co-pays at \$1 totaled \$95K; increase to \$3 would save MO HealthNet an additional \$300K
  - Missouri's neighboring states have higher copays for physician services
  - Illinois, Kansas and Kentucky all have copays of \$2 per visit, while Iowa has copays of \$3 per visit
- Clinic Services:
  - FY09 co-pays at \$0.50 totaled \$889K; increase to \$3 would save an additional \$4.4 million
  - Nationally, copays for clinic services on average range from \$1 to \$3
  - Oklahoma is the only neighboring state that has copays for clinic services; its copay is at \$1 per public health service

Note: Estimates based on incurred claims for FY09

# Areas for further consideration by MO HealthNet

- Reinstatement of Managed Care Provider Tax if Congress extends ability to tax only Medicaid MCOs
  - Proposed House bill includes language to extend ability to tax only Medicaid MCOs
  - Budget estimates of \$7.4 million lost revenue in FY11 due to loss of tax
  - Consider introducing a tax on all MCOs, perhaps phasing in to avoid a popular vote under Article X, Section 18(e) of the Missouri constitution
- Ensure Medicare coverage for ESRD after four months of dialysis
  - Data indicate that some, though not many, may be eligible for Medicare but continue to bill the Medicaid program
- Obtaining match for State-only users
  - Does claims information indicate possibility that participants are SSI eligible?
- Blind pension program
  - Review requirements for eligibility, including income, and the ongoing need for the program in its current form
- Optimal targeting of Thomson dashboards and follow-up on appropriate action steps
  - Dashboards are a contracted service provided by Thomson and should be targeted toward areas of particular relevance to MO HealthNet
  - Dashboards that identify areas of concern should be run and worked routinely
  - Current dashboard development has been limited by availability of state staff to work the results; State should consider additional staff to expand investigations to additional areas

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# Appendix A - Opportunities Included in LTC Deliverable

# NF Medicare Crossover Claims - Summary

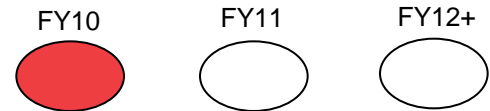
## Opportunity summary:

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)
- $\$44.5 \times 80\% = \$35.6\text{M}$
- $\$44.5 \times 90\% = \$40.0\text{M}$

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

# 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.

# 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:

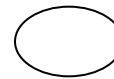
FY10



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:  $\$329\text{m} \times 10\% = \$33\text{m}$  TF savings
- Homemaker:  $\$66\text{m} \times 10\% = \$6.6\text{m}$  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.

# 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

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- Calculation: TBD by MHN staff

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- 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)

# 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)

# Reduce Payment Rates for Adult Day Health Care - Summary

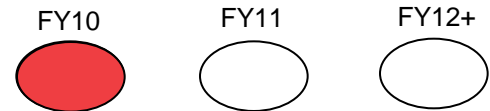
## Opportunity summary:

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:  $\$19.2\text{m} \times 1.05 = \$960,000$  ( $\$960\text{k} \times 1.065 \times 1.065 = \$1.1\text{m}$ )

## ■ 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.

# 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:

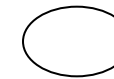
FY10



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.

# Establish a High-Cost HCBS Case Review Team - Summary

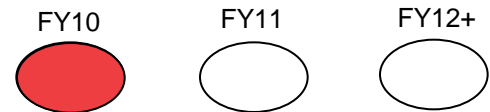
## Opportunity summary:

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.

# 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.

# Selective Contracting Pilot for NF Services - Summary

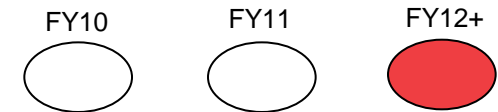
## Opportunity summary:

- 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 ( $\$130 \times 52 \text{ people} \times 365 \text{ days} = \$2.5\text{m}$ ), 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

# Adjust CON Rules - Summary

## Opportunity summary:

Amend CON regulations and bed need formula

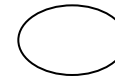
## Projected Savings:

**unquantifiable**

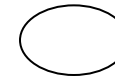
(total funds over 12 months)

## 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.

# Electronic Verification System for Personal Care - Summary

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

Projected Savings:

**\$8m**

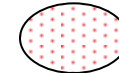
(total funds over 12 months)

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 ( $5\% \times \$313\text{m} \times 50\% = \$7.8\text{m}$ ); 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)



# 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.

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## Appendix B - Opportunities Included in Pharmacy Deliverable

# Summary of Short-Term Savings Estimates

Prioritized Item #	Cost Containment Measure	Estimated Year 1 Savings	State Share of Savings at Enhanced Match (75.16%)	State Share of Savings at Regular Match (63.595%)	Legislative Statute Change Required to Implement This Item?	Estimated FY2010 Net Savings (at best four months of savings is assumed)
1	Psychotropic Medication Review and Management	\$27,186,973	\$6,753,244	\$9,897,418	Yes	\$0
2	Lower Unenhanced Fill Fee to \$4.20	\$5,384,818	\$1,337,589	\$1,960,343	No	\$445,863
3	Tailored Management of 3,000+ Selected Persons	\$14,900,760	\$3,701,349	\$5,424,622	No	\$370,135
4	Managed Care Carve-In (if/when DRE is enacted)	\$2,877,015	\$0	\$1,829,638	Yes	\$0
5	Lower Brand Ingredient Payment to WAC + 6.0%	\$20,547,036	\$5,103,884	\$7,480,148	No	\$1,701,295
6	Specialty Drug MAC Pricing	\$9,125,000	\$2,266,650	\$3,321,956	Yes	\$755,550
7	Pursue Additional Supplemental Rebates	\$2,888,194	\$717,427	\$1,051,447	No	\$239,142
	<b>Total, All Above Measures</b>	<b>\$55,722,824</b>	<b>\$13,126,899</b>	<b>\$21,068,155</b>		<b>\$7,477,088</b>

## Table Notes:

- 1) Above net savings are contingent on pharmacies continuing to pay tax at current percentage levels.
- 2) FY2010 savings values assume measure is in effect for four months (beginning March 1, 2010).

# MO HealthNet Has Developed a Detailed, Thoughtful Approach to Improving Management of Psychotropics

- Incorporation of Evidence Based Medicine (EBM) recommendations
- Consistent with medication management for other therapy classes
- Patient safety is key concern with avoidance of potentially dangerous drug interactions, grandfathering provisions to minimize disruption of existing therapeutic regimens, etc.
- Approach emphasizes assessing unapproved and potentially inappropriate utilization
- Supported by Missouri Department of Mental Health
- MO HealthNet staff have catalogued other states' psychotropic care and cost management approaches
- 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.

# Reducing Dispensing Fees

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- Each \$0.10 reduction in the dispensing fee will yield annual savings of \$0.84 million (all Medicaid funds).
- Reducing unenhanced dispensing fee from \$4.84 to \$4.20, approximately the average of the neighboring states, will yield approximately \$5.4 million in gross annual savings (all Medicaid funds).
- This figure equates to \$1.3 million in state fund savings during CY2010 at the enhanced FY10 federal match rate (75.16%), and \$1.9 million in state savings at the “regular” match rate (64.51%).

# Net Savings Based on Dispensing Fee Reductions

## Estimated 2010 Savings

	# of claims	\$0.10 decrease	\$0.20 decrease	\$0.40 decrease	\$0.64 decrease
Gross Medicaid Savings	8,413,778	\$841,378	\$1,682,756	\$3,365,511	\$5,384,818
State Share using Regular FFY10 FMAP of 64.51%	8,413,778	\$298,605	\$597,210	\$1,194,420	\$1,911,072
State Share using Enhanced FFY10 FMAP of 75.16%	8,413,778	\$208,998	\$417,996	\$835,993	\$1,337,589

- These savings assume the P-tax percentage payment remains unchanged.
- Annualized 2009 costs were trended at 2.5% to estimate 2010 levels.
- Only prescriptions with either \$9.66 dispensing fee on the claim were included.
- The number of scripts was multiplied by the reduction amount (e.g., \$0.10) to estimate the savings.
- As the savings would reduce total pharmacy revenues, the gross savings would be offset at least 1.2% due to a decrease in P-tax revenue collected.

# Many Persons Are High Volume Users On Every Criteria We Assessed

- During 2008, 3,399 persons reached all of the following six usage thresholds:
  1. \$5,000 or more in Rx claims (pre-rebate)
  2. 80 or more prescriptions
  3. 25 or more different NDCs
  4. 15 or more different Standard Therapeutic Classes
  5. 8 or more prescribers
  6. 4 or more different pharmacies used
  
- Total pharmacy claims costs for these beneficiaries (pre-rebate) were \$51.1 million, an average of more than \$15,000 per person
  - These individuals accounted for 8% of total pharmacy spending.
  
- A net 25% reduction in these person's costs would create total Medicaid savings of \$17.9 million and state fund savings of \$6.4 million



# Immediate Suggestions To Intervene And Interact With The High-User Subgroup

- Our short-term recommendation: provide tailored outreach to selected beneficiaries (e.g., those persons meeting all six criteria shown on previous slide during 2008 and/or 2009 to date)
  - Outreach could be performed by an expansion of the existing MO HealthNet Clinical Management Team and its work effort, by an external contractor (possibly APS through a modification of the CCIP program), or by pharmacies under enhancements to existing Medication Therapy Management program
  - Specific scope of work needs to be defined: all targeted patients will receive a comprehensive medication review; interventions will then be tailored based on findings of that review; all intervention activities would be logged so that efficacy of each approach can be tracked; etc
  - State's technology (e.g., Smart PA) can be utilized to create several algorithm-based clinical criteria targeted at potential excess Rx users
  - Substantial share of any external contractor's revenue for this work would be contingent on level of savings achieved
  - MO HealthNet can commission independent survey of these individuals (and possibly their primary prescribers) to discern their satisfaction with the interventions that have occurred
- Based on findings from these initial efforts, adjust and/or broaden the initiative to maximize its effectiveness

# Pharmacy Carve-Out/Carve-In Dynamics

- All indications are that Drug Rebate Equalization (DRE) provisions will be included in any federal health reform bill that is enacted.
- Lewin has estimated that annual savings of up to 15% will occur if Drug Rebate Act is enacted, in situations where carve-out states switch to a carve-in approach.
- However, pharmacy tax program would remove several million prescriptions from the enhanced fill fee setting that is drawing down additional Federal matching funds. The lost Federal match on the enhanced fill fees will offset some, but not all of the savings.
- In Missouri, we estimate that annual net state fund savings of the carve-in will be \$0.3 million to \$3.4 million per year for current capitated covered lives, at regular Federal match rates (after accounting for P-Tax program-related offsets).
- Savings are created by lower usage of medications and lower-cost mix of medications when MCOs are at full risk (rather than no risk) for Rx costs, and by lower dispensing fees and initial ingredient cost payments in MCO setting.
- If DRE and/or a Missouri carve-in is not enacted, there may be ways to strengthen the savings that occur under the carve-out approach (e.g., MCO bonus/penalty clauses tied to effectiveness of medication management).

# Comparison of Advantages: Carve-In and Carve-Out Options

Carve-Out Advantages	Carve-In Advantages
Access full federal and supplemental rebates	Lower volume of medications likely to occur
Single PDL for Medicaid easier for physicians who participate in multiple MCOs	Less costly mix of medications likely to occur
Carve-out substantially increases fill fees and Federal match on the enhanced fill fees.	“Private” PDLs not nearly as much of a target for lobbying and protections (as public PDL)
Rapidly available program-wide Rx data base with claims paid in single MMIS	Best supports integrated care model operationally
Carve-out does not require changing current policy	Aligns financial incentives to focus on each person’s overall costs
	Considerably lower average fill fees
	Members need just one card to access all covered services

# Pharmacy Carve-In: Fiscal Impact Estimate

	Carve-In (Conservative Estimate)	Carve-In (Favorable Estimate)	Carve-Out	Comments
Annual Prescriptions for MCO Enrollees	2,850,000	2,760,000	3,000,000	5% - 8% lower in carve-in
Fill Fee Per Script	\$3.00	\$2.50	\$9.66	\$2.50 - \$3.00 estimated for MCOs
Ingredient Cost Per Script (pre-rebate)	\$58.28	\$56.44	\$61.35	5% - 8% lower in carve-in
Total Cost Per Script	\$61.28	\$58.94	\$71.01	
Total Paid to Pharmacy	\$174,655,125	\$162,679,920	\$213,030,000	
Less Rebates	\$58,136,794	\$54,522,972	\$68,160,000	35% - 37% rebate on ingredient cost assumed
Net Medicaid Cost for Rx	\$116,518,331	\$108,156,948	\$144,870,000	
Net Medicaid Cost Including MCO Risk Margin	\$118,848,698	\$110,320,087	\$144,870,000	2% MCO margin assumed; no admin difference
State Funds Cost at Regular Federal Match (63.595%)	\$43,266,868	\$40,162,028	\$52,739,924	
State Funds Cost at Enhanced Match (75.16%)	\$29,522,017	\$27,403,510	\$35,985,708	
Initial Total Medicaid Savings of Carve-In Model	\$26,021,302	\$34,549,913		
Initial State Fund Savings at Regular Match (63.595%)	\$9,473,055	\$12,577,896		
Initial State Fund Savings at Enhanced Match (75.16%)	\$6,463,691	\$8,582,198		
<b>Federal Match and P-Tax Dynamics</b>				
Enhanced Fill Fee Revenue	\$0	\$0	\$14,460,000	\$4.82 x 3,000,000 scripts
Federal Match on Enhanced Fill Fee Revenue (at 63.595% match)	\$0	\$0	\$9,195,837	
Federal Match on Enhanced Fill Fee Revenue (at 75.16% match)	\$0	\$0	\$10,868,136	
<b>Net State Funds Savings (Loss) at 63.595% Fed Match</b>	<b>\$277,218</b>	<b>\$3,382,059</b>		
<b>Net State Funds Savings (Loss) at 75.16% Fed Match</b>	<b>(\$4,404,445)</b>	<b>(\$2,285,938)</b>		

Note that savings will not accrue in a given year unless: 1) the DRE bill is enacted; 2) pharmacy benefits are carved in; and 3) the bill's equalized rebate provisions are in effect.

Note that carve-in savings require that MCO capitation rates reflect the net costs of the MCOs' effective benefits management efforts.

# Reducing Ingredient Costs: Brand Drugs

- For drugs paid based on WAC, each additional percentage point reduction yields annual savings of approximately \$5.1 million (in total Medicaid funds)
- Moving from WAC plus 10% to the national and regional mean of WAC plus 6% would yield annual savings of \$20.5 million (in total Medicaid funds). This figure equates to \$5.1 million in state fund savings during CY2010 at the enhanced FY10 federal match rate (75.16%), and \$7.3 million in state savings at the “regular” match rate (64.51%)
- P-Tax program is jeopardized by any reduction in ingredient costs
  - Reductions in ingredient costs will likely trigger expiration of the tax. Statutory changes are therefore needed in order for this cost containment option to create net State savings

# Net Savings Based on Reductions to WAC Reimbursement Methodology

## Estimated 2010 Savings

	Est. 2010 Total Ingredient Cost (WAC + 10%)	Gross Savings from Change in Reimbursement			
		WAC + 9%	WAC + 8%	WAC + 7%	WAC + 6%
Gross Medicaid Savings	\$565,043,484	\$5,136,759	\$10,273,518	\$15,410,277	\$20,547,036
State Share using Regular FFY10 FMAP of 64.51%	\$200,533,932	\$1,823,036	\$3,646,071	\$5,469,107	\$7,292,143
State Share using Enhanced FFY10 FMAP of 75.16%	\$140,356,801	\$1,275,971	\$2,551,942	\$3,827,913	\$5,103,884

- These savings assume the P-tax percentage payment remains unchanged.
- Annualized 2009 costs were trended at 5% to estimate 2010 levels.
- Drugs reimbursed using MAC (allowed charge source code = 2 or 3) were not included.
- Each 1% decrease from WAC plus 10% equates to approximately 0.9% savings on ingredient cost.
- As the savings would reduce total pharmacy revenues, the gross savings would be offset at least 1.2% due to a decrease in P-tax revenue collected.

# MO HealthNet is Implementing an Array of Initiatives to Achieve Short-Term Cost Savings in Specialty Pharmacy Area

## Project Timeline

<b>Project</b>	<b>Implementation</b>	<b>Status</b>	<b>Projected Annual Savings</b>
Specialty MAC Pricing	6/24/09	On-going	\$7-10 million
Waste Management	4 <sup>th</sup> Quarter '09		\$1 million
Dose Optimization	November '09		\$125,000
Lab Edit	Pending		\$1 million

- Largest-scale short-term financial savings opportunity involves implementing specialty MAC pricing for more than 1,200 new medications
- A recent Mercer report (April 2009) estimates that a \$6-7 million Year 1 savings could be achieved by implementing specific discounts for single-source brand specialty products
- MO HealthNet staff estimate that savings will increase to \$10 million in Year 2

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